ARKANSAS TECH UNIVERSITY

DEPARTMENT OF NURSING

NUR 4405

PRACTICUM IN NURSING III

NURSING CLIENTS IN CRISIS

Spring 2019

INDEX

Topic **Page**

ARKANSAS TECH UNIVERSITY
Department of Nursing

Course: NUR 4405 (01)

Course Title: Practicum in Nursing III - Nursing Clients in Crisis

Credit Hours: Five (5) Hours

Contact Hours: Five (5) Hours

Placement: Senior Year

Instructors:

Kay Cox
Office: Dean Hall 218 B
Office hours: Posted on Bulletin Board
Phone: 479-964-0583 x4653, Cell 264-9691
Home (501) 440-2338
E-mail: kcox@atu.edu

Loyce Kennedy
Office: Fort Smith
Office Hours: Contact Nursing Office
Phone: Cell 479-414-9208
Home 479-996-4064
E-mail: lkennedy@atu.edu

Carolyn Ricono
Office: Dean Hall 218C
Office Hours: Posted on Bulletin Board
Phone: 479-964-0583 x4667
E-mail: cricono@atu.edu

Laura Jobe
Office: Dean Hall 224M
Office Hours: Posted on Bulletin Board
Phone: 479-964-0583 x 4662
E-mail: ljobe@atu.edu

TBA

Required Textbooks:

Retain texts from previous nursing courses.

Additional Texts:

Hinkle, J., & Cheever, K. (2014). *Brunnar & Suddarth's Textbook of medical-surgical nursing* (13th ed.). Philadelphia, PA: Lippincott, Williams, & Wilkins.

American Nurses Association (2001). *Code of ethics for nurses with interpretive statements*. Silver Spring, MD.

Townsend, M.C. (2018). *Psychiatric mental health nursing* (9th ed.). Philadelphia, PA: F. A. Davis.

American Nurses Association (2004). *Nursing scope and standards of practice.* Silver Spring, MD.

Optional Text:

Nursing Diagnosis Text

Auto-tutorial materials are available in the Student Learning Laboratory for student use.
Required Resources:
Simulation Kit- Purchase at Bookstore

Catalogue Description:

This is a clinical nursing course that provides the opportunity for the integration of concepts and theories taught in NUR 4206. Expected nursing behaviors include promotive, supportive and restorative behaviors. The nursing process is applied in a caring way to the care of clients undergoing major psychosocial and/or physiological maladaptations. The nursing roles utilized in the delivery of care are those of communicator, care giver, collaborator, researcher, teacher, and advocator. The quality of care is measured according to the criteria of professional nursing standards. The practicum is conducted in hospitals, outpatient treatment programs and other community settings.

Justification/Rationale for the Course

By the completion of this course the student will progress toward student learning outcomes 1, 2, 3, 4, and 5.

This upper division professional nursing practicum course provides opportunities for the student to apply knowledge and skills from the general education component and from nursing courses to the care of individuals, families and groups.

Course Objectives:

On completion of the course, the student should be able to:

1. Utilize the nursing process to provide care for individuals, families, and groups who are experiencing physical and/or psychological mal-adaptation.

2. Incorporate promotive, supportive, and restorative concepts in the application of nursing care to individuals, families, and groups in crises.

3. Incorporate roles of care giver, communicator, researcher, teacher, collaborator, and advocator in delivery of nursing care.

4. Apply nursing theories and concepts in the care of individuals, families, and groups experiencing crises.

5. Integrate professional nursing standards into nursing practice.

6. Recognize legal and ethical issues related to the delivery of professional nursing care for clients in crises.

7. Demonstrate scientifically based psychomotor and psychosocial skills.

8. Value the bio-psycho-social, spiritual, and cultural aspects of man in the delivery of caring, holistic nursing care.

9. Apply clinical research findings as they relate to the care of individuals, families, and groups who are experiencing physical and/or psychological crises.

Discrimination Statement:

Arkansas Tech University does not discriminate on the basis of color, sex, sexual orientation, gender identity, race, age, national origin, religion, veteran status, genetic information, or disability in any of our practices, policies, or procedures. If you have experienced any form of discrimination or harassment, including sexual misconduct (e.g. sexual assault, sexual harassment, stalking, domestic or dating violence), we encourage you to report this to the institution. If you report such an incident of misconduct to a faculty or staff member, they are required by law to notify Arkansas Tech University's Title IX Coordinator and share the basic fact of your experience. The Title IX Coordinator will then be available to assist you in understanding all of your options and in connecting you with all possible resources on and off campus. For more information please visit: http://www.atu.edu/titleix/index.php.

Disability Statement:

Arkansas Tech University adheres to the requirements of the Americans with Disabilities Act in order to prevent barriers to academic accessibility. If you need an accommodation due to a disability, please contact the ATU Office of Disability Services, located in Doc Bryan Student Center, Suite 171, or visit http://www.atu.edu/disabilities/index.php.

Attendance and Tardy Policy

The student must attend, on a regular basis, all nursing experiences as attendance is an indicator of professionalism. Absences will be reflected in the evaluation of the student's ability to meet course objectives and may seriously jeopardize the student's grade. For clinical rotations, an absence will result in a make-up assignment. Make-up assignments will equal the number of clinical hours missed. Assignments may vary with instructor. Failure to make up clinical assignments will result in failure of the course. The student is responsible for contacting the instructor regarding make-up assignments within one week of absence. If a student is absent for more than 2 clinical days, the student may be dropped from the course.

The student is responsible for being prepared and on time for all clinical experiences. The student shall review pertinent content and objectives from Nursing 4206 and pertinent objectives and content from this syllabus prior to arrival at the clinical setting.

In the rare event of a necessary absence, personal notification must be made to the proper agency as well as to the clinical instructor prior to the absence.

Planned learning experiences outside the classrooms are an integral part of the nursing course. These experiences will be announced at least three (3) weeks in advance and all students are expected to participate.

The student is responsible for verbally notifying the instructor if he/she will be late to clinicals. Tardiness reflects a lack of professionalism and excessive tardiness will be reflected on students evaluations.

Please refer to Attendance Policy in Student Handbook for further information.

Cell Phone Policy

There is a NO cell phone policy for all upper division testing/test review. This includes paper/pencil testing, test review, cooperative testing, and computer testing. If you are discovered with having a cell phone on your person, this will be considered a violation of the Academic Honesty Policy. If we discover that you have your cell phone with you during a unit exam/cooperative testing or unit exam review you will receive a 0 for the test grade. Also, cell phones are not allowed while on "the floor" in clinical. You may check it at break/lunch. Smart phone use for drug books, resources, etc. are at the discretion of the instructor. Most facilities have alternate resources as many of the cell phones interfere with computer/monitoring technology.

Assessment (Evaluation) Methods

1. Grading Scale

   A = 90-100
   B = 80-89
   C = 75-79
   D = 68-74
   F = 67 and below

2. A grade of "C" or above must be achieved in every nursing course in order to progress in the nursing program.

3. A semester grade of "I" or "Incomplete" maybe recorded for a student who has not completed all the requirements of a course because of illness or other circumstances beyond the student's control, provided work already completed is of passing quality. Before a grade of "I" may be recorded, the student and instructor must determine course requirements to be completed and the completion date. (See Student Handbook)Course Grade

Clinical Performance.....65%

20% Intensive Care	2 clinical quizzes Clinical paperwork
20% Medical-Surgical	2 clinical quizzes Clinical paperwork
20% Psychiatry	2 clinical quizzes Clinical paperwork
5% Professionalism	Professionalism evaluated on five behaviors (5 pt each clinical) A. Professional Dress B. On Time C. Prepared D. Notifies clinical faculty of absence or tardiness E. Follows policy and procedure of clinical facility

Case Presentation 25%
Clinical Articles…..…….....10%

100%

4. All paperwork is due on the date assigned. Failure to meet the deadline may result in a lower grade on paperwork.

Clinical performance must be at least 75% before case presentation will be averaged with that grade.

A grade of 75% or above must be achieved in each clinical area before a passing grade is earned for the course. If a clinical grade falls below a 75%, the student will not be successful in passing Practicum III. The student must also receive S or NI on the Clinical Performance Evaluation Tool as the final grade in each clinical area before a passing grade is earned for the course.

Professional Points: Maximum of two points may be designated for this course.

Academic Honesty

Students are expected to be honest and truthful in both classroom and practicum experiences. They are expected to adhere to the Code of Ethics and uphold current standards of care. Students are referred to the Arkansas Tech University Student Handbook for more specific regulations regarding academic honesty.

Students are expected to:

a. Perform their assigned tasks in the practicum experiences. Students should have the permission of the clinical instructor before using assistance from the staff.
b. Notify the instructor immediately of any clinical error made so that steps can be taken to prevent harm to the patient.
c. Present written work that is theirs alone.
d. Correctly document any materials from a textbook, pamphlet, journal, etc., that is used for an

assignment.

e. Be honest and truthful when writing clinical logs and giving verbal or written reports regarding patient care or the student's clinical experiences or assignments.
f. Only use authorized devices or materials for an examination and not copy from other students' papers.
g. Document material correctly. Plagiarism is defined as stealing and presenting as one's own ideas or words of another, or not documenting material correctly**.** Student papers may be evaluated by turnitin.com which can detect plagiarism. For the first occurrence of academic dishonesty, the student will receive an F. If there is a second occurrence, the student will be dismissed from the program. Students are referred to the ATU catalog and handbook for policies regarding plagiarism.

Conduct of the Course

Communication

A great deal of communication between faculty and students will take place through Blackboard. It is the student's responsibility to regularly check for email messages on their ate.edu e-mail and Blackboard announcements.

Background Checks/Insurance/ C.P.R. Certification/TB Skin Test/Hepatitis B Vaccination:
It is the student responsibility to have all course and agency requirements uploaded to Castlebranch prior to the first day of class. This includes (but is not limited to) any updates to any immunizations, drug screens, unexpired TB skin test, etc. If you do not have this updated PRIOR to the first day of class, ***YOU WILL BE DROPPED FROM THE COURSE AND UNABLE TO PROGRESS IN THE PROGRAM.*** Please see page 22 of Student Handbook "Students are required to keep all documentation current. Students failing to provide current documentation will result in the student being dropped from nursing courses for the current semester."

Students will be required to complete a criminal background check per departmental policy.

Insurance:

All students must show evidence of having liability insurance prior to starting clinical experience.

C.P.R. Certification/TB Skin Test/Hepatitis B Vaccination

All students must present evidence of American Heart Association certification for cardiopulmonary resuscitation, negative TB skin test, and completion of the Hepatitis B vaccinations, as required by the Department of Nursing.`

Transportation:

Students are responsible for having transportation to clinical sites. Students may be required to attend clinical in cities such as Fort Smith, Morrilton, or Conway.

Dress and Behavior:

1. The student must wear the standard school uniform while attending any clinical experience. Appropriate street clothes will be worn in psychiatric care settings. Students are expected to be neat and clean in appearance. When obtaining clinical data for the client assignments, students must wear a laboratory coat with an ATU name badge over their appropriate street clothes (see Dress Code, Student Handbook).

2. The students will be expected to maintain a professional attitude at all times while in the clinical area. Client **confidentiality** must be maintained. Students will abide by the agency's regulating policies.

3. Students are expected to:

   a. Present written work that is theirs alone.
   b. Correctly document any materials from a textbook, pamphlet, journal, etc. that is used for an assignment.
   c. Only use authorized devices or materials for an examination and no copying from other students' papers.

4. All resources must be documented on clinical paperwork.

Clinical Facility Policies

All students will adhere to each clinical facility's policies regarding time spent in the facility, i.e., background check, drug screening, HIPPA training, orientation, etc.

Medication Calculation Exam:

1. The student must pass the Level III medication calculation exam before administering medications in the clinical setting.

2. Passing score is considered to be 100%.

3. The student may have three attempts to pass the exam.

4. If the student does not pass the exam after the third attempt, the student will be withdrawn from the course.

Clinical Expenses

Students may be required to travel for clinical experiences. Expenses may include travel, lodging, and meals. Students are responsible for these expenses. Students will be responsible for a $10 fee to access passport for hospital orientation.

Students will not be allowed to:

Take verbal or telephone orders.
Administer chemotherapy drugs.
Administer anesthesia or conscious/moderate sedation medications.
Manage epidural pain medications.
Administer a medication prepared by another person.
Obtain or sign out narcotics or carry the narcotic key or count narcotics alone.
Draw ABGs.
Witness consent form signatures or other legal patient signatures.
Be a witness on paperwork for blood transfusions.

*Do not give narcotics **(CONWAY CLINICAL GROUP)***
*Do not give medications you CANNOT PULL FROM PYXIS **(CONWAY CLINICAL GROUP)***

Research Day

In either Level III or Level IV (Spring semester) students are required to attend Research Day. Students are encouraged to keep the research day objectives for a Level IV portfolio.

COURSE OUTLINE

PRACTICUM IN NURSING III:

I. Orientation

II. Psychosocial related foci

III. Physiological related foci

IV. Research Day

Teacher Role:

Demonstrator, Evaluator, Facilitator, Resource Person, Role Model, Communicator, and Supporter

Student Role:

Learner, Teacher, Advocate, Care Giver, Collaborator, Communicator, and Researcher

Teacher-Learning Strategies:

A variety of critical thinking activities, including:

Pre and post care conferences, actual and simulated demonstrations, use of resource persons, charts, diagrams, anatomical models, selected observational experiences, nursing interventions for selected groups and selected clients, role play and role modeling, nursing rounds, process recordings, nursing care plans, auto-tutorial materials, and milieu and mental status assessments.

Guidelines for Case Presentation

Each student will present a patient case study. You will be required to present a PowerPoint presentation to your selected group members and instructor(s). Groups will be formed at the beginning of the semester and will be posted in Blackboard. Each instructor will facilitate the group assigned to them and may require group discussions prior to presenting your case presentation. Below are the minimum requirements for your presentation, but please make sure you provide all important information related to your patient. Please use the headings below for your PowerPoint slides. No more than 15 slides should be used. A reference slide in APA format should be included. Provide a copy of the PowerPoint to the instructor. *Note: A maximum of 30 minutes per student will be allowed for presentation. Bring a copy of your presentation and grading tool for the instructor when presenting.*

Each student will be graded on their discussion with the presenter, demonstrating critical thinking and posing a critical thinking question for the presenter to answer. You will be scored with each group member and the total score will be averaged on this section.

1. **Introduction**
   Give an introduction to your patient (age, gender, growth and development, etc.)
   Discuss the medical diagnosis (diagnosis, what happened, etc.)
   Discuss the priority nursing problem (What should you as a nurse focus on or do?)

2. **History**
   Identify past medical history/psychiatric history
   Identify past treatments received up to the time of admission
   (medications, treatments, surgeries, lab tests, etc.)

3. **Pathophysiology/Psychopathology**
   Fully explain their disease process
   Cause and manifestations

4. **Nursing Physical Assessment/Mental status Assessment**
   Write out a complete Head to Toe assessment or Mental Assessment, including: vital signs, intake and outputs, diet therapy, intravenous therapy (Be specific)

5. **Related treatments**
   Discuss medical and/or environmental treatments your patient is receiving at the time of care, addressing patient's present diagnosis. Include group therapy, classroom times, milieu therapy, etc.

6. **Nursing care plan**
   Identify <u>at least 3</u> nursing diagnosis. Summarize care and what you did for this patient and what their discharge goals are.

7. Legal/Ethical Issues

Identify a legal or ethical issue
Discuss your actions or actions that should have been done
Discuss how you applied the ANA Code of Ethics
Guardianship, power of attorney, etc.

8. Cultural/Ethnic Considerations

Discuss the culture of your patient (socioeconomic, ethnicity, etc.)
Discuss care specific to cultural consideration for your patient
Health/healing traditions influencing health care.

9. Teaching

Discuss the patient/family's educational needs
Discuss how you determined these needs
Discuss your interventions to meet these educational needs
Discuss the continued educational support needed for your patient/family
To whom should teaching be addressed and when

10. Related Nursing Research

At least one research article related to the care of the patient. Summarized and explanation given as to how research article applied in caring for the patient.

11. Critical Thinking Questions

Each group member will present a critical thinking question to the presenter at the end of the presentation. The presenter will answer the question based on their current knowledge of their patient. The presenter and the audience will be graded on how well they articulate these questions.

12. References

Complete list of references in APA format.

Theories and Concepts III: Guidelines for Case Presentation

Student Name: _____ Date: _____

Group Members: _____

CATEGORY	4	3	2	1	0
Introduction:	Detailed and specific including all aspects mentioned in guidelines.	Detailed and specific, but missing one aspect mentioned.	Detailed or Specific (not both) and/or missing 2 aspects mentioned	Not detailed or specific and missing 1-2 aspects mentioned.	Not detailed or specific and missing more than 3 aspects mentioned.
History: PMH Treatments until admission	Detailed and specific including all aspects mentioned in guidelines.	Detailed and specific, but missing one aspect mentioned.	Detailed or Specific (not both) and/or missing 2 aspects mentioned	Not detailed or specific and missing 1-2 aspects mentioned.	Not detailed or specific and missing more than 3 aspects mentioned.
Pathophysiology Disease process, cause and manifestations.	Extensive detail with causes and manifestations. Comparing your patient to the classic presentation.	Detailed with causes and manifestations & comparison of patient to classic presentation.	Detailed but without causes or manifestations OR comparisons	Detailed but without causes or manifestations and comparisons	Not detailed and without causes, manifestations, and comparisons.
Assessment: Complete Head to Toe OR Mental assessment.	Detailed and specific assessment includes all aspects mentioned in guidelines.	Detailed and specific, but missing one aspect mentioned.	Detailed or Specific (not both) and/or missing 2 aspects mentioned	Not detailed or specific and missing 1-2 aspects mentioned.	Not detailed or specific and missing more than 3 aspects mentioned.
Related Treatment: Discuss treatments DURING your care that are specific to the diagnosis.	Detailed treatments specific to diagnosis, as well as other treatment/tests important to care.	Detailed treatments specific to diagnosis.	Detailed treatments not specific to the diagnosis. Could not identify relevant data	Unable to identify treatment related to diagnosis or care.	No related to treatment mentioned.
Nursing Care: Nursing diagnoses with at least 3 interventions each.	3 or + with 3 interventions each and listed by prioritization.	3 or + either incorrectly prioritized, or with less than 3 interventions.	2 with 3 interventions each and listed by prioritization.	2 either incorrectly prioritized, or with less than 3 interventions.	1 or less diagnosis.

Legal/Ethical: Legal/Ethical Issue. Actions taken (or should have been taken). Application of ANA Code of Ethics.	Detailed discussion of L/E Issue, actions taken (or should have been taken), and application of ANA Code of Ethics.	Detailed discussion of L/E Issue without either actions taken or application of ANA Code of Ethics	Detailed discussion of L/E Issue without actions taken or application of ANA Code of Ethics	Issue addressed that is neither legal or ethical.	Statement that no ethical/legal issue existed.
Cultural/Ethnic: Culture of pt (socioeconomics and/or ethnicity). Discuss specific cultural care. Health/healing traditions influencing health care.	Detail culture of pt with specific cultural considerations. Discuss actual or possible traditions influencing care.	Detail culture of pt including either cultural considerations or traditions influencing care.	Detail culture of pt with no cultural considerations or traditions influencing care.	Incorrectly identify cultural/ethnic considerations	State there is no cultural/ethnic considerations for this patient.
Teaching: Who to teach? What to teach (content and method)? How to teach? Why teach? When to teach?	Detailed teaching plan that answers all the questions.	Detailed teaching plan that answers 4 of the questions.	Detailed teaching plan that answers 3 of the questions.	Detailed teaching plan that answers 2 of the questions.	Detailed teaching plan that answers 1 of the questions. Or inappropriate teaching plan.
Related Research: research articles related to the specific care of your patient	1 or more research articles summarized and applied to your patient. APA citation	1 research articles summarized and applied to your patient. No APA citation	1 research articles summarized and/or applied to your patient. APA citation	1 research articles summarized and/or applied to your patient. No APA citation	1 research articles not summarized or applied to your patient.
Critical Thinking (presenter)					
Critical Thinking (audience)					

Add each topic score to find the total points earned _____/(divide it by) 48
(total points possible) x 100 = _____ percentage earned

Faculty comments and signature:

Weekly Journal

Use complete sentences with reflective thought. If you are unable to define critical thinking you must look up the definition prior to answering question 5. **Due each week of clinical.**

1. What did you learn today that was the most beneficial?

2. What would you like to learn more about or what did you not fully understand?

3. What will you do to accomplish this?

4. If you could live today over, what would you do differently?

5. How do you feel about your experience today?

6. Give an example of how you used the critical thinking process today?

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III
Research Article Summary

Here is a sheet to help you organize the information in the research articles you are presenting for clinical. Please note if you cannot complete these sections, then the article is probably not research and therefore not applicable. If you have concerns about an article being research, please discuss with your clinical faculty prior to presenting the article.

Title:

Purpose:

Methodology:

Sample:

Results:

Application to practice:

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing
Clinical Performance Evaluation Key
Psychiatric Nursing

```
S = Competent
NI= Needs Improvement
U = Unable to perform
```

1. **Patient Centered**
   A. Elicit patient values, preferences, knowledge and perception of illness, expressed needs and recovery goals as part of clinical interview, implementation of care.
   B. Demonstrates effective interviewing skills that facilitate the development of a therapeutic relationship.
   C. Communicate patient values, preferences, knowledge and perception of illness, expressed needs and recovery goals to other members of health care team.
   D. Assess presence and extent of physiologic and psychological pain and suffering.
   E. Assess levels of physical and emotional comfort.
   F. Assess socioeconomic or legal issues facing the patient.
   G. Elicit expectations of patient and family for relief of physical and psychological pain, discomfort or suffering.
   H. Use therapeutic principles to understand the patient's emotions, thoughts, behaviors and condition.
   I. Recognize the boundaries of therapeutic relationships.

2. **Teamwork/Collaboration**
   A. Assesses own communication skills in interactions with patient's, family members, and health care team members
   B. Develops communication and conflict resolution skills.
   C. Treats peers and healthcare team members with respect, trust and dignity.
   D. Contributes own professional perspective in discussions with health care team members.
   E. Initiate plan for self-development as a team member
   F. Function competently within own scope of practice as a member of the health care team.
   G. Initiate requests for help when appropriate to situation.
   H. Integrate the contributions of others in care plan development and implementation.

3. **Critical Thinking**
   A. Prioritize care activities based on the immediate condition and the anticipated needs of the patient.
   B. Recognizes deviations from expected outcomes and uses this information to guide future assessment.
   C. Actively seeks information to plan care.
   D. Raises questions about issues to clarify.
   E. Resolves issues with a well thought out approach
   F. Makes sense out of data.

4. Evidence Based

A. Utilizes evidence-based nursing knowledge to guide patient care activities.
B. Read original research and evidence reports related to clinical practice topics.
C. Demonstrates knowledge of basic scientific methods and processes.
D. Compare routine approaches of care to evidence based protocols.
E. Utilizes milieu therapy to support patient's progress toward care goals.

5. Quality Improvement

A. Seeks information about long-term effects of psychiatric illnesses.
B. Uses the results of quality improvement activities to change own nursing practice.
C. Identify gaps between local and best practice.
D. Participate in quality improvement activities as opportunities arise.

6. Safety

A. Demonstrate effective use of technology and standardized practices that support safety and quality.
B. Demonstrate effective strategies that reduce risk of harm to self or others.
C. Communicate observations or concerns related to hazards and errors to patients, families, and the health care team.
D. Use organizational error reporting systems for near miss and error reporting.
E. Participate actively in analyzing errors and designing system improvements.
F. Use national patient safety resources for own professional development and to focus attention on safety in care settings.

7. Informatics

A. Seek education about how information is managed in care settings before providing care.
B. Apply technology and information management tools to support safe processes of care.
C. Document and plan patient care in an electronic health record.
D. Employ communication technologies to coordinate care for patients.
E. Use information management tools to monitor outcomes of care processes.
F. Use high quality electronic sources of health care information.

S = Satisfactory
NI = Needs Improvement
U = Unsatisfactory
N/A = Not Applicable
N/O = No Opportunity

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III (Psych)
Clinical Performance Evaluation Tool Scoring

Student: _____ Clinical Area _____

	1	2	3	4	
Core Competencies					Overall
Provides Patient Centered Care **Values** **Caring** **Human Dignity** **Ethics**					
Exhibits Teamwork and Collaboration **Communication** **Personnel (faculty, staff, patients, peers, family)** **Oral (nonverbal)**					
Critical Thinking **Intervention** **Plan of Care**					
Evidence based practice **Research** **Plan of care** **Nursing process**					
Understands and applies quality improvement methods **Improvement** **Evaluation** **Goals**					
Promotes Safety					
Technical skills **Standards of care** **Reporting observations**					
Understands and Utilizes Informatics **Professional sources used** **EHR documentation** **Role of informatics in health care** **Role of informatics in patient safety**					
Grade Calculation	**Clinical Course Work**				
Clinical Quiz I (20pts)					
Clinical Quiz II (20pts)					
Research Article I (10 pts)					
Research Article II (10 pts)					
Professionalism (5 pts)					
Professional Dress					
On Time					
Prepared					
Notifies clinical faculty of absence or tardiness					
Follows policy and procedure of clinical facility					
Paperwork (35 pts)					

Faculty Signature: _____ Student Signature: _____Date:_____

COMMENTS:

Interpersonal Process Recording

Items To Be Included

I. Introductory Material

A. Description of the client
Chief complaint, age, marital status, predisposing causes of illness, etc.
B. Description of setting (lighting, noise, temperature, etc.)
Where interaction took place
What client was doing when approached, etc.
C. Description of your thoughts and feelings prior to the interaction.
D. Therapeutic objectives/goals of the interaction (patient centered)

II. Recording of Interaction (use 3 columns)

A. Describe how interaction was initiated
B. Client communication:
verbal, non-verbal, silence, etc.
C. Nurse communication: verbal, thoughts, feelings, hypotheses, and validation with client
D. Applicable behavioral concepts/principles and meaning of the communications/
behaviors
E. Describe termination of the interaction
F. Analysis: communication techniques, why are they used, what are you hoping to accomplish?

III. Evaluation for Nursing Intervention

A. Description of your thoughts after the interaction.
B. Goals for future interactions.
C. Describe areas for improvement related to therapeutic communication.
D. Evaluate planned objective/goals of the interaction.

Review communication techniques, and process recording, prior to communicating with clients.

EXAMPLE ONLY

ARKANSAS TECH UNIVERSITY
Department of Nursing

Interpersonal Process Recording Example

NURSE: VERBAL AND NONVERBAL	**PATIENT: VERBAL AND NONVERBAL**	**PRINCIPLES THAT EXPLAIN BEHAVIOR AND INTERVENTION, FEELINGS AND OBSERVATIONS**
Date:	**Interaction Number 12**	***Goal: Patient will identify situations arousing discomfort and how he handles them.**
Mr. E. had just returned from a home visit. He came over to me and said he had to check his clothes and would be right back. I said I would wait for him in the usual place. He returned ten minutes later at 8:10 a.m.		I was a little irritated that Mr. E. would be late; even though I knew it was ward policy that his clothes be checked at once. However, I waited in the usual place. Reinforcing trust by being on time and remaining there for patient. Maintaining terms of contract.
	How was your weekend?	
Fine, and yours?		Focus conversation back to patient.
	Well, I was out on pass. I had a good time. I spent a lot of time straightening things up - putting summer clothes away and sorting out things. I could only work a few hours and then had to take a snooze.	Fatigue may be emotional as well as physical. Sleep can be a defense against a trying situation.
	We had company too. My sister had just told people that I wasn't feeling well. She didn't tell them what was wrong and they expected to see me with casts or something. She left it to me to tell them what was wrong.	Patient's anxiety rose here, shown by much moving around in his chair, embarrassed laughter, and lack of eye contact. Sister probably gave responsibility to patient because of her own feelings.
How did you feel about telling them?		Focusing to get pt to express feeling.
	Oh, I had no feelings about it at all. They're friends and they understand. They've seen me upset and angry. They understand.	Denial of feelings as a protective mechanism. Hopes friends understand but not sure.
What do you do when you get angry?		Exploring pt.'s usual coping strategies and helping patient to be aware of his behavior in reaction to stress.
	Well, I count to ten. Mostly I keep it in. My friends realize that. I don't get violent like some people.	– Continue – *** This is an example <u>only</u>. Your IPR should be longer than this example.**

ARKANSAS TECH UNIVERSITY
Department of Nursing

MILIEU ASSESSMENT

Setting _____ Date _____ Name _____

Evaluate the milieu in terms of the following characteristics:

1. Provision for physical safety and security

2. Provision for validation of humanity (include family, cultural, religious and other affiliations)

3. Provision for structured interaction

4. Provision for open communication with client by nursing staff and other members of the health care team.

Summary of the strengths and weakness of this milieu:

Suggestions for change:

Geropsychiatric Nursing
MINI- MENTAL STATUS ASSESSMENT

STUDENT'S NAME _____ Setting _____
CLIENT INITIALS _____ Date _____

Maximum Score	Score	
		ORIENTATION
5	( )	What is the (year) (season) (date) (day) (month)? (1 point for each)
5	( )	Where are we (state) (county) (town) (hospital) (floor) (1 point for each)
		REGISTRATION
3	( )	Name three objects: Give one second to say each. Then ask the patient to repeat all three after you have said them. (1 point for each item) Give one point for each correct answer. Then repeat them until the patient learns all three. Count trials and record.
		ATTENTION AND CALCULATION
5	( )	Serial sevens. Give one point for each correct. Stop after five answers. Alternatively, spell "world" backwards.
		RECALL
3	( )	Ask for three objects repeated above. Give one point for each correct.
		LANGUAGE
9	( )	Name a pencil and watch when pointed to (2 points) Repeat the following, "No ifs, ands, or buts." (1 point) Follow a three-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." (3 points) Read and obey the following: "Close your eyes." (1 point) Write a sentence. (1 point) Copy design. (1 point)

Total Score _____ What does this score mean?

Nursing Diagnoses based on your exam:

From: Townsend. (2018). Psychiatric Mental Health Nursing.

PSYCH CLINICAL

STUDENT:_____ _____CLINICAL DATE:_____

I. Data Collection *(Collected the day you pick up your patient plus current LABS)*

Patient's Initials: _____Room:_____ Age:_____ Gender:_____

Admission Date: _____ Code Status: _____ (Full, Dnr, Dni)

Height (Inches):_____ft. _____inches Weight _____lbs _____Kg

Allergies:_____

History of Present Problem (*What brought them into the hospital – the story)*:

Personal/Social History **(Includes growth and development, legal issues, and past medical history):**

What data from the histories is important & RELEVANT; therefore it has clinical significance to the nurse?

RELEVANT Data from Present Problem:	**Clinical Significance:**
RELEVANT Data from Social History:	**Clinical Significance:**

What is the RELATIONSHIP of your patient's past medical history (PMH) and current psychotrophic meds?(After PMH, put the medication number that correlates with that illness; This should also include hospital meds)

PMH:	Home and Hospital Meds:	Pharm. Classification:	Expected Outcome:	Side Effects
		1. 2. 3. 4. 5. 6. 7.	1. 2. 3. 4. 5. 6. 7.	1. 2. 3. 4. 5. 6. 7.

Nutrition

Diet	Height	Weight	BMI	Snacks

Nutritional Assessment (What are the nutritional needs for your patient based on his/her health status and diagnoses; this may differ from the actual ordered diet)?

Lab Results: (Complete for day before/most recent and then day of clinical)

What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

Complete Blood Count (CBC:)	Norms	Mm/dd/yy	Mm/dd/yy	High/Low/WNL?
WBC				
Hgb				
Platelets				
UDS				
TSH				

What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Misc. Labs:	Norms	Date:	Date:	High/Low/WNL?
Tegretol				
Glucose				
Valproic Acid				
LiCo3				
HCG				
ASO Titer				
Other:				

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Liver Function Test (LFT:)	Norms	Date:	Date:	High/Low/WNL?
Albumin				
Total Bilirubin				
Alkaline Phosphatase				
ALT				
AST				

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Urine Analysis (UA:)	Date:	Date:	High/Low/WNL?
Color (yellow)			
Clarity (clear)			
Specific Gravity (1.015-1.030)			
Protein (neg)			
Glucose (neg)			
Ketones (neg)			
Bilirubin (neg)			
Blood (neg)			
Nitrite (neg)			
LET (Leukocyte Esterase) (neg)			

MICRO:			
RBC's (<5)			
WBC's (<5)			
Bacteria (neg)			
Epithelial (neg)			

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

II. Clinical Reasoning Begins *(completed before coming to clinical; based on Section I and labs obtained the day before clinical)*

1. What is the primary problem that your patient is most likely presenting with?

2. What is the underlying cause/psychopathology of this concern?

3. What nursing priority(s) captures the "essence" of your patient's current status and will guide your plan of care?*(if more than one-list in order of PRIORITY; this is a NURSING DIAGNOSIS)*

4. What interventions will you initiate based on this priority(s) (This should be comprehensive and thorough with AT LEAST 4 interventions) ?

Nursing Interventions:	Rationale:	Expected Outcome:

5. What is the worst possible/most likely complication to anticipate based on the primary problem?

6. What nursing assessments will identify this complication EARLY if it develops?

7. What nursing interventions will you initiate if this complication develops (it's ok to put the expected orders that will be received) ?

III. Patient Care Begins: *(Day of clinical)*

Current VS:	**WILDA Pain Assessment** (5th VS):	
T: (oral)	**W**ords:	
P: (regular)	**I**ntensity:	
R: (regular)	**L**ocation:	
BP:	**D**uration:	
O2 sat:	**A**ggravate: **A**lleviate:	

What VS data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT VS Data:	**Clinical Significance:**

CURRENT MENTAL STATUS ASSESSMENT:	
GENERAL APPEARANCE:	
Mood/Affect:	
Thought/Content:	
Flow of Thought / Speech	
Orientation:	

SENSORIUM AND COGNITION:	
Memory:	
Intellectual Functioning	
Concentration/ Calculation	
General Information/ Intelligence	
Abstract Thinking	
Judgement	
Insight	

What assessment data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Assessment Data:	**Clinical Significance:**

IV. Clinical Reasoning (*Now that you have assessed the pt and seen today's behavior)*:

Does your initial nursing priority or plan of care need to be modified in any way after your assessment and obtaining these observations?

What are your current nursing priorities and interventions that will determine your plan of care?

Nursing Interventions:	**Rationale:**	**Expected Outcome:**

V. Evaluation:

Evaluate the response of your patient to nursing & medical interventions during your shift. All

physician orders have been implemented that are listed under medical management. Should include:

1. Nurses Note
2. Participation in unit activities
3. Interactions with peers
4. Risk level

1. What clinical data is RELEVANT that must be recognized as clinically significant?

RELEVANT VS Data:	**Clinical Significance:**
RELEVANT Assessment Data:	**Clinical Significance:**

2. Has the status improved or not as expected to this point?

3. Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?

a. Based on your current evaluation, what are your nursing priorities and plan of care?

It is now the end of your shift. Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following 5 Ps report to the nurse who will be caring for this patient:

1. Patient or project. What will you be handing off?
2. Plan. What needs to happen next? :
3. Purpose of the plan. What is the desired end state? How will you help make sure that the patient handoff is complete and critical information about the patient communicated?

4. Problems. What do you know about the patient that is different, unusual or complicated about this patient?
5. Precautions. What could be expected to be different, unusual or complicated about this patient?

VI. Education Priorities/Discharge Planning

1. ***What will be the most important discharge/education priorities you will reinforce with their psychiatric condition to prevent future readmission with the same problem?***

2. ***What are some practical ways you as the nurse can assess the effectiveness of your teaching with this patient?***

3. ***What cultural/ethnic considerations should be made regarding the teaching/discharge planning/care of this patient?***

VII. Caring and the "Art" of Nursing

1. ***What is the patient likely experiencing/feeling right now in this situation?***

2. ***What can you do to engage yourself with this patient's experience, and show that he/she matter to you as a person?***

Practicum Guide

Valley Behavioral Psychiatric Hospital, Fort Smith
Turning Point, Russellville

The student will upon completion of this practicum experience:

1. Recognize problems associated with a diagnosis of a psychiatric disorder for the :

   a. individual
   b. family
   c. community

2. Recognize own feelings concerning acute psychiatric clients.

3. Describe activities/services provided by the agency that improve mental functioning.

4. Evaluate the nurslings' role in the institution, utilizing the ANA Scope and Standards of Psychiatric-Mental Health Nursing Practice as well as the roles of the baccalaureate prepared nurse.

5. Correlate nursing research to practicum experiences.

6. Evaluate group process based on the presence of Yalom's curative factors.

7. Read Townsend chapters 9, 10, 18 and 19

8. Select a patient in the unit to which you are assigned and develop a plan of care for this patient for each practicum day. (This will include a Mental Status Exam [at least one during this practicum experience] or a Mini Mental Status Assessment.)

9. Complete a psychopharmacologic profile of current psychopharmacologic interventions being utilized and you will select one drug and contact a local pharmacy for the cost for a months supply. This will be presented in post conference.

10. Complete a milieu assessment and at least one IPR during this practicum experience.

11. Submit a log answering the above objectives and documenting learning experiences in conferences during a practicum period.

ARKANSAS TECH UNIVERSITY
Department of Nursing

PRACTICUM GUIDE

Geropsychiatric Nursing

Objectives:

1. Recognize own feelings about both the aging process and clients with neurocognitive disorders.
2. Describe characteristics of aging that you observed in the clients at the center.
3. Recognize the problems associated with a neurocognitivily impaired client for the individual, the family, particularly the care giver, and the community.
4. Describe the services provided by the center for this population.
5. Identify criteria used for accepting clients into the geropsychiatric center.
6. Identify various behavioral manifestations of neurocognitive impairment.
7. Identify possible nursing diagnoses for clients with neurocognitive impairment.
8. Perform a mini-mental status exam on at least one client.
9. Participate in at least one structured group activity offered to the clients at the center.
10. Identify support groups that are helpful for families of client with neurocognitive disorders.
11. Discuss how a nurse contributes to the care provided by the center.
12. Describe the role of each multidisciplinary team member involved in the care provided by the center.

Prior to experience, review: Townsend, Chapters 22 and 34

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing
MEDICAL SURGICAL/INTENSIVE CARE/OTHER/OBS
Clinical Performance Evaluation Key

```
S = Competent
NI= Needs Improvement
U = Unable to perform
```

1. **Patient Centered**

A. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care.

B. Communicate patient values, preferences and expressed needs to other members of health care team.

C. Follow a patient-centered plan of care with sensitivity and respect for the diversity of human experience.

D. Assess presence of and extent of pain and suffering

E. Assess levels of physical and emotional comfort.

F. Elicit expectations of patient and family for relief of pain, discomfort, or suffering

G. Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs.

H. Remove barriers to presence of families and other designated surrogates based on patient preferences.

I. Assess level of patient's decisional conflict and provide access to resources.

J. Recognize the boundaries of therapeutic relationships.

K. Use SBAR to communicate care provided and needed at each transition in care.

2. Teamwork/ Collaborations

A. Demonstrate awareness of own strengths and limitations as a team member.

B. Act with integrity, consistency and respect for differing views.

C. Function competently within own scope of practice as a member of the health care team.

D. Assume role of team member or leader based on the situation.

E. Initiate requests for help when appropriate to situation.

F. Collaborates with team members in the prioritization and treatment of patient

G. Initiate actions to resolve conflict.

3. Critical Thinking

A. Determines appropriate action in patient/family care.

B. Recognizes deviations from expected outcome and uses this information to guide assessment.

C. Actively seeks information to plan care.

D. Raises questions about issues to clarify.

E. Resolves issues with a well thought out approach.

F. Determines priorities of care and action.

G. Makes sense out of data

4. Evidence Based

A. Base individualized care plan on patient values, clinical expertise and evidence.

B. Read original research and evidence reports related to clinical practice topics and guidelines.

C. Consult with clinical experts to deviate from evidence-based protocol.

D. Question rationale for routine approaches to care that result in less-than-desired outcomes or adverse event.

5. Quality Improvement

A. Seek to improve documentation and assessment skills as needed

B. Identify gaps between local and best practice.

C. Evaluate nursing interventions related to goals associated with nursing diagnosis

6. Safety

A. Demonstrate effective use of technology and standardized practices that support safety and quality.

B. Demonstrate effective strategies that reduce risk of harm to self or others.

C. Communicate observations or concerns related to hazards and errors to patients, families, and the health care team.

D. Use organizational error reporting systems for near miss and error reporting.

E. Use national patient safety resources for own professional development and to focus attention on safety in care settings.

7. Informatics

A. Seek education about how information is managed in care settings before providing care.

B. Apply technology and information management tools to support safe processes of care.

C. Document and plan patient care in an electronic health record.

S = Satisfactory
NI = Needs Improvement
U = Unsatisfactory
N/A = Not Applicable
N/O = No Opportunity

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III (**Med-Surg/ICU)**
Clinical Performance Evaluation Tool Scoring

Student: _____ Clinical Area _____

	1	2	3	4	
Core Competencies					Overall
Provides Patient Centered Care **Values** **Caring** **Human Dignity** **Ethics**					
Exhibits Teamwork and Collaboration **Communication** **Personnel (faculty, staff, patients, peers, family)** **Oral (nonverbal)**					
Critical Thinking **Intervention** **Plan of Care**					
Evidence based practice **Research** **Plan of care** **Nursing process**					
Understands and applies quality improvement methods **Improvement** **Evaluation** **Goals**					
Promotes Safety					
Technical skills **Standards of care** **Reporting observations**					
Understands and Utilizes Informatics **Professional sources used** **EHR documentation** **Role of informatics in health care** **Role of informatics in patient safety**					
Grade Calculation	**Clinical Course Work**				
Clinical Quiz I (20pts)					
Clinical Quiz II (20pts)					
Research Article I (5 pts)					
Research Article II (5 pts)					
Professionalism (10 pts)					
Professional Dress					
On Time					
Prepared					
Notifies clinical faculty of absence or tardiness					
Follows policy and procedure of clinical facility					
Paperwork (40 pts)					

Faculty Signature: _____ Student Signature: _____Date:_____

COMMENTS:

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Clinical Objectives for Practicum in Intensive Care Unit

The nursing student is expected to:

1. Locate the crash cart and all emergency equipment/supplies in the unit.
2. Observe use of special equipment used in the ICU (e.g. ventilator) and demonstrate proper use of such equipment after receiving instructions on use.
3. Identify priority physiological and psychological nursing diagnosis and appropriate interventions for selected clients.
4. Utilize the nursing process to care for clients and families in the critical care setting.
5. Incorporate physical examination into assessment of clients.
6. Analyze the ICU milieu and its effects on clients and care givers.
7. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.
8. Compare normal laboratory values with those of clients in the ICU setting.
9. Evaluate effects of nursing interventions and revise interventions as necessary.
10. Seek assistance from instructor when unfamiliar with any aspect of client care.
11. Discuss ethical-legal issues in the ICU environment.
12. Be prepared to present verbal care plan to clinical instructor.
13. Analyze and interpret cardiac rhythm strips for selected clients.

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Clinical Objectives for the Practicum in Emergency Department (ED)

The nursing student is expected to:

1. Locate the crash cart and all emergency/supplies in the unit.

2. Familiarize self with the special equipment used in the Emergency Department and demonstrate appropriate interventions in the use of that equipment.

3. Utilize the nursing process to provide care for a variety of clients, comparing normal and abnormal values of lab and x-ray exams.

4. Incorporate physical examination into the assessment procedure of such clients.

5. Observe a minimum of three clients in crisis. Discuss coping patterns used, adequacy of these coping patterns, and the effectiveness of patient's support system.

6. Familiarize self with the triaging of clients. Identify principles being used.

7. Discuss ethical-legal issues in the ED environment.

8. Analyze the ED milieu and its effects on clients, care givers and staff.

Review Chapter 71 in your textbook.

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Clinical objectives for practicum in cardiac/medical-surgical unit

The nursing student is expected to:

1. Locate the crash cart and all emergency/supplies in the unit.
2. Observe use of special equipment used in the cardiac/medical-surgical unit and demonstrate proper use of such equipment after receiving instructions on use.
3. Identify priority physiological and psychological nursing diagnosis and appropriate interventions for selected clients.
4. Utilize the nursing process to care for clients and families in the cardiac/medical-surgical unit.
5. Incorporate and demonstrate physical examination into assessment of clients.
6. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.
7. Compare normal laboratory values with those clients in the cardiac/medical-surgical unit.
8. Evaluate effects of nursing interventions and revise interventions as necessary.
9. Seek assistance from instructor when unfamiliar with any aspect of client care.
10. Discuss ethical-legal issues in the cardiac/medical-surgical unit.

ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Objectives for Orthopedic/Rehabilitation/Post Surgical Unit Experience

The nursing student is expected to:

1. Locate the crash cart and all emergency/supplies in the unit.
2. Observe use of special equipment used in the ortho/rehab/post surg unit and demonstrate proper use of such equipment after receiving instructions on use.
3. Identify priority physiological and psychological nursing diagnosis and appropriate interventions for selected clients.
4. Utilize the nursing process to care for clients and families in the ortho/rehab/post surg unit.
5. Incorporate and demonstrate physical examination into assessment of clients.
6. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.
7. Compare normal laboratory values with those clients in the ortho/rehab/post surg unit.
8. Evaluate effects of nursing interventions and revise interventions as necessary.
9. Seek assistance from instructor when unfamiliar with any aspect of client care.
10. Discuss ethical-legal issues in the ortho/rehab/post surg unit.
11. Utilize the nursing process to provide care to clients with orthopedic or neurological dysfunction.
12. Identify the diversity of health care team members giving care to ortho/neuro clients.
13. Explain the impact of various medical conditions on clients with orthopedic dysfunction.
14. Describe protocol that determines a client's eligibility and potential for rehabilitation.

Verbal Care Plan

The student will be **prepared** to answer the following questions at the beginning of the clinical day. The instructor may choose a time later in the day to discuss the care plan with the student; however, the student should always be prepared at the beginning of the clinical shift. This information is presented to the clinical instructor *without* the use of notes, with the exception of lab values and medications. The instructor may ask the student to update this information during the course of the day.

1. What acute disease does your client have?

   Explain the basic pathophysiology

2. What chronic diseases does your client have?

   Explain the basic pathophysiology of each and how they may relate to the acute disease.

3. Explain lab and radiology data (may use notes).

4. Tell about your client's medications (may use notes).

   Discuss purpose, common side effects, and priority nursing implications.

5. Describe the client's social, spiritual, and personal status.

   How does this impact care? Who lives with the client? Describe client's relationships. Does the client have any spiritual needs or concerns?

6. Identify two to three nursing diagnoses for this client in order of priority.

   Which nursing diagnosis in first in priority? Explain rational for the order of priority of these diagnoses.

7. Describe your plan of care today.

   List one goal for each nursing diagnosis. Explain interventions. What teaching will be planned for client and/or family?

8. At the end of your clinical day, evaluate your plan of care.

   What changed during the course of the shift? Was it necessary to revise the plan of care based on changes in the client's condition or diagnosis? Was it necessary to revise priorities of diagnosis? Was nursing care holistic?

MED SURG/ICU CLINICAL
STUDENT:_____CLINICAL DATE:_____

I. Data Collection (*Collected the day you pick up your patient plus current LABS)*

Patient's Initials: _____Room:_____ Age:_____ Gender:____

Admission Date: _____ Code Status: _____ (Full, Dnr, Dni)

Height (Inches):_____ft. _____inches Weight _____lbs _____Kg

Allergies:_____

History of Present Problem (*What brought them into the hospital – the story)*:

Personal/Social History (*includes Past Medical History)*:

What data from the histories is important & RELEVANT; therefore it has clinical significance to the nurse?

RELEVANT Data from Present Problem:	**Clinical Significance:**
RELEVANT Data from Social History:	**Clinical Significance:**

What is the RELATIONSHIP of your patient's past medical history (PMH) and current meds?(After PMH, put the medication number that correlates with that illness; This should also include hospital meds)

PMH:	Home and Hospital Meds:	Pharm. Classification:	Expected Outcome:
		1. 2. 3. 4. 5. 6. 7.	1. 2. 3. 4. 5. 6. 7.

Nutrition

Diet (TPN/Lipds, Enteral, Oral)	Rate or Frequency	Benefits:

Nutritional Assessment (What are the nutritional needs for your patient based on his/her health status and diagnoses; this may differ from the actual ordered diet)?

Lab Results: (Complete for day before/most recent and then day of clinical)

What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

Complete Blood Count (CBC:)	Norms	Mm/dd/yy	Mm/dd/yy	High/Low/WNL?
WBC				
Hgb				
Platelets				
Neutrophil %				
Band forms				

What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Basic Metabolic Panel (BMP:)	Norms	Mm/dd/yy	Mm/dd/yy	High/Low/WNL?
Sodium				
Potassium				
Chloride				

CO2 (Bicarb)				
Anion Gap (AG)				
Glucose				
Calcium				
BUN				
Creatinine				

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**

Misc. Labs:	**Norms**	**Date:**	**Date:**	**High/Low/WNL?**
Magnesium				
Ionized Calcium				
Amylase				
Lipase				
Lactate				
GFR				
Coags:				
PT/INR				

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**

Liver Function Test (LFT:)	**Norms**	**Date:**	**Date:**	**High/Low/WNL?**
Albumin				
Total Bilirubin				
Alkaline Phosphatase				
ALT				
AST				

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**

ABG:	**Norms**	**Date:**	**Date:**	**High/Low/WNL?**
Vent Settings	N/A			
pH				
PO2				

O2 Saturation				
PCO2				
HOC3				
Base Excess				

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**

Urine Analysis (UA:)	**Date:**	**Date:**	**High/Low/WNL?**
Color (yellow)			
Clarity (clear)			
Specific Gravity (1.015-1.030)			
Protein (neg)			
Glucose (neg)			
Ketones (neg)			
Bilirubin (neg)			
Blood (neg)			
Nitrite (neg)			
LET (Leukocyte Esterase) (neg)			
MICRO:			
RBC's (<5)			
WBC's (<5)			
Bacteria (neg)			
Epithelial (neg)			

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**

Cardiac Labs:	**Norms**	**Date:**	**Date:**	**High/Low/WNL ?**
Troponin				
CPK total				
CPK-MB				
BNP (B-natriuretic Peptide)				

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**

II. Clinical Reasoning Begins *(completed before coming to clinical; based on Section I and labs obtained the day before clinical)*

1. What is the primary problem that your patient is most likely presenting with?

2. What is the underlying cause/pathophysiology of this concern?

3. What nursing priority(s) captures the "essence" of your patient's current status and will guide your plan of care?*(if more than one-list in order of PRIORITY; this is a NURSING DIAGNOSIS)*

4. What interventions will you initiate based on this priority(s) (This should be comprehensive and thorough with AT LEAST 4 interventions) ?

Nursing Interventions:	Rationale:	Expected Outcome:

5. ***What body system(s) will you most thoroughly assess based on the primary problem or nursing care priority?***

6. What is the worst possible/most likely complication to anticipate based on the primary problem?

7. What nursing assessments will identify this complication EARLY if it develops?

8. What nursing interventions will you initiate if this complication develops (it's ok to put the expected orders that will be received) ?

III. Patient Care Begins: *(Day of clinical)*

Current VS:	**WILDA Pain Assessment** (5th VS):	
T: (oral)	**W**ords:	
P: (regular)	**I**ntensity:	
R: (regular)	**L**ocation:	
BP:	**D**uration:	
O2 sat:	**A**ggravate: **A**lleviate:	

What VS data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT VS Data:	**Clinical Significance:**

Current Assessment:	
GENERAL APPEARANCE:	
RESP:	
CARDIAC:	
NEURO:	
GI:	
GU:	
SKIN:	

What assessment data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Assessment Data:	**Clinical Significance:**

Therapy Sheet:

Primary IV (peripheral, central line, PICC)

Type of IV*	**Site of IV insertion**	**Primary fluid infusing/rate of infusion**

Antibiotics

Antibiotic	Drug amount/total fluids	cc/hr	dose/hr

Infusion drips and continuous drips

Drug	Ordered dose	Drug amount/total fluids	Drug amount/ ml	cc/hr	dose/min	dose/hr

IV Sedation

Drug	Ordered dose	Drug amount/total fluids	Drug amount/ml	cc/hr	dose/hr

Heparin

Dose	Rate	Dose/ml	Dose/min	Dose/hr

PCA

Drug	Background/Basal	Bolus	Lockout

Cardiac Telemetry Strip:

Interpretation:
Clinical Significance:

Radiology Reports:

What diagnostic results are RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Results:	Clinical Significance:

Lab Planning: *what labs do YOU think need to be ordered to get a better picture of the patient?*

Lab:	Normal Value:	Clinical Significance:	Nursing Assessments/Interventions Required:

IV. Clinical Reasoning (*Now that you have assessed the pt and seen today's labs)*:

Does your initial nursing priority or plan of care need to be modified in any way after your assessment and obtaining these lab results?

What are your current nursing priorities and interventions that will determine your plan of care?

Nursing Interventions:	Rationale:	Expected Outcome:

V. Evaluation:

***Evaluate the response of your patient to nursing & medical interventions during your shift. All physician orders have been implemented that are listed under medical management*.**

Last Vital signs of the day…

Current VS:	**Most Recent:**	**Current WILDA:**	
T:		**W**ords:	
P:		**I**ntensity:	
R:		**L**ocation:	
BP:		**D**uration:	
O2 sat:		**A**ggravate: **A**lleviate:	

Current Assessment:	
GENERAL APPEARANCE:	
RESP:	
CARDIAC:	
NEURO:	
GI:	
GU:	
SKIN:	

2. What clinical data is RELEVANT that must be recognized as clinically significant?

RELEVANT VS Data:	**Clinical Significance:**
RELEVANT Assessment Data:	**Clinical Significance:**

2. Has the status improved or not as expected to this point?

3. Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?

b. Based on your current evaluation, what are your nursing priorities and plan of care?

It is now the end of your shift. Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following 5 Ps report to the nurse who will be caring for this patient:

1. Patient or project. What will you be handing off?

2. Plan. What needs to happen next? :
3. Purpose of the plan. What is the desired end state? How will you help make sure that the patient handoff is complete and critical information about the patient communicated?
4. Problems. What do you know about the patient that is different, unusual or complicated about this patient?
5. Precautions. What could be expected to be different, unusual or complicated about this patient?

VI. Education Priorities/Discharge Planning

1. ***What will be the most important discharge/education priorities you will reinforce with their medical condition to prevent future readmission with the same problem?***

4. ***What are some practical ways you as the nurse can assess the effectiveness of your teaching with this patient?***

5. ***What cultural/ethnic considerations should be made regarding the teaching/discharge planning/care of this patient?***

VII. Caring and the "Art" of Nursing

3. ***What is the patient likely experiencing/feeling right now in this situation?***

4. ***What can you do to engage yourself with this patient's experience, and show that he/she matter to you as a person?***

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III

Research Day

Objectives:

At the end of the Research Day, the student will be able to:

1. Discuss at least two poster presentations the student found interesting.
2. Summarize at least two presentations made by speakers. Discuss application of research to nursing practice.
3. Discuss the importance of nursing research to the advancement of the profession.
4. Identify the role of the BSN, RN in the research process.
5. Evaluate attendance to the conference.