ANGelo State University generic bachelor of science in

nursing clinical practicum

NUR 4321

Adult health nursing II practicum

Fall 2017

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ANGelo State University

Department of nursing & rehabilitation sciences
COURSE NUMBER
NUR 4321

COURSE TITLE
Adult Health Nursing II Practicum

CREDITS
Three Semester Credit Hours (0-0-9)

PREREQUISITE COURSES
Nursing 3320 Adult Health Nursing I Practicum

CO-REQUISITES
Nursing 4411 Adult Health Nursing II

PRE-REQUISITE SKILLS
Accessing internet web sites, use of ASU Library resources, and proficiency with Microsoft Word and/or PowerPoint are an expectation of the Generic BSN program. Computer requirements are further delineated in the Undergraduate Handbook. Tutorials for ASU Library and for Blackboard are available through RamPort. The ASU Nursing Program Undergraduate Student Handbook should be reviewed before taking this course (http://www.angelo.edu/dept/nursing/handbook/index.html).

BROWSER COMPATIBILITY CHECK
It is the student’s responsibility to ensure that the browser used to access course material on his/her computer is compatible with ASU’s Blackboard Learning System. The faculty reserve the right to deny additional access to course assignments lost due to compatibility issues. Students are responsible for reviewing the guidelines posted in this course regarding accessing Blackboard assignments. Problems in this area need to be discussed with faculty at the time of occurrence, either via a phone call (preferred) during posted acceptable hours for calling, or via email notification during times outside those posted for calls.

Be sure to perform a browser test. Select the “Technology Support” tab from the Blackboard homepage (http://www.blackboard.angelo.edu). Then select “Test your Browser” option located under the Browser Test header.

Please see computer requirements for BSN classes at this link:

http://www.angelo.edu/dept/nursing/student_resources/computer_requirements.php

COURSE DELIVERY
This is a clinical practicum nursing course that involves direct delivery of patient care services.
FACULTY
Alfredo Becerra III, MSN, RN
Clinical Instructor
Office: VIN 284
Phone: (325) 486-6855
Fax (325) 942-2236
Abecerra1@angelo.edu

OFFICE HOURS
Onsite Office Hours: Mondays 0900-1130 and Wednesdays 1330-1600
Virtual Office Hours by appointment

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FNP-C
Clinical Instructor
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pam.darby@angelo.edu

OFFICE HOURS
Onsite Office Hours: Mondays 0930-1630
Virtual Office Hours by appointment

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CCRN
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OFFICE HOURS
Onsite Office Hours: Wednesdays 0730-1230, Fridays by appointment
Virtual Office Hours by appointment

COURSE DESCRIPTION
Students provide research-based, safe, and appropriate care to culturally diverse adult patients with chronic complex medical and psychiatric conditions. Students use standards of care, advanced informatics/technology, interdisciplinary communication, and error prevention techniques in a variety of settings. Grading will be pass or fail.

COURSE OVERVIEW
The purpose of this clinical nursing course is to involve students in the direct delivery of patient care services to adult clients and their families.
BSN PROGRAM OUTCOMES
Upon completion of the program of study for the Generic BSN, the graduate will be prepared to:
1. Integrate nursing and related theories into the planning and/or delivery of safe nursing care.
2. Engage leadership concepts, skills and decision-making in the planning and/or implementation of patient safety and quality improvement initiatives.
3. Identify and appraise best research evidence to improve and promote quality patient outcomes.
4. Utilize technology to access information, evaluate patient data and/or document care.
5. Participate in political/legislative processes to influence healthcare policy.
6. Engage in effective collaboration and communication within interdisciplinary teams.
7. Design and/or implement health promotion & disease prevention strategies for culturally competent care.
8. Demonstrate standards of professional, ethical, and legal conduct.
9. Practice and/or coordinate, at the level of the baccalaureate prepared nurse, to plan and/or implement patient centered care.

Student Learning Outcomes

<table>
<thead>
<tr>
<th>Student Learning Outcome</th>
<th>Assignment(s) or activity(ies) validating outcome achievement:</th>
<th>Mapping to BSN Program Outcomes</th>
<th>Mapping to BSN Essentials</th>
<th>Mapping to QSEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform, synthesize, prioritize, and document nursing assessments and patient care using a variety of appropriate resources for up to two patients with complex health deviations.</td>
<td>Clinical Competency Performance Clinical Evaluation Weekly Clinical Experience Forms Discharge Planning/Coordination of Care Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>III, IV, VI, VII, IX</td>
<td>PCC, EBP, I, S, TC, QI</td>
</tr>
<tr>
<td>2. Integrate principles of safety and quality into research-based interventions for adult patients with chronic complex medical and mental health conditions.</td>
<td>Clinical Competency Performance Clinical Evaluation Weekly Clinical Experience Forms Clinical Assignment for ER Discharge Planning/Coordination of Care Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>II, III, IV, VI, VII, IX</td>
<td>PCC, EBP, I, TC, S, QI</td>
</tr>
<tr>
<td>3. Deliver and coordinate appropriate patient-centered care based on evidence, guidelines, standards, and legal statues/regulations</td>
<td>Clinical Competency Performance Clinical Evaluation Weekly Clinical Experience Forms Clinical Assignment for ER Discharge Planning/Coordination of Care Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>I, II, III, IV, VI, VII, VIII, IX</td>
<td>PCC, EBP, I, TC, S, QI</td>
</tr>
<tr>
<td>4. Provide and document effective health teaching for multiple adult patients addressing risk reduction, health promotion, preventive care and discharge planning.</td>
<td>Clinical Competency Performance Clinical Evaluation Weekly Clinical Experience Forms Discharge Planning/Coordination of Care Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>II, III, IV, VI, VII, IX</td>
<td>PCC, EBP, I, TC, S, QI</td>
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<tr>
<td>5. Demonstrate collaboration and communication skills in advocacy actions including improvements in quality, safety and error prevention.</td>
<td>Clinical Competency Performance Clinical Evaluation Weekly Clinical Experience Forms Clinical Assignment for ER Discharge Planning/Coordination of Care Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>II, III, IV, VI, VII, VIII, IX</td>
<td>PCC, EBP, I, TC, S, QI</td>
</tr>
<tr>
<td>6. Interact with peers, colleagues and interprofessional team members to facilitate positive patient outcomes and a professional clinical environment.</td>
<td>Clinical Competency Performance Clinical Evaluation Clinical Assignment for ER Discharge Planning/Coordination of Care Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>II, III, IV, VI, VII, VIII, IX</td>
<td>PCC, EBP, I, TC, S, QI</td>
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<tr>
<td>7. Demonstrate and facilitate moral, ethical, and professional conduct in the clinical setting.</td>
<td>Clinical Competency Performance Clinical Evaluation Mental Health Assignment</td>
<td>1,2,3,4,6,7,8,9</td>
<td>I, III, IV, VI, VII, IX</td>
<td>PCC, EBP, I, TC, S, QI</td>
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</table>
CLINICAL REQUIREMENTS
1. Maintain student liability insurance and current American Heart Association Health Care Professional CPR certification.
2. Provide safe nursing care to adult clients within level of knowledge and nursing skills.
3. Refer to the Angelo State University Undergraduate Nursing Handbook for the following:
   - Clinical Attire- regulations; general appearance
   - Behavior in Clinical Agency
   - Professional Conduct
   - Standards of Nursing Practice
   - Patient Client Confidentiality
   - Student absences
   - Dosage Calculation Testing Policy
   - Policy on Exam Make-Up
   - Policy on Universal Precautions
   - Guidelines or Written Work
   - BON Declaratory Statement
   - All Guidelines for Referencing Materials

REQUIRED TEXTS AND MATERIALS
- Refer to NUR 3410 syllabus under required texts
- Electronic Health Record (EHR) Tutor. Information @ehrtutor.com-440-305-6188
- Materials – Bandage scissors, watch with a second hand, stethoscope, penlight, ASU uniform, name tags, appropriate reference books, and appropriate clinical forms.
- We recommend the use of a PDA.

OTHER REQUIRED MATERIALS
- Computer with MAC or Windows Operating System
- High Speed Internet Access

RECOMMENDED TEXTS
- Refer to NUR 4411 syllabus under recommended texts

TOPIC OUTLINE
N/A

GRADING SYSTEM
Course grades will be dependent upon completing course requirements and meeting the student learning outcomes.

The following grading scale is in use for this course:

P (Pass), F (Fail), NC* (No Credit), W (Withdrawn)
*Note: NUR 4411 & NUR 4321 must be successfully completed simultaneously to receive credit in either course or progress through the program.

UNSATISFACTORY Clinical Performance: A student will be considered "Unsatisfactory" if clinical experiences reflect negative performances, lack of preparation or absence. Unsatisfactory incidents indicate that students may not be able to meet course requirements. A student whose clinical practice is UNSATISFACTORY will be given (a) counseling, opportunities for improvement, and/or remediation, and (b) a verbal and written warning. Faculty may remove a student from the clinical setting for lack of preparation or other unsatisfactory performance.

A pattern of three (3) clinical "unsatisfactories" may result in the student failing the clinical portion of the course, and as a result, receive a failing grade for the course.

UNSAFE clinical performance: When direct patient care is part of the learning experience, patient safety and well-being is of paramount concern. If a faculty member evaluates that a student is unable to provide safe nursing care in accordance with Standards of Professional Nursing Practice (BON, Nursing Practice Act, 2001), and if this deficit is such that it cannot be remedied, the student will be removed from the clinical setting and will receive a grade of "F" in the course.

Course Learning

TEACHING STRATEGIES

- Clinical participation
- Pre & Post conference, case studies, and interactions
- Written assignments
- Simulation
- Students are expected to be "active learners." It is a basic assumption of the instructor that students will be involved (beyond the materials and lectures presented in the course) discovering, processing, and applying the course information using peer-review journal articles, researching additional information and examples on the Internet, and discussing course material and clinical experiences with their peers.

EVALUATION AND GRADES

Required assignments, activities comprising the overall course grade:

<table>
<thead>
<tr>
<th>Assessment Activity</th>
<th>Course Objective</th>
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</thead>
<tbody>
<tr>
<td>Clinical Competency Performance and Clinical Evaluations</td>
<td>CO# 1,2,3, 4, 5, 6</td>
</tr>
<tr>
<td>Weekly Clinical Experience Forms (Flow sheet, NCP, Meds)</td>
<td>CO# 1, 2, 3, 5</td>
</tr>
<tr>
<td>Clinical Assignment for ER</td>
<td>CO# 2, 3, 5, 6</td>
</tr>
<tr>
<td>Discharge Planning/Coordination of Care Assignment</td>
<td>CO# 1, 2, 3, 4, 5, 6</td>
</tr>
<tr>
<td>Mental Health Assignments</td>
<td>CO# 1,2, 3,4,6,7</td>
</tr>
</tbody>
</table>
ASSIGNMENT/ACTIVITY DESCRIPTIONS
*Please note: Rubrics for all assignments and activities are located at the end of this syllabus.

Clinical Competency Performance and Clinical Evaluations
Students will randomly be assigned one or more skills to perform from the list below. The student should be prepared to perform all skills.

1. IV Insertion
2. Trach Care
3. Foley Catheter Insertion
4. NG Tube Insertion
5. Suctioning (Trach, ET tube, Nasotracheal)
6. Intramuscular Injections/oral medications/subcutaneous injections
7. Care of Central Lines
8. Wound Care/Dressing Changes

Appointments will be scheduled during the first week of the semester for students to do competencies. During Week Four, Week Eight, and Week Fifteen, the student is responsible for completing the AH II Clinical Evaluations. Once completed, a copy must be given to the instructor, via fax, electronically, or hand delivery by Thursday at 2359 of the corresponding week. See more details regarding “Evaluation Tools” in Appendix G.

Weekly Clinical Experience Forms (Flow sheet, NCP, Meds)
The purpose of this clinical nursing course is to involve students in the direct delivery of patient care services to adult clients and their families. During the clinical preparation period, the student goes to a health care facility on the day or night before the actual clinical rotation, and gathers information from the client’s chart to complete the assigned sheets (per instructor’s instruction). See Appendix B. The student prepares to apply the theory, concepts, and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with the particular occupation and the business/industry. Students will be prepared for all clinical activities. The faculty has an obligation to remove a student from the clinical setting if the student is not prepared. Repeated behavior reflects failure to meet clinical objectives.

Clinical Assignment for ER
Prior to the ER rotation, students will do a library database assignment looking at research recommendations and standards for safety, and patient-centered care (this also includes cultural diversity). Students create a 1-2 page single sheet document (front and back) summarizing recommendations in the articles. On a separate sheet, students create a table comparing the standards or literature recommendations with actual practice on the units. Under the table students describe personal reflections on the safety and patient-centered care issues on that unit.

Discharge Planning/Coordination of Care Assignment
At or shortly after admission of the patient (during the assessment phase), it is the nurse’s responsibility to begin a discharge plan. These plans are based upon information obtained on admission and can be revised as necessary as the patient’s condition changes. The student creates an appropriate
plan for the patient diagnosis and condition.

**Mental Health Assignment**
The purpose of this assignment is to provide the student experience with mental health concepts and application. The questions will promote clinical reasoning as it relates to the mental health client with comorbidities. The assignment is completed during 20 hours of Mental Health clinical. The student will utilize all available resources including informatics, library data bases, mental health textbooks, nursing journals, clinical staff, instructors, etc. APA formatting of sources cited and reference page required.

**GENERAL POLICIES RELATED TO THIS COURSE**
All students are required to follow the policies and procedures presented in the following documents:

**IMPORTANT UNIVERSITY DATES**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 28th</td>
<td>Fall classes officially begin</td>
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<tr>
<td>September 4th</td>
<td>Labor Day Holiday – No class</td>
</tr>
<tr>
<td>November 3rd</td>
<td>Last day to drop a class or withdraw from the University for Fall Semester</td>
</tr>
<tr>
<td>November 22nd-23rd</td>
<td>Thanksgiving Holiday Break – No class</td>
</tr>
<tr>
<td>December 4th-8th</td>
<td>Lab Finals</td>
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<tr>
<td>December 11th-15th</td>
<td>Final Exams Week</td>
</tr>
<tr>
<td>December 15th</td>
<td>Last Day of Fall Semester</td>
</tr>
<tr>
<td>December 16th</td>
<td>Fall Graduation</td>
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</tbody>
</table>

**STUDENT RESPONSIBILITY & ATTENDANCE**
- Come to clinical prepared to apply the theory, concepts, and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economic,
- Environmental, social, and legal systems associated with the particular occupation and the business/industry.
- Demonstrate legal and ethical behavior, safety practices, communication, interpersonal and teamwork skills
- Participate in clinical opportunities, simulation, pre & post conference discussions and Blackboard discussions (if assigned).
- Ask questions as needed.

*The teaching team reserves the right to make additional or alternative assignments in order to meet the needs of an individual student or a particular class.*

**Attendance:** A week’s worth of cumulative absences in any one course will result in faculty evaluation of
the student’s ability to meet clinical objectives and may result in failure of the course. This means that if you have one clinical day a week, missing ONE clinical practicum places you in jeopardy of course failure. Three tardies (over five minutes late for lecture, campus laboratory, or clinical) will equal one hour of absence.

COMMUNICATION
Faculty will respond to email and/or telephone messages within 24 hours during working hours Monday through Friday. Weekend messages may not be returned until Monday.

Written communication via email: All private communication will be done exclusively through your ASU email address. Check frequently for announcements and policy changes.

In the event of extenuating circumstances preventing a student from attending a clinical experience, the student will:

- Notify the **agency** before scheduled time to report on duty.
- Notify the **clinical instructor** a minimum of **one hour** before scheduled time to report on duty.

Failure to call in will result in an **UNSATISFACTORY** for that clinical day. Students missing more than **one week** of clinical will result in reevaluation of a student’s ability to meet course objectives and may result in an unsatisfactory clinical grade. The instructor may assign the student work to supplement the experience.

**Use Good "Netiquette":**

- Check the discussion frequently and respond appropriately and on subject.
- Focus on one subject per message and use pertinent subject titles.
- Capitalize words only to highlight a point or for titles. Otherwise, capitalizing is generally viewed as SHOUTING!
- Be professional and careful with your online interaction. Proper address for faculty is by formal title such as Dr. or Ms./Mr. Jones unless invited by faculty to use a less formal approach.
- Cite all quotes, references, and sources.
- When posting a long message, it is generally considered courteous to warn readers at the beginning of the message that it is a lengthy post.
- It is extremely rude to forward someone else's messages without their permission.
- It is fine to use humor, but use it carefully. The absence of face-to-face cues can cause humor to be misinterpreted as criticism or flaming (angry, antagonistic criticism). Feel free to use emotions such as J or :) to let others know you are being humorous.

(The "netiquette" guidelines were adapted from Arlene H. Rinaldi's article, The Net User Guidelines and Netiquette, Florida Atlantic University, 1994, available from Netcom.)

**ASSIGNMENT SUBMISSION**
In this class, some assignments may need to be submitted through the Assignments link in the Blackboard course site. This is for grading purposes. Issues with technology use arise from time to time. If a technology issue does occur regarding an assignment submission, email your clinical instructor and attach a copy of what you are trying to submit. This lets your faculty know you completed the assignment on time and are just having problems with the online submission feature in Blackboard. Once the problem is resolved, submit your assignment through the appropriate submission feature. This process will document the problem and establish a timeline. Be sure to keep a backup of all work.
Policy on Late Work, Revisions, or Missed Assignments: Due dates and times for assignments are posted. Failure to submit an assignment by the deadline will result in a fifteen point deduction per day past the posted deadline. Assignments submitted more than one week past the deadline will result in a documented counseling, unsatisfactory, and a revised deadline. If revisions to the late assignment are deemed necessary, a new submission deadline will be assigned and an automatic 15 point deduction will be taken (i.e. all revised assignments will start at an 85% as the maximum grade). Failure to submit the revised assignment by the deadline will result in another documented counseling and unsatisfactory. Further revisions are at the discretion of the instructor.

Revisions of Assignments: Failure to score a 70 on an assignment is unsatisfactory performance which requires counseling and revisions. A new submission deadline will be assigned and an automatic 15 point deduction will be taken (i.e. all revised assignments will start at an 85% as the maximum grade). Failure to score a 70 on the revised assignment by the deadline will result in another documented counseling and unsatisfactory. Further revisions are at the discretion of the instructor.

ACADEMIC INTEGRITY
Academic honesty is expected on all work. Students are expected to maintain complete honesty and integrity in their educational experiences. Any student found guilty of any form of dishonesty in academic work is subject of disciplinary action and possible expulsion from ASU. All codes and policies are set forth in the University Student Handbook of Angelo State University http://www.angelo.edu/student-handbook/ as well as the Department of Nursing Undergraduate Student Handbook http://www.angelo.edu/dept/nursing/handbook/index.html.

The University "faculty expects all students to engage in all academic pursuits in a manner that is above reproach and to maintain complete honesty and integrity in the academic experience both in and out of the classroom setting and may initiate disciplinary proceedings against a student accused of any form of academic dishonesty, including but not limited to, cheating on an examination or other academic work, plagiarism, collusion, and the abuse of resource materials."

PLAGIARISM
Plagiarism at ASU is a serious topic. The Angelo State University’s Honor Code gives specific details on plagiarism and what it encompasses. Plagiarism is the action or practice of taking someone else's work, idea, etc., and passing it off as one's own. Plagiarism is literary theft.

In your discussions and/or your papers, it is unacceptable to copy word for word without quotation marks and the source of the quotation. We use the APA Style Manual of the American Psychological Association as a guide for all writing assignments. Quotes should be used sparingly. It is expected that you will summarize or paraphrase ideas giving appropriate credit to the source both in the body of your paper and the reference list. Papers are subject to be evaluated for originality via Bb Safe Assignment or Turnitin. Resources to help you understand this policy better are available at the ASU Writing Center http://www.angelo.edu/dept/writing_center/academic_honesty.php.

PERSONS WITH DISABILITIES AND SPECIAL ACCOMMODATIONS REQUEST
“Disability Services is part of the Office of Student Affairs at Angelo State University. Angelo State’s Office of Student Affairs works to ensure that qualified students with disabilities have equal access to all institutional
programs and services. The office advocates responsibly for the needs of students with disabilities and educates the campus community so that others can understand and support students with disabilities.”

For more information on learning disabilities and how to apply for accommodations through the ASU Disability Services visit http://www.angelo.edu/services/disability-services/

The following includes contact information for Disability Services at ASU:

    ada@angelo.edu
    Phone: 325-942-2047
    Fax: 325-942-2211
    Address: Houston Harte University Center, 112, ASU Station #11047, San Angelo, TX 76909

INCOMPLETE GRADE POLICY (OP 10.11 Grading Procedures)
It is policy that incomplete grades be reserved for student illness or personal misfortune. Please contact faculty if you have serious illness or a personal misfortune that would keep you from completing course work. Documentation may be required.

STUDENT ABSENCE FOR OBSERVANCE OF RELIGIOUS HOLY DAYS
“A student who intends to observe a religious holy day should make that intention known in writing to the instructor prior to the absence.” Please see ASU Operating Policy 10.19.

COPYRIGHT POLICY
Students officially enrolled in this course should make only one printed copy of the given articles and/or chapters. You are expressly prohibited from distributing or reproducing any portion of course readings in printed or electronic form without written permission from the copyright holders or publishers.

SYLLABUS CHANGES
The faculty member reserves the option to make changes as necessary to this syllabus and the course content. If changes become necessary during this course, the faculty will notify students of such changes by email, course announcements and/or via a discussion board announcement. It is the student’s responsibility to look for such communications about the course on a daily basis.

WEBLINKS:
Board of Nursing for the State of Texas http://www.bne.state.tx.us/
BSN Student Resources http://www.angelo.edu/dept/nursing/student_resources/

COURSE EVALUATION
Students are provided the opportunity and are strongly encouraged to participate in an end of the semester course evaluation. There is a student evaluation of clinical facility and a student appraisal of teacher effectiveness – clinical practicum evaluation that is provided for feedback.

“In order to ensure consistent, sufficient student feedback regarding programs and services provided for students by the Department of Nursing, as required by our accreditation requirements, opportunities for students to evaluate both their courses and course instructor will be provided. Student opinions and
feedback are valued and are part of each Course and Instructor evaluation process.”

RUBRICS FOR ASSIGNMENTS
ROLE OF RN DURING CARDIAC EMERGENCIES & CARDIAC OR RESPIRATORY ARREST

SUBJECT: Nursing Resuscitation and Cardiac Arrest Management

PURPOSE: To provide the student with theoretical knowledge in performance of the nursing interventions essential during a cardiac arrest in the practice of professional nursing.

SUGGESTED READING: Skills Manual

LEARNING ACTIVITIES: Skills Performance
CPR for Health Care Professionals

VIEW: Videos: Cardiac Emergencies and Cardiac Arrest

OBJECTIVES: The student will be able to demonstrate basic understanding related to the following assessment and psychomotor skills.

1. Assessment of need for and initiation of cardiopulmonary resuscitation.
2. Utilization of the institutions mechanism of reporting a cardiac arrest that summons appropriate help.
3. Know the location of and routine checking of “Crash Cart” with emergency equipment and medications on your unit.
4. Recognize the role of the arrest team and leader and helping facilitate the life sustaining interventions.
5. Identify the progression of resuscitative interventions until client is stabilized and/or heroic measures are terminated.
6. Provide psychosocial comfort and understanding emotional support to family members of arrest victim.
7. Identify the elements of Cardiac output.
9. Recognize the role of the nurse in assessing the client with chest pains.
10. Analyze signs and symptoms of myocardial infarction.

EVALUATION: Required current American Heart Association “Health Care Professional.”
A. GOAL: To provide opportunities for the student to gain knowledge and participate in patient care.

B. DEFINITION: The Nurse must possess good assessment skills and sound clinical knowledge and be able to apply this knowledge.

C. OBJECTIVES: The student will:

1. Become aware of the various aspects of nursing care as an interdisciplinary component of patient care.
2. Identify the operation of the department, i.e.
   a. Duties and functions of the various personnel
   b. Equipment
   c. Communication system
3. Observe and/or assist with the use of treatments and therapeutic measures related to the department.
4. Identify the needs for skills in assessment based on all body systems.
5. Identify the skills needed in patient and family teaching.
6. Provide emotional support for the client, family members as needed.
7. Infection control
   a. Reporting communicable diseases required
   b. Universal precautions

D. PREPARATION:
   a. Going to the hospital the night before and selecting your patients. Write your name and title by the room number on the student assignment sheet at the hospital.
   b. Obtaining database information and complete flow sheets and care plans.
   c. Research patient’s medications and complete medication sheet.

E. EVALUATION: Short evaluation of your experience to be presented in post conference.
A. GOAL: To provide selected opportunities for the student to gain knowledge of patient care and equipment utilized in the ICU.

B. DEFINITION: An ICU nurse works with smaller client-nurse ratio, and has the ability to utilize skilled emergency nursing care.

C. PREPARATION: Clinical ICU Rotation

D. The day before ICU rotation: pick one patient who will be available throughout your rotation.

E. OBJECTIVES: The student will:

1. Become more aware of the pathophysiologic changes that occur in ICU.
2. Practice recognizing the clinical manifestations of disorders of the cardiovascular system.
3. Gain knowledge of the treatments used in the care of patients in the ICU.
4. Develop skill in planning and providing nursing care (physical and psychological) to patients and their families.
5. Show initiative by finding learning experiences on their own.
6. Observe the use of treatments and/or therapeutic measures related to the ICU setting, for the skills listed below:
   a. oxygen administration
   b. tracheal intubation and care
   c. arterial blood gases monitoring
   d. use of the Ambu bag
   e. nebulization and humidification of ventilatory treatments
   f. chest tube placement and drainage bottle controlled suction
   g. electrocardiographic monitoring
   h. nasogastric tubes and irrigation/suction controls
   i. hemodynamic monitoring
7. Observe specialized monitoring and nursing implications related to:
   a. respiratory function via volume ventilator
   b. Central Venous Pressure monitoring lines and infusions
   c. Pulmonary artery wedge pressure monitoring lines
8. Refine physical assessment skills in relation to the critically ill ICU patient’s:
   a. respiratory status
   b. cardiovascular status
   c. neurological status
   d. renal function status
9. Observe use of emergency equipment with checks for working function of:
   a. crash cart - defibrillator - emergency medications
   b. emergency suction equipment and airway/ventilation maintenance equipment
   c. emergency oxygen therapeutic modalities

The experience will include client care assignments with the assistance of the ICU staff.

**EVALUATION:**

Short evaluation of your experience, safety scan, and patient-centered interview presented in post conference.
EMERGENCY OR AMBULATORY CARE UNIT GUIDELINES

F. GOAL: To provide opportunities for the student to gain knowledge and participate in emergency/ambulatory patient care.

G. DEFINITION: The Emergency/Ambulatory Care Nurse must possess good assessment skills and sound clinical knowledge and be able to apply this knowledge.

H. OBJECTIVES: The student will:

1. Become aware of the various aspects of emergency care/ambulatory care.
2. Identify the operation of the emergency/ambulatory department, i.e.
   a. Duties and functions of the various personnel
   b. Equipment
   c. Communication system
   d. Become familiar with hospital policy and procedure when a patient is admitted to a nursing unit from the emergency/ambulatory care unit.
3. Observe and/or assist with the use of treatments and therapeutic measures related to the emergency/ambulatory care unit.
4. Identify the needs for skills in assessment based on all body systems.
5. Identify the skills needed in patient and family teaching.
6. Provide emotional support for the client, family members, and/or others accompanying the patient to the emergency/ambulatory care unit.
7. Infection control
   a. Reporting communicable diseases required
   b. Universal precautions

I. EVALUATION:

Short evaluation of your experience to be presented in post conference. Written: Clinical Assignment for ER
CLINICAL ASSIGNMENT FOR ER

Instructions – Prior to the ER rotation, students will do a library database assignment looking at research recommendations and standards for safety, and patient-centered care (this also includes cultural diversity). Use literature and standards for the ER or relevant to the ER.

Create a 1-2 page single sheet document (front and back) summarizing recommendations in the articles. This part of the assignment is not APA formatted and can be single spaced. On the back, include an APA formatted reference list of 3 or more peer-reviewed sources. Two must be journal articles. Make 10 copies of this front-and-back sheet or email so you can share it with the units and your peers. On a separate sheet, create a table comparing the standards or literature recommendations with actual practice on the units. Under the table, describe your personal reflections on the safety or patient-centered care issues on that unit.

<table>
<thead>
<tr>
<th>Recommendations/Standards</th>
<th>Unit Practices</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Personal Reflections of Patient-Centered Care and Safety

- Describe how you respect and encourage individual expression of patient values, preferences, and needs
- Describe personally held attitudes about working with patients from different ethnic, cultural, and social backgrounds
- Share observations of identified safety concerns
- Identify system actions you can take as a professional nurse to improve care delivery and/or implement research findings
NUR 4321 Clinical Practicum  
Clinical Assignment for ER  
Grading Rubric

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Points Possible</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use library databases to review the literature exploring safety or patient-centered care. Include an APA formatted reference list of 3 or more peer-reviewed sources (Two must be journal articles).</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>2. Create a 1-2 page single sheet document (front and back) summarizing recommendations in the articles.</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>3. Create a table comparing the standards or literature recommendations with actual practice on the unit.</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>4. Describe personal reflections of patient-centered care and safety.</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>5. Identify system actions you can take as a professional nurse to improve care delivery and/or implement research findings.</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>6. Make 10 copies of the summarization of the recommendations and APA formatted reference list to share with the unit and your peers.</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total (Must have a 70 for Satisfactory performance)</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Please do not plagiarize, as this is grounds for failure. As much as possible one should paraphrase (put into your own words) when referencing sources. One may use quotes as appropriate. All papers are subject to submission to Safe Assignment or Turnitin to assess for plagiarism. Spelling, punctuation, and grammar needs to be correct.
DISCHARGE PLANNING/COORDINATION OF CARE ASSIGNMENT

At or shortly after admission of the patient (during the assessment phase), it is the nurse’s responsibility to begin a discharge plan. These plans are based upon information obtained on admission and can be revised as necessary as the patient’s condition changes. Communicate and interact with the patient, intraprofessional health care team, family, and the community to develop the discharge plan. It is each student’s responsibility to complete a Discharge Planning/Coordination of Care Assignment. Include an appropriate plan for patient diagnosis and condition. At a very minimum, these plans should include:

Assessment
Perform a comprehensive assessment of the patient needs including patient resources (educational level, literacy level, social support, and financial resources), educational resources, and nursing resources. Explore issues with patient’s home environment.

PATIENT: ___________ ADMISSION DATE: _________ PREDICTED DISCHARGE DATE: _________
PLANS TO DISCHARGE TO: HOME_______ NURSING HOME_______ SNF _________ OTHER___________
HEALTHCARE COVERAGE:________________________________________________________________
ADMITTING DIAGNOSES:
HISTORY OF PRESENT ILLNESS AND HOSPITAL COURSE:
PRESENT DIAGNOSIS: (if changed from admitting)
CHRONIC ILLNESSES:
PATIENT RESOURCES (educational level, literacy level, social support, and financial resources):
EDUCATIONAL RESOURCES:
NURSING RESOURCES:
HOME ENVIRONMENT:

Patient Outcomes
Develop expected patient outcomes which realistic, measurable, and include a timeframe.

Plan
Collaborate with the patient, family, Case Manager/Coordinator of Care and intraprofessionals for development of discharge plan. Document communication and collaboration with a minimum of 4 members of the intraprofessional health care team. Advocate for the patient.
Community Resources
Identify agencies for nutrition, finances, personal care, medical equipment needs, and professional care service. Provide overview of services provided.

Implementation
Health Education
Explain initiation of the referral process and arrangements made for equipment. Improve coordination and communication between providers, settings, or periods of time during illness applying METHOD Guidelines:

A ACTIVITY: Does the patient have activity restrictions? Assess the patient’s functional level and instruct the patient on the plan for progression of activities as identified by the interdisciplinary team.

M MEDICATIONS: The patient is (or will be) taking. Does the patient know what the medication is for; when to take it; how long to keep taking it; what the expected actions of the medications are; and what kind of side effects to watch for? Should the patient request an easy-open container or can he manipulate a “child-proof” one? Pain management instruction?

Written at level of patient understanding, i.e. 3 times a day with medication.

E EQUIPMENT: Will the patient require special equipment (i.e., walker, bedside commode, etc.)? Will he need special instructions on how to use it?

EXERCISES: Are there any special exercises to be done at home?

T TREATMENTS: Does the patient know how to take care of the wound? Will special instruction need to be given to family members? Can the patient return-demonstration any procedure that will be required at home?

H HELP: Will the patient need special help at home or can family manage care? If family cannot manage care, should alternative home arrangements (i.e., nursing home, home health) be made?

O ORGANIZATIONS: Are community resources needed? If so, have referrals been made to proper person(s)?

OFFICE VISIT: Does patient know when next office appointment is? Does he have transportation to get there? Does he understand if he needs to have lab or x-rays done before the visit?

D DIET: Are these any diet modifications needed? Does patient understand diet restrictions? Is consult needed?

S SAFETY: Plan ways to adapt the home environment to the patient’s current functional ability. Patient’s strengths as well as limitations are considered. Goal is for as much independence as safely possible. Collaborate with the interdisciplinary team and the patient to identify a safe and feasible plan. Should the
patient avoid driving, operating machinery, etc. due to drowsiness?


STRESS MANAGEMENT: Determine what was helpful in the past and develop a plan with the patient. Instruct the patient on coping strategies-specific skills or actions consciously used to manage effects of stress.

**Evaluation**
Describe the interventions utilized in relation to discharge planning and evaluate them in terms of measurable outcome criteria.
<table>
<thead>
<tr>
<th>Points Earned/Possible</th>
<th>Grading Criteria Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>/15</td>
<td><strong>Assessment</strong>&lt;br&gt;-Performs a comprehensive assessment of the patient needs including patient resources (educational level, literacy level, social support, and financial resources), educational resources, and nursing resources&lt;br&gt;-Explores issues with patient’s home environment</td>
<td></td>
</tr>
<tr>
<td>/5</td>
<td><strong>Patient Outcomes</strong>&lt;br&gt;-Develops expected patient outcomes&lt;br&gt;-Each outcome is realistic and measurable, timeframe included</td>
<td></td>
</tr>
<tr>
<td>/15</td>
<td><strong>Plan</strong>&lt;br&gt;-Collaborates with the patient, family, Case Manager/Coordinator of Care and intraprofessionals for development of discharge plan&lt;br&gt;-Advocates for patient</td>
<td></td>
</tr>
<tr>
<td>/5</td>
<td><strong>Community Resources</strong>&lt;br&gt;-Identifies agencies for nutrition, finances, personal care, medical equipment needs, and professional care service&lt;br&gt;-Provides overview of services provided</td>
<td></td>
</tr>
<tr>
<td>/20</td>
<td><strong>Implement</strong>&lt;br&gt;-Improves coordination and communication between providers, settings, or periods of time during illness applying METHOD Guidelines&lt;br&gt;-Health Education&lt;br&gt;-Explains initiation of the referral process and arrangements made for equipment</td>
<td></td>
</tr>
<tr>
<td>/20</td>
<td><strong>Evaluate</strong>&lt;br&gt;-Describes the interventions utilized in relation to discharge planning and evaluates them in terms of measurable outcome criteria</td>
<td></td>
</tr>
<tr>
<td>/10</td>
<td><strong>Quality References</strong>&lt;br&gt;-Uses at least 3 references from professional, peer-reviewed journals and/or publications, published within the last five years. References demonstrate use of RAMNET and RAMCAT library search tools-professional nursing databases such as CINAHL.</td>
<td></td>
</tr>
<tr>
<td>/10</td>
<td><strong>APA Format</strong>&lt;br&gt;-Cites references correctly in the body of the paper&lt;br&gt;Title page is included and follows APA style&lt;br&gt;Reference list is formatted following APA style</td>
<td></td>
</tr>
<tr>
<td>/100</td>
<td><strong>Total (Must have a 70 for Satisfactory performance)</strong></td>
<td></td>
</tr>
</tbody>
</table>
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CLINICAL ASSIGNMENT FOR MENTAL HEALTH

Instructions- The purpose of this assignment is to provide the student experience with mental health concepts and application. The questions will promote clinical reasoning as it relates to the mental health client with comorbidities. The assignment is to be completed during the assigned 20 hours of Mental Health clinical. The student will utilize all available resources including: facility forms, informatics, and clinical staff; library data bases and internet resources; mental health textbooks; nursing journals; instructors, etc. Assignment is to be written in APA format with corresponding use of references and citations.

Student Name: ______________________________

Client age__________  Client sex__________

**Diagnoses:**

Axis I diagnosis:

Axis II diagnosis:

Axis III diagnosis:

Axis IV diagnosis:

Axis V diagnosis:
History of Present Illness:

Past Medical/Surgical History:

Past Mental Health History:

Family History:

Social History:

Medications: [med, dose, route, time, reason (Include the Axis Dx)]

Lab results: Pertinent labs and labs routinely ordered for this client; notes whether results are high, low, normal; include the rationale for ordering the labs
**Client Response to Illness:** Identify client’s response to illness including any **psychological, psychosocial, or spiritual** components.

**Ethical Legal issues/concerns:** Explore any current or potential ethical-legal issues related to the care or institutionalization of your assigned client.

**Health/Wellness Risks and Behaviors:** Describe risks or behaviors related to the client’s health and wellness.

Identify barriers to changing these risks/behaviors.

How could you approach the client or effect a change to improve health/wellness?)

**Individualized Patient Needs:** (Identify individual patient care needs for this client based on **ethnicity, culture, age, sexuality, religion, etc.**

Explain how care should be adapted to meet these individual needs.

**Nursing Care Plan:** Use ADPIE format. May utilize 4 column care plan forms. Include three priority nursing care diagnoses. Diagnoses must include “related to” and “as evidenced (subjective/objective)” data pulled from client assessment and data gathered above. Plan/goal must include a timeframe for completion.

**Assessment** – utilize facility **shift** assessment tool as a guide for your client assessment.

**Diagnosis (Nursing Problem #1) _________ related to__________ as evidenced by___________**

**Plan (Timed goal)**

**Interventions**

**Evaluation**

**Diagnosis (Nursing Problem #2) _________ related to__________ as evidenced by___________**
Plan (Timed goal)
Interventions

Evaluation

Diagnosis (Nursing Problem #3) _________ related to__________ as evidenced by__________
Plan (Timed goal)
Interventions

Evaluation
1. Describe the components of an RN admission assessment (not a daily shift assessment) of a client in a mental health facility. Provide a rationale for each component of the assessment. Utilize facility RN admission assessment tools and textbooks as a guide.

2. Describe the types of client restraints used in the mental health facility. Discuss indications for each type of restraint.

3. Describe the types of clients in the mental health facility that would have nutritional deficits and provide the rationale for the nutritional deficits.

For each, identify the nutritional interventions recommended.

4. What items are restricted from units in the mental health facility?

5. What are ways clients can hurt themselves even when items which could be dangerous to a client are restricted?
6. What are some types of infection control issues you might find in a mental health facility?

What types of infection control practices did you observe?

Identify and explain three transmission based isolation techniques used in healthcare to prevent the spread of an infectious agent from an infected or colonized patient to susceptible persons.

Describe your recommendations for quality improvement of the infection control practices you observed in the mental health facility.

7. How is recreational therapy pertinent to treatment at a mental health facility?

What types of recreational therapy did you observe?

How was it effective?

8. Describe any hostile, angry or aggressive client behavior that you observed and how it was handled by mental health staff.

What interventions were used?

Were they effective - why or why not?
What staff behaviors were good examples that you would like to emulate?

9. Describe at least 3 therapeutic communication techniques you observed or implemented during your interaction with mental health clients in this setting.

Were there communication barriers? How were they overcome?

10. Describe how the mental health setting you visited met the individualized needs of the mental health client.
### NUR 4321 Clinical Practicum
#### Clinical Assignment for Mental Health
#### Grading Rubric

<table>
<thead>
<tr>
<th>Grading Criteria and Instructor Comments</th>
<th>Points Earned/Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis Diagnoses</td>
<td>/2</td>
</tr>
<tr>
<td>HPI, Past Medical/Surgical, Mental Health, Social History, Family History</td>
<td>/5</td>
</tr>
<tr>
<td>Medications</td>
<td>/8</td>
</tr>
<tr>
<td>Lab</td>
<td>/4</td>
</tr>
<tr>
<td>Client Response to Illness</td>
<td>/2</td>
</tr>
<tr>
<td>Ethical Legal Issues/Concerns</td>
<td>/5</td>
</tr>
<tr>
<td>Health/Wellness Risks and Behaviors</td>
<td>/5</td>
</tr>
<tr>
<td>Individualized Client Needs</td>
<td>/5</td>
</tr>
<tr>
<td>Nursing Care Plan</td>
<td>/15</td>
</tr>
<tr>
<td>RN Admission Assessment and Rationale</td>
<td>/10</td>
</tr>
<tr>
<td>Restraints</td>
<td>/2</td>
</tr>
<tr>
<td>Nutritional Interventions and Rationale</td>
<td>/5</td>
</tr>
<tr>
<td>Safety/Infection Control</td>
<td>/5</td>
</tr>
<tr>
<td>Recreational Therapy</td>
<td>/2</td>
</tr>
<tr>
<td>Behavior Modification Interventions</td>
<td>/5</td>
</tr>
<tr>
<td>Therapeutic Communication</td>
<td>/5</td>
</tr>
<tr>
<td>Individualized Client Needs</td>
<td>/5</td>
</tr>
<tr>
<td>BSN level writing, APA formatting, Appropriate Use of References, and Reference page:</td>
<td>/10</td>
</tr>
<tr>
<td><strong>Total (Must have a 70 for Satisfactory performance)</strong></td>
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Clinical evaluation provides the student with criteria for achieving clinical objectives. It also measures whether or not the student has satisfactorily met the learning outcomes during the clinical practicum. These tools evaluate four broad areas: Member of the Profession, Provider of Patient Centered Care, Patient Safety Advocate, and Member of the Healthcare Team. (These areas derived from the Board of Nurse Examiners document Differentiated Entry Level Competencies of Graduates of Texas Nursing Programs, 2002. Additional clinical behaviors, derived from the same document, are listed under each of these broad areas.) If the clinical instructor observes behaviors, which in his/her judgment indicates that the student is not satisfactorily meeting criteria for any one of the three areas, the student will receive an “ Unsatisfactory” rating for that area. An “ Unsatisfactory” final rating on a critical behavior will result in failure of the clinical practicum, regardless of the behaviors assessed in the remainder of the tool.

Please read the guidelines below, as well as the tools, to be sure that you clearly understand the clinical evaluation process.

**Responsibilities of the clinical instructor:**

a. Clarify any part of the tools that are unclear to the student. Discuss how the tools will be used to evaluate clinical performance.

b. Assign an evaluation for each of the categories on the tool, based on the applicable behaviors listed under each category.

c. Make additional comments as indicated to note deficiencies, as well as strengths or outstanding performance.

d. Document an evaluation during the fourth, eighth, and fifteenth week of the semester.

e. Allow the student to review the evaluation during the fourth, eighth, and fifteenth week of the semester.

**Responsibilities of the student:**

a. Review the tools carefully and ensure that you understand it. Obtain clarification from the clinical instructor if necessary.

b. Be accountable for learning and provide evidence of that learning.

c. Participate fully in clinical assignments to meet as many of the clinical objectives and listed clinical behaviors as possible.

d. Review the assigned evaluation rating and sign in the space indicated. It is the student’s responsibility to discuss areas of difference with the clinical instructor.
**NUR 4321 Adult Health II**  
**Clinical Evaluation**  

<table>
<thead>
<tr>
<th>Competency Score:</th>
<th>Deficient-0</th>
<th>Novice-1</th>
<th>Developing-2</th>
<th>Competent-3</th>
<th>Accomplished-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Site/Unit:</td>
<td></td>
<td></td>
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<tr>
<td>Faculty/Preceptor:</td>
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</table>

**Preceptor or Faculty Score:**  

**Preceptor/ Faculty Comments:**

### MEMBER OF THE PROFESSION

<table>
<thead>
<tr>
<th>Professionalism</th>
<th>1. Functions within nursing legal and ethical principles according to national and state standards of practice.</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2. Assumes responsibility for actions and nursing care delivered.</td>
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<tr>
<td></td>
<td>3. Actively contributes to the learning process through self-reflection to promote self-growth and seeks out own learning opportunities.</td>
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<tr>
<td></td>
<td>4. Strictly complies with professional appearance, professional behaviors such as integrity, respect, punctuality, clinical preparedness and safety requirements according to ASU Nursing and facility/organizational standards policies.</td>
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<tr>
<td></td>
<td>5. Utilizes feedback and constructive criticism from faculty or clinical nurses positively to improve performance.</td>
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</tbody>
</table>

### PROVIDER OF PATIENT CENTERED CARE

<table>
<thead>
<tr>
<th>Nursing Plan of Care</th>
<th>1. Prioritize and participates in the nursing care plan for 2 patients with critical and acute illness in a timely manner.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Performs comprehensive nursing assessment to identify needs, preferences, and problems to create patient centered goals for acute, complex patient populations, families and communities.</td>
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<tr>
<td></td>
<td>4. Safely implements and adapts nursing interventions to meet patient populations, family, and community holistic health care needs.</td>
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<tr>
<td></td>
<td>5. Evaluates patient outcomes and modifies nursing care to meet patient population, family, and/or community needs.</td>
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</tbody>
</table>

35
<table>
<thead>
<tr>
<th>Documentation</th>
<th>6. Utilizes evidence-based research to develop and participate in teaching plans and discharge planning for patients and families with acute or critical illness.</th>
</tr>
</thead>
</table>
| Clinical Reasoning | 7. Actively participates in reports and accurately documents ongoing nursing care and patient outcomes in a timely manner using informatics, EMR, or standard narrative formats.  
8. Elaborates upon connections of patient diagnosis, complex disease processes, laboratory values, medication administration and nursing treatments.  
9. Readily discusses and synthesizes reasons for deviation from plan of care and identifies and reports change in health care status of patients. |
| Evidence Based Practice | 10. Integrates evidence-based research nursing practices to promote quality health care outcomes for patient populations, families, and communities with complex medical and psychiatric conditions. |

**PATIENT SAFETY ADVOCATE**

| Safety & Quality | 1. Implements measures to promote quality and safety in all environments for patient/families/staff and assesses environment for risks or hazards and intervenes appropriately.  
2. Obtains instruction, supervision, or training as needed when implementing nursing procedures or practices.  
3. Clarifies, reports, and/or intervenes in specific issues affecting safety or quality of care.  
4. Uses evidence and research to develop strategies to increase teamwork, prevent errors, and improve quality. |
| Advocacy | 5. Advocates for patients/families health care rights and access.  
6. Adapts nursing care to provide individualized care for a diverse, complex patient population. |

**MEMBER OF THE HEALTHCARE TEAM**

| Communication | 1. Communicates and interacts appropriately with the intraprofessional healthcare team, faculty, staff, peers, colleagues, patients, families and communities to increase quality, safety, and continuity of patient care.  
2. Utilizes health care informatics and EMR to document comprehensive patient information to promote continuity of care. |
<p>| Resources | 3. Coordinates available resources effectively to meet patient, family, and community health care needs including discharge planning while practicing cost containment measures. |</p>
<table>
<thead>
<tr>
<th>Leadership</th>
<th>4. Participates with faculty or assigned nurse in safe delegation, supervision, leadership, and management of nursing care.</th>
</tr>
</thead>
</table>

4 = Accomplished (Independent without direction; Proficient, coordinated, confident; Expedient use of time. Focuses on patient; Proficient skills)
3 = Competent (Supervised with occasional physical or verbal direction; Efficient, coordinated, confident; Reasonable use of time; competently skilled)
2 = Developing (Assisted with frequent verbal and/or physical direction; Partial demonstration of skills. Inefficient or uncoordinated; Delayed time expenditure)
1 = Beginning/Novice (Marginal, requires continuous verbal and/or physical direction; Unskilled and inefficient; Considerable and prolonged time expenditure)
0 = Deficient (Dependent, continuous verbal and/or physical direction; Unable to demonstrate procedures; Lacks confidence, coordination, and/or efficiency. Potential harm to self and patient)

Recommendations/Comments:

Preceptor/Faculty Signature:________________________________________________________  Students Signature:________________________________________________________ Date:____________________
Student Action/Remediation Plan Initiated:________YES________NO
Student Referred:________________________YES________________________NO
End of syllabus.