Appendices

HOW TO GET THE CHART TO HELP YOU DO YOUR PREP SHEET AND CARE PLAN

A. REVIEW EACH OF THE FOLLOWING RECORDS ANALYZING THE INFORMATION ON EACH

1. Vital sign sheet

2. Intake and output sheet

3. Physician's orders

4. Physician's progress notes, history and physical

5. Nurse's notes

6. Medication records (MARS)

7. Nursing admission assessment

8. Admission record

B. ASK YOURSELF THE FOLLOWING QUESTIONS

1. Why was my client admitted to the hospital? (clinical area)

2. What medical interventions has my client undergone?

3. What is the expected plan of care for this client?

C. REVIEW THE LAST TWO DAYS OF THE PATIENTS CHART

1. What are the actual and potential nursing diagnoses for this client? Place them in the priority of care.

2. Examine the lab and diagnostic tests that have abnormal results. What implications do these have for your nursing care and your client's outcomes?

3. What medications is your client taking? Why is your client on these medications? Are they different than the ones your client takes at home? What are the nursing implications of these drugs?

D. WHY DO I NEED TO DO THIS?

1. It will assist you in giving safe client care.

2. It will speed up your time reading the chart, yet allow you to obtain the necessary baseline data.

3. It will allow you an appropriate, efficient and timely use of the client's chart.

4. It will assist you in developing skills in using the client's chart as a forerunner of giving care.

Adapted from:

Guttmen. (1996). Orientation to the clients chart: A clinical learning tool. *Nurse Educator, 21(5), 5-6.*

ILLUSTRATIVE BEHAVIOR TERMS FOR STATING LEARNING OUTCOMES

COGNITIVE DOMAIN	
KNOWLEDGE	Defines, describes, identifies, labels, lists, matches, names, outline, reproduces, selects, states
COMPREHENSION	Converts, defends, distinguishes, estimated, explains, extends, generalizes, gives examples, infers, paraphrases, predicts, rewrites, summarizes
APPLICATION	Changes, computes, demonstrates, discovers, manipulates, modifies, operates, predicts, prepares, produces, relates, show, solves, uses
ANALYSIS	Breaks down, diagrams, differentiates, discriminates, distinguishes, identifies, illustrates, infers, outlines, points out, relates, selects, separates, subdivides
SYNTHESIS	Categorizes, combines, compiles, composes, creates, devises, designs, explains, generates, modifies, organizes, plans, rearranges, reconstructs, relates, reorganizes, revises, rewrites, summarizes, tells, writes
EVALUATION	Appraises, compares, concludes, contrasts, criticizes, describes, discriminates, explains, justifies, interprets, relates, summarizes, supports
AFFECTIVE DOMAIN	
RECEIVING	Asks, chooses, describes, follows, gives, holds, identifies, locates, names, points to, selects, sits erect, replies, uses
RESPONDING	Answers, assists, complies, conforms, discusses, greets, helps, labels, performs, practices, presents, reads, recites, reports, selects, tells, writes
VALUING	Completes, describes, differentiates, explains, follows, forms, initiates, invites, joins, justifies, proposes, reads, reports, selects, shares, studies, works
ORGANIZATION	Adheres, alters, arranges, combines, compares, completes, defends, explains, generalizes, identifies, integrates, modifies, orders, organizes, prepares, relates, synthesizes
CHARACTERIZATION BY A VALUE OR VALUE COMPLEX	Acts, discriminates, displays, influences, listens, modifies, performs, practices, proposes, qualifies, questions, revises, serves, solves, uses, verifies
PSYCHOMOTOR DOMAIN	
PERCEPTION	Choose, describes, detects, differentiates, distinguishes, identifies, isolates, relates, selects, separates
SET	Begins, displays, explains, moves, proceeds, reacts, responds, shows, starts, volunteers
GUIDED RESPONSE	Assembles, builds, calibrates, constructs, dismantles, displays, dissects, fastens, fixes, grinds, heats, manipulates, measures, mends, mixes, organizes, sketches, works
MECHANISM	Same as guided response
COMPLEX OVERT RESPONSE	Same as guided response
ADAPTATION	Adapts, alters, changes, rearranges, reorganizes revises, varies
ORIGINATION	Arranges, combines, composes, constructs creates, designs, originates

Modified from
Gronlund, N.S. (1978) Stating behavioral objectives for classroom instruction, (2nd ed.). New York: The Macmillan Co. Used with permission.

ARKANSAS TECH UNIVERSITY
NUR 3404-Practicum 1
Prep Sheet

Textbook physiology of normal functioning based on patient's diagnosis.	Textbook variations in normal physiology based on patient's diagnosis.	Growth and development: Identify stage, developmental task, anticipatory guidance needed, and incorporate into care plan.
Take the patient's diagnosis and explain in this column the normal anatomy and physiology of the malfunctioning body part. For example, CHF. Explain the normal anatomy and physiology of the heart and lungs.	In this column, explain the pathophysiology of CHF, or the disease/condition. Explain **why** this is bad. How is ADL affected? How does this affect your patient? What are the signs/symptoms exhibited? What lab values would you expect? What results would you expect from the diagnostic tests completed for the diagnosis, like EKG, EEG, CT Scan, x-ray...? What complications would you expect to see from this disease process?	In this column, select what stage of growth and development the patient exhibits; explain the stage and the relevant behaviors; and discuss how this information is useful in planning the care of your patient. For example, Maslow or Erickson, or Havinghurst. Use this information in helping you select nursing interventions, rationales. 1) What level of development is the client? 2) What are the developmental tasks for the client at this stage (level) of development? 3) What anticipatory guidance is needed?

Patient Initials: _____ **NURSING CARE PLAN** Student's Name _____ Date _____

DATE	NURSING DIAGNOSIS	PLAN (Outcome)	IMPLEMENTATION	RATIONALE	EVALUATION
	PRIORITY # ___ Nsg Dx: The problem you have identified for your pt. R/T – What caused the problem AEB – data you have that supports this as a problem, including but not limited to: Diet Meds Labs Dx Tests Physical Assessment Textbook Info.	Goal comes from your nsg dx statement, not R/T or 2^0 Goal: What the pt is to accomplish during your clinical time. By accomplishing this goal you help to reduce, remove or eliminate most or all of the problem listed in column one. You will help to eliminate, reduce, or remove the data under AEB or the R/T. Must be pt specific, measurable, and with a specific time frame.	Actions you will take to meet the goal. May be actions pt will take. Should be a guideline that anyone can follow and meet the same, or do better than what you would do. Should be specific, with numbers, ranges, measurable. Each intervention should be associated with a goal. Should include actions <u>you took</u> during your clinical day. Should be aimed at meeting your goal.	Supports the chosen intervention. Should be specific. Should come from some type of reference book, not out of your head.	Look at your intervention and determine your pt's response to the intervention. Look at your goal. Did you meet the goal? Identify what changes you will make to your plan of care. Write these changes here.

CLINICAL LOG

PRACTICUM I

NAME_____

CLINICAL INSTRUCTOR_____

Adapted From:
Cassidy, V. R., & Davidson, J. L. (1992). *A diary for effective clinical experiences in nursing*. Cortland, Illinois: Prairie Publications.

Directions

This clinical log was developed by Virginia Cassidy and Jane Davidson to help you reflect about your clinical experiences as a nursing student. Thoughtful reflection is useful in the process of self-evaluation.

Your first entry in the log should reflect your overall goals for the semester. The remaining pages of the log have three kinds of entries: a ranking from high to low on four core areas of nursing practice, some open-ended statements to guide your thinking about your experiences, and your own personal impressions. An "other" category has also been included in the ranking component to provide for the self-evaluation of an area specific to the clinical course.

The log is designed so that you can make an entry as you begin the clinical experience, after each of your clinical experiences, at the midterm of the semester, and at the end of the semester. Ideally your daily entry should be written as soon as possible after the clinical experience so that your recollection of the events of the day is fresh in your mind. Your daily entries should be reviewed at the midterm to help you reflect on your clinical experience to date. Daily and the midterm entries should be reviewed at the end of the semester so that your entry at the end of the clinical experience accurately reflects the events of the past semester.

Questions to help you to reflect about your clinical experiences have been provided below. Review these questions to guide your thinking as you write your entries. You may also have some additional elements you would like to add.

Communication Skills: (Consider verbal an written skills)

How effective was my communication in talking to patients/families? What kinds of things did I discuss? How do I know I was communicating effectively?

How effective was my written communication? Was I able to write my thoughts clearly? Was I able to use nursing terminology effectively? How do I know?

Clinical Skills:

How effective was I in carrying out clinical procedures? How do I know?

Teaching Skills:

How effective was I in teaching activities involving my patient and the patient's family? Were they receptive to my teaching? How do I know they could carry out or understand what I taught?

Nursing Process:

Assessment: How effective was I in conducting nursing assessment? How do I know? Nursing Diagnosis: Was I able to effectively diagnose the problem? How do I know? Planning: How effective was I in planning care? How do I know? Intervention: How effective was I in implementing a plan of care? How do I know? Evaluation: How effective were my interventions or my plan of care: How do I know?

Other:

What other elements of nursing were important to me? How effective was I in addressing these elements? How do I know I was effective?

Write your thoughts about your daily experiences. You may choose to write about a particular experience or an aspect of the experience that is of concern to you. You may wish to choose some element at random. The questions that are provided will help you structure your thoughts. In addition, a space is provided for you to write your general personal impressions about each day.

TODAY'S ENTRY: DUE WEEKLY

STUDENT'S NAME:_____

DATE:_____

CLINICAL SITE:_____

CLINICAL ASSIGNMENT:_____

Objectives I planned to meet today:

How I met the objectives:

Why I didn't meet the objectives:

Place an X on the continuum where it best reflects your assessment.

	low high
Communication Skills	
Verbal	____/____/____/____/____
Written	____/____/____/____/____
Clinical tasks	____/____/____/____/____
Teaching skills	____/____/____/____/____
Use of Nursing Process	
Assessment	____/____/____/____/____
Nursing Diagnosis	____/____/____/____/____
Planning	____/____/____/____/____
Implementation	____/____/____/____/____
Evaluation	____/____/____/____/____
Professionalism	
Standards of Care	____/____/____/____/____
Code of Ethics	____/____/____/____/____
Other_____	____/____/____/____/____

I felt good about...

I was uncomfortable with...

The decision I made during the clinical experience that stays most in my mind was...

I had problems with...

The thing that surprised me most about the experience was...

My patient's response(s) was (were)…

Things I would do differently next time are (state why)...

Overall, when I think about the experience, I learned...

Personal Impressions (Summarize briefly your day/learnings/conclusions)

DUE: FIRST SET CLINICAL PAPERWORK

GOALS FOR THE SEMESTER

Date:_____ Student's Name:_____

My personal goals in preparing to become a professional nurse this semester are...

How do my personal goals for this course relate to the course goals outlined in the syllabus?

This clinical course will help me to achieve my goals in the following ways:

End of Semester Evaluation: **Due with Final Set Paperwork**

Date:_____ Student's Name:_____

What kinds of new questions about course content have you developed by now that you would not have thought of at the beginning of the semester?

Place an X on the continuum where it best reflects your assessment.

	low				high
Communication Skills					
Verbal	____/	____/	____/	____/	____
Written	____/	____/	____/	____/	____
Clinical tasks	____/	____/	____/	____/	____
Teaching skills	____/	____/	____/	____/	____
Use of Nursing Process					
Assessment	____/	____/	____/	____/	____
Nursing Diagnosis	____/	____/	____/	____/	____
Planning	____/	____/	____/	____/	____
Implementation	____/	____/	____/	____/	____
Evaluation	____/	____/	____/	____/	____
Professionalism					
Standards of Care	____/	____/	____/	____/	____
Code of Ethics	____/	____/	____/	____/	____
Other_____	____/	____/	____/	____/	____

I have learned the following about myself as an effective, professional nurse...

I learned this by...

My nursing approach has changed in the following ways because...

I learned the following about patient care...

My professional goals for the coming semester are...

My plans for achieving these goals are...

Personal Impressions about the past semester

Student Name**:** _____ Date of care**:** _____

Arkansas Tech University
NUR 3404: Practicum in Nursing I
Assessment Form

Patient Initials: _____ M / F Room #_____DOB: _____Age:_____
Ht/Wt:_____ M / D / W / S Race:_____LMP_____
Tobacco Use Y / N : Amount:_____: Alcohol Use Y/ N : Amount:_____
Date of Admission: _____ Physician:_____
Admitting Diagnosis(es): _____
_____
Other Medical Diagnosis(es): _____
_____Spiritual/Cultu
ral beliefs affecting care? Y / N
_____

Allergies

Med/Food/Other	Reaction	Med/Food/Other	Reaction

History

Cardiovascular: MI/CHF/Angina/HTN Pacer/Defib/Arrhythmia Valve problems/PVD Other:	Hematology/Oncology: Anemia/PE/DVT/Phlebitis Prev blood transfusion Vascular Access Device Other:	Neuro: Stroke/CVA/TIA/Seizures Fainting/Dizzy/HA Mental disorder/MS Head injury Other:
GU/GI: Renal failure/Dialysis UTI/Prostate/Stones Ulcers/Hernia/UC Diverticulitis Other:	Musculoskeletal: Arthritis/Back pain Osteoporosis/MD Amputation Other:	Endocrine: Diabetes I / II Thyroid problems Other:
Pulmonary: Asthma/COPD/Emphysema Pneumonia/TB Other:	Infectious Diseases: HIV/AIDS/STD/TB Hepatitis-type_____ MRSA/MRSE/VRE Other:	Surgical: _____ _____ _____ _____

General Appearance: Alert & Responsive / Apathetic / Nonresponsive / Lethargic

Notes:_____
_____
Student Name: _____ Date of Care_____

Vital Signs: Temp/Route: _____ P:_____ R: _____ BP:_____
Pulse Ox: _____ Room Air: Y / N O_2 @_____L/min via _____

Skin: Dry Warm Cold Moist Edema Pink Flushed Cyanotic Other:_____
Turgor: < 3 sec/ > 3 sec _____ Elastic Nonelastic Fragile
Edema Y / N Location: Sacral Pedal Facial Arm Pitting: Y / N { 1+ 2+ 3+ 4+}
Oral Membranes: Pink Pale Dry Lesions: Y / N
Dressings/ Wounds/ Incisions Y/N Location:_____

Braden Pressure Ulcer Risk Assessment					
Sensory Perception:		Mobility:		Moisture:	
Completely Limited	1	Completely Immobile	1	Constantly Moist	1
Very Limited	2	Very Limited	2	Very Moist	2
Slightly Limited	3	Slightly Limited	3	Occasionally Moist	3
No Impairment	4	No Limitations	4	Rarely Moist	4
Nutrition:		Activity:		Friction & Shear:	
Very Poor	1	Bedfast	1	Problem	1
Probably Inadequate	2	Chairfast	2	Potential Problem	2
Adequate	3	Walks Occasionally	3	No Apparent Problem	3
Excellent	4	Walks Frequently	4		
Total Score: _____					

Notes/Actions_____
_____
_____

Respiratory: Effort: Easy / Labored / Equal / Unequal Accessory Muscle Use: Y / N
Rate: Regular / Slow / Rapid / Apnea Other:_____
Cough: Y / N Sputum Color: _____ Night sweats: Y / N
Sounds: Clear / Crackles / Wheezes / Rhonchi / Diminished Other: _____

Notes:_____
_____
_____

Cardiovascular: Telemetry: Y / N Rhythm: _____ Regular / Irregular
Radial Pulse: R 1+/ 2+/ 3+/ 4+ L 1+/ 2+/ 3+/ 4+
Pedal Pulse: R 1+/ 2+/ 3+/ 4+ L 1+/ 2+/ 3+/ 4+
Carotid Pulse: R 1+/ 2+/ 3+/ 4+ L 1+/ 2+/ 3+/ 4+
Jugular Venous Distention: Y / N
Cap refill/blanch: Y / N Color: Pale / Pink / Dusky / Cyanotic Homan's: Y / N
Other: _____

Notes:_____
_____
_____

Student Name: _____ Date of Care_____

Fall Risk Assessment		
Recent Falls *(To score this, complete history of falls)*	None in last 12 months…… One or more between 3 and 12 months ago... One or more in last 3 months…….. One or more in last 3 months while inpatient/resident……	2 4 6 8
Medications *(Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Antihypertensives, Hypnotics)*	Not taking any of these…….. Taking one……. Taking two …… Taking more than two……	1 2 3 4
Psychological *(Anxiety, Depression, Cooperation, Insight or Judgment, re: mobility)*	Does not appear to have any of these…… Appears mildly affected by one or more…… Appears moderately affected by one or more Appears severly affected by one or more…..	1 2 3 4
Cognitive Status *(Alert and Oriented to date, time, place, person)*	Alert & Oriented x 4 Alert and Oriented x 3 Alert and Oriented x 2 Alert and Oriented x 1	1 2 3 4
Low Risk: 5-11 Medium Risk: 12-15 High Risk: 16-20 **Risk Score: ____/20**		

Measures to prevent falls: _____
_____

Nutrition: Dentures: Y / N Ordered Diet: _____
IV therapy solution: _____ Rate:_____
PEG Tube: Y / N Ordered solution: _____Rate:_____
TPN: Y / N Rate:_____
Dextro: _____ Insulin given: Y / N Amount & Type: _____

Pain: Absent / Present If present, where? _____
Duration: Often / Constant / Occasionally / Rarely Other: _____
Pain Scale: Numeric / Wong / FLACC Severity (0-10):_____
Med given: _____ Amount: _____ IVP / PO / IM
After Med Administration: Severity: _____
Other comfort measures utilized: _____
_____
Aggravating factors:_____

Notes: _____
_____
_____

Cognitive-Perceptual/Sleep: Difficulty hearing? Y / N Smelling: Y / N Tasting: Y / N
Touch: Y / N Vision: Y / N Glasses: Y / N Contacts: Y / N
Sleep: Usual Pattern: _____ hours/night

Student Name: _____ Date of Care_____

Abdomen: Soft / Distended / Rigid / Tender / Nontender
If tender, where: RUQ / RLQ / LUQ / LLQ / Epigastric Bowel Sounds Present: Y / N- location
Drains: Y / N Type & Location: _____
NG Tube: Y / N NG Tube to: Suction / Clamped
Dressings/Wounds/Incisions: Y / N Location:_____

Notes:_____
_____
_____

Elimination:
Problems: Constipation / Diarrhea / Incontinence / Hemorrhoids / Bloody Stool
Daily Habit: Daily / Every other day / Other: _____ Last BM:_____
Colostomy: Y / N Ileostomy: Y / N
Voiding without difficulty: Y / N Indwelling Foley: Y / N Shift output: _____

Notes:_____
_____
_____

Musculoskeletal: Stiffness / Joint Swelling / Fractures / Amputation Where?_____
Range of Motion: FROM / Limited ROM Where limited?_____

Deep Vein Thrombosis Risk Assessment
Age > 40 / Decreased Mobility / Recent Hospitalization / Prior Hx of DVT / Obesity
Ischemic Stroke / Heart Failure / Lung Disease / Respiratory Failure / Pneumonia
Sepsis / Malignancy / Varicose Veins / Estrogen therapy / Birth Control Pills / Trauma
Recent Surgery / LE Fracture / Pelvic or Hip Fracture None

Notes:_____
_____
_____

Neuro: Oriented to: Time / Place / Person / Event Responds to: Speech / Noise / Pain
LOC: Alert / Drowsy / Stuporous / Comatose Pupils: Equal / Round / Reactive to Light
Strength: Hand grasps Equal / Unequal Feet flexion Equal / Unequal
Difficulty swallowing: Y / N Speech: Clear / Slurred Other: Deaf / Blind / Mute

Notes:_____
_____
_____

Activity: Up ad lib / Bedrest / BRP / Dangle / Up in Chair
ADL's: Requires: Complete assistance/ Partial assistance / Self performs
If assistance is needed, ADL's require assistance: x1 / x2 / Completely dependent

Student Name: _____ Date of Care_____

Diagnostic Tests & Results: Xray, U/S, Heart Cath, Upper GI, Colonoscopy, etc.

_____
_____
_____

Medications: See Med Sheets

Lab: See Lab Sheet

Potential Nursing Diagnosis (List all):

1)_____
_____
_____

2)_____
_____
_____
_____

3)

4)

5)

6)

7)

8)

9)

10)

***Lab Normals to be completed by student weekly. This is to be completed even if your patient did not have that lab test ordered.**

LAB TEST	Clients Values	Normal Values	⇧⇩	POTENTIAL/ ACTUAL CAUSE
CBC				
WBC				
RBC				
HGB				
HCT				
MCV				
MCH				
MCHC				
PLT (MPV)				
Auto Diff Neutro, lymph, mono, eosin, bands				
CMP				
Glucose				
BUN				
Creatinine				
Sodium				
Potassium				

***Potential/Actual Cause: Why is this lab test abnormal for my patient. Do not copy every reason why this test is abnormal.**

Chloride				
Bicarbonate				
Calcium				
ALK				
ALT (SGPT)				
AST (SGOT)				
Bilirubin				
Albumin				
Total Protein				
BUN/Creat Ratio				
Magnesium (not part of CMP)				

LAB TEST	Clients Values	Normal Values	⇧⇩	POTENTIAL/ ACTUAL CAUSE
Troponin				
CPK				
LDH				
CPK-MB				
Lipid Panel				
Total Cholesterol				
Triglycerides				
HDL				
LDL				
Misc. Lab				
BNP				
Digoxin Level				
Thyroid Studies				
Dilantin Level				
PT				
APTT				
INR				

ABG's				
pH				
PaCO2				
PaO2				
HCO3				
BE				
SaO2				
Other				

Nursing Assessment Form Explanation*

1. Student name and date of care

    a. Your name and date of care are important to place on your nursing assessment form. It is beneficial to your instructor and helps the instructor to keep your paper work separate from other students. It also helps you to review your paper work and see the progress that you have made from week to week.

2. Patient initials

    a. Never put the patient's name on your paper work. Only use initials. All information recorded on your patient's chart is confidential and falls under the HIPPA law. Ethical and legal ramifications are possible if any information about your patient, or can identify your patient is removed from the clinical setting. Clipboards that have your patient identification and information should not be left lying around where family members, friends, or even other healthcare workers not responsible in the care of your patient, may be seen. Never give information to others inside or outside the hospital, unless they are directly involved in your patient's care. Patient care should never be discussed in elevators, hallways, Wal-Mart, etc.

3. M/F

    a. Each page of the patient's chart should have a sticker on it that has this information on it. You will also find the information on the face sheet, located at the back of the chart. This is the page that the hospital registration department completes at the time of admission to the hospital or clinical site. There are many differences between the sexes that you need to know in order to better care for you patient. For example, communication, relationships, psychological, physiological, emotional and mental aspects of life.

4. Room #

    a. Located on the census sheet and/or the faxed med sheet. If you are making your own assignment, you will usually start off looking at a census sheet that has the patient's room number, name, diagnosis, and physician. It will also be found on the patient's chart, or the computer program being used by the clinical site.

5. DOB and age

    a. The patient's date of birth (DOB) and age will be found on every sheet on the chart by looking at the sticker on the chart page. It can also be found from the face sheet on the chart. This is usually located in the back of the chart. Age is associated with developmental tasks that a person must pass through as he/she experiences life. You have discussed various theories of growth and development, such as Havinghurst and Maslow. Looking at your patient's age will give you an idea of what tasks have been accomplished and are to be accomplished and then

you can take the health problems that you identify and determine how these problems can affect your patient's ability to accomplish the developmental tasks at hand.

6. Ht/Wt

    a. Part of the physical assessment, this information will usually be found in the admission nurse's notes. Your nursing care and the medical plan of care uses this information to determine weight loss, weight gain, medication dosage, outcome of care, fluid replacement, nutrition, etc. Both of these parameters reflect your patient's nutritional status. Some patients are weighed daily and this information is usually found on the graphics page.

7. Marital status

    a. This is located on the face sheet of the chart. It may also be found on the nursing admission sheet. It is an indication of an available social support system your patient may have in recovering from his/her health problems. It may also indicate reasons that you patient may or may not be adhering to his/her medical regimen. Spouses, or significant others need to be included in the care plan because they usually participate in the patient's health recovery.

8. Race

    a. This information is located on the face sheet in the back of the chart. View this section as a reflection of your patient's cultural window. Each race/culture have views on health, recovery, and adherence to the plan of care that you develop with your patient and the family and knowing these views will enable you to provide holistic care. Incorporating the cultural differences increases your patient/family adherence and cooperation in the developed plan of care.

9. LMP

    a. Last menstrual period. This information should be found on the nursing admission sheet. If not, and it is pertinent to your patient, obtain this information from your patient and record in the nurse's notes. Medications, diagnostic tests can affect the fetus.

    b. Another point to remember is that females are now beginning their menstrual periods as early as eight years of age. Sexual activity has increased among younger kids, not to mention rape or incest as a possible cause of pregnancy.

10. Tobacco use/Alcohol use

    a. This information should be found in the nursing admission notes and/or the history and physical. Obtaining this information alerts you to potential problems or causes of current health problems. It may also affect your care and the timing of that care for your patient. It will alert you to the need for education of the patient and compliance with the Arkansas

Federation of Medical Care requirements for smoking cessation, and the Arkansas State law prohibiting smoking on hospital grounds.

11. Date of admission

    a. This information should be located on every chart form in the area of sticker information. It can also be located on the face sheet. It is important to know how long the patient has been in the health care system. With the reimbursement of insurance companies, certain conditions are expected to be cared for on a limited time basis and knowing how long your patient has been in the system will alert you to insurance coverage, home health need, additional resource needs, and if the patient is on or off the expected course of treatment.

12. Physician

    a. Knowing who your patient's physician is alerts you to standing orders, method of communication, visitation times and usual methods of treatment. This can be found on each chart form in the sticker section. It can also be found on the face sheet.

    b. If a specialty physician has seen your patient, you will find this information on consultation reports. Based on the physician's specialty, you will know which physiological components of the body to assess most carefully because consultants usually focus on one body system.

13. Admitting Diagnosis

    a. This information is located on the face sheet, the history and physical and the nursing admission form. Usually this is a medical diagnosis or a surgical procedure. Though many may be listed, the admitting diagnosis will be the reason the patient was admitted to the hospital. Your physiology and pathophysiology will be completed on the admission diagnosis.

    b. If your patient is being admitted for a surgical procedure, review the physician's orders and/or consent form. The procedure should be spelled out on the consent form with no abbreviations being used.

    c. You may also find operative notes that the surgeon has made in reference to the procedure. Physiology on your prep sheet should correspond to the organ, bone, or system that the surgery is being performed. Pathophysiology should correspond as to what the problem is that surgery was required.

14. Other medical diagnoses

    a. Every health problem your patient has is usually included under this information found on the nursing admission form, the history and physical, the consultation form and sometimes on the face sheet. These are important to know because each diagnosis will affect the reason for admission and must be addressed while caring for your patient. You should look up each

diagnosis for a definition, etiology, and other information that will assist you to care for your patient holistically.

15. Spiritual/Cultural beliefs affecting care

    a. Religion, beliefs, culture are important in rendering holistic care to your patient. These influence a patient's view of sickness and types of treatment that are considered acceptable to your patient. They may influence dietary practices. Death and dying may require certain rituals. To find this information, look at the face sheet and/or the nursing admission form.

16. Allergies

    a. To locate allergies that your patient may have, look on the nursing admission information, the MARS, and/or the history and physical. You may find that they have food and medication allergies. For example, if your patient is allergic to latex, then they will also need to avoid kiwi. If they are allergic to kiwi they could possibly have a latex allergy. If a patient is allergic to penicillin, this should alert you to obtain more information from the patient if he/she is receiving the medication, Rocephin.

    b. A person's reaction to an allergy is important to know because it can mean life or death. Having a family history of allergic reactions to medications or food does not necessarily mean your patient will have that allergy, but knowing how the family member reacted will alert you to be observant of your patient for the same or similar types of reactions.

17. History

    a. This section of your assessment form is important to know because the patient's medical/surgical history can affect the success of the recovery of your patient. It can also alert you needs of your patient and what education does he/she have and what is needed. This information can be located in the nursing admission form, the history and physical, and/or from the patient or family. If you are not familiar with the answers your find, you need to at least get out your medical dictionary and get a general idea about that condition.

18. General appearance

    a. Obtained by closely observing your patient. After speaking with your patient and using your observational skills, what is your impression of the patient? If you do not know the definition of the words, look them up.

19. Notes:

    a. Record your impressions here. If you discover a problem, notate it here. This is a place to jot down your thoughts/impressions/concerns/problems identified and will refresh your memory when you complete the assessment form.

20. Vital signs

a. Vital signs are temperature, pulse, respiration, blood pressure, pulse ox, and some consider pain to be the 5th vital sign. You obtain this information when you arrive on the floor. If the aides have completed this assessment, look at the results and compare it to the previous recordings. You will find these results on the posted I & O form, the graphic, or the aide may still have them in a pocket because he/she has not had time to record. If using computerized charting, the results may be in the computer notes. Trends are what are important in vital signs. Fluctuations in vital signs are normal, but too high or too low deviations from the patient's normal are important for you to follow up on and investigate possible reasons for this deviation. Upward or downward trends require follow up also. Obtaining vital signs is more than just getting numbers. Temperatures reflect the immune system. Pulse and blood pressure reflect the cardiovascular system. Respirations reflect lung function. Pulse ox reflects oxygenation and ventilation. Pain assessment reflects many aspects of your patient's recovery process.

21. Skin

a. You complete this during your day of care of your patient. The initial skin assessment will be found in the nursing admission form. Your assessment should focus on moisture, color, turgor, edema, and oral mucous membranes must also be assessed for color and moisture. Notice if any lesions are present and describe these. If you are not familiar with the terms, look them up.

b. If your patient has a pressure ulcer, you will find additional forms in the patient chart that will reflect daily assessments, treatments and sometimes photographs of the area. They may be under physical therapy, consultation, nurse's notes, or under treatments. It is important to review these prior assessments and have an idea of what to expect when you do your assessment. You will be recording your assessment using the Braden Pressure Ulcer Risk Assessment, along with your subjective and objective assessment. If you are not familiar with this assessment, review it in your health assessment book. Also review what information is expected to be obtained in your assessment. You will record your findings in the nurse's notes and/or the skin assessment sheet.

c. Using the Braden Pressure Ulcer Risk Assessment form allows you to determine if your patient is at risk for pressure ulcers. The risk level is based on sensory perception, mobility, nutrition, activity and friction shear. Each section will be scored and then totaled. If the score is > 9, the patient is at a high risk.

d. Medicare has alerted all hospital facilities that they will not pay for treatments if the patient develops a pressure ulcer while in the hospital. Other insurances will soon follow.

e. Common nursing diagnoses associated with the skin include, but are not limited to, **Skin integrity, Impaired; Skin integrity, Impaired, Risk for; Tissue integrity, Impaired.**

22. Respiratory

a. You will assess your patient's respiratory status by auscultation and inspection. You may palpate and percuss also. The depth, rate, rhythm, use of accessory muscles, effort, symmetry auscultation of breath sounds, skin color, presence of cough (productive/nonproductive), sputum production, use of oxygen therapy, type of oxygen therapy and the rate, and if night sweats are present, are just a few of the parameters you must success.

b. Common nursing diagnoses associated with the respiratory system include, but are not limited to, **Impaired gas exchange; Ineffective airway clearance; Aspiration, Risk for.**

23. Cardiovascular

a. Part of your routine assessment of your patient will be to assess heart sounds, regularity of the heart beat, jugular vein distension, pulses peripherally, nail bed color, cap refill/blanch, edema, presence of Homan's sign, and electrical pattern of the heart.

b. Common nursing diagnoses associated with the cardiovascular system include, but are not limited to, **Decreased cardiac output, Fluid volume deficit, fluid volume excess, Fluid volume, Risk for deficit/excess; Tissue perfusion, Ineffective (renal, cerebral, cardiopulmonary, gastrointestinal, and peripheral).**

24. Abdomen

a. Review the history and physical, progress notes, nursing admission notes and the prior shift's findings.

b. Assess all 4 quads by inspection, auscultation, palpation, and possibly percussion. Always auscultate first before you palpate. If no bowel sounds, then you should listen for 5 minutes or longer. Be knowledgeable about whether your patient should even have bowel sounds at this point of hospitalization/surgery.

c. Record your findings in the nurse's notes.

d. If tubes are present, describe where and the contents: color, consistency, odor, amount, etc. Some agencies record this information on the I & O sheets.

e. If an incision is present, document about the dressing: intact, dry, clean, color of drainage if drainage is present, quantity of drainage, etc.

25. Elimination

a. This includes urine output and bowel movements. Intake must equal output, or at least close to equal. I & O sheets are usually kept taped to a door in the room and both are added at the end of each shift and then recorded on the graphic sheet/flow sheet. Medications, diet, and

fluid intake can be governed by the urine output. Recovery process of some health problems is also measured by the urine output. Typical measurements include foley catheter, urine, liquid stools, emesis, drains, colostomy bags, to name just a few.

b. Common nursing diagnoses associated with elimination include, but are not limited to, **Constipation; Constipation, Perceived; Constipation, Risk of; Incontinence, Bowel, Incontinence, Functional; Incontinence, Reflex; Incontinence, Risk for urge; Incontinence, Stress; Incontinence, Total; Incontinence, Urge; Self care deficit, Toileting; Diarrhea; Urinary elimination, Impaired; Urinary retention.**

26. Musculoskeletal

a. This assessment involves ROM, edema, and assessment of DVT risk. You perform this on your patient with your initial assessment and depending on your findings, as needed or routinely. It will be recorded in your nurse's notes. It is wise to review the nurse's notes or ask the off going nurse for a description of the previous assessment for comparison purposes. Any patient, who has an immobilization device, should have sensation, motor, and circulation (SMC) assessed frequently.

b. Every hospital/nursing patient should be assessed for the risk of deep vein thrombosis (DVT), especially if they are immobile or bed ridden. If you are not familiar with the DVT assessment, you need to review the scale, how to complete the assessment and what you need to do with your findings.

c. Common nursing diagnoses associated with the musculoskeletal system include, but are not limited to, **Activity Intolerance; Impaired physical mobility; Mobility, Impaired bed; Mobility, Impaired wheelchair; transfer ability, impaired; Walking impaired.**

27. Neuro

a. One of the first signs of decreased oxygenation to the brain is a change in your patient's level of consciousness. It is important to assess your patient's level of consciousness on your first assessment of the day and thereafter if your patient's diagnoses and your assessment findings indicate it. Neuro assessment includes level of consciousness: AVPU—awake, responsive to verbal stimuli, responsive to pain, or unresponsive; alert, orientation to person, place, time and situation (A&O x4); speech, motor status, pupil: PERRLA: pupils equal, round, reactive to light and accommodation; hearing, vision, taste, smell assessment and swallowing abilities. Your patient's medical/surgical diagnoses and your initial assessment will dictate what and how frequent these assessments must be made. You will record the obtained information in your nursing notes and/or a flow sheet.

b. Common nursing diagnoses associated with the neurological system include, but are not limited to, **Self care deficit; Disturbed sensory perception; Impaired verbal communication; Acute or Chronic confusion and Impaired memory.**

28. Activity

a. This will be found in the physician's orders and/or the Physical Therapy notes. You will also find information about past activity in the initial nurse's notes upon admission.

b. Be sure to note if your patient needs assistive devices, his/her gait, activity restrictions, and need for restraints.

c. If your patient is an orthopedic patient, be sure to note the amount of weight bearing on the injured bone is allowed. If no weight bearing, you will usually see NWB as the abbreviation.

d. Completing a fall risk assessment will help to ensure that your patient is safe and no further harm will occur. It is based on history of recent falls, medications, and psychological and cognitive status. You will record your findings on the nurse's notes and make sure that the chart reflects that your patient is/isn't at fall risk. To complete the form, circle the appropriate number, add the scores, and then outline the measures you plan to take to prevent falls.

e. Common nursing diagnoses associated with activity are: **Activity Intolerance, Fatigue, Impaired mobility, Self-care deficit, Risk for falls.**

29. ADL's

a. Review the admission nurse's notes for information concerning your patient's ability to care for himself/herself. Does your patient need complete assistance—is unable to do own self care; partial assistance—can do part of own self-care; or can your patient complete own self-care without assistance: Allowing your patient to do as much for himself/herself, helps to foster independence and increases likelihood of going home sooner and a higher rate of successful recovery.

b. Record your information in the nurse's notes.

c. Common nursing diagnosis for ADL's is **Self-care deficit.**

30. Nutrition

a. The patient's chart will indicate the patient's nutritional status through a consult by the hospital's nutritionist or dietitian. Physician's order the diet and this is found in the physician's initial admission orders, or in subsequent orders as the patient's condition changes. Knowing your patient's diet ensures that the patient does not receive more than or less than what is needed; that your patient does not receive restricted foods; that he/she does not receive food when the patient has been restricted to nothing by mouth (NPO). If you are not familiar with

the different type of diets that are ordered in the hospital/nursing home setting, please review these: liquid diet, soft diet, low fat diet, low sodium diet, low protein diet, low sugar diet, weight reduction diet, high fiber diet, low residue diet, bland diet, and tube feeding formulas. This is a good time to remember you nutrition course information.

b. Completing a nutritional assessment involves need for assistance in eating, ability to swallow effectively, ability to chew, presence of dentures/teeth, presence of a gag reflex, ability to cough, sneeze, presence of a feeding tube, PEG tube, appetite, amount consumed, likes and dislikes, I & O.

c. Fluids are sometimes ordered for patients for numerous reasons: fluid replacement, medication administration, replacement of electrolytes, total parental nutrition (TPN). In your initial assessment of your patient you need to know the type of IV fluid, the flow rate, IV site appearance, and the amount administered. This information is usually on the nurse's notes, I & O sheet, Physician orders, or the MAR sheet. It is important to relate the information about the IV being administered to the medical and nursing diagnoses.

d. Some patients may be diabetic. If this applies to your patient, you will need to perform Accu-checks, usually before meals and sometimes on a routine of every 2-4 hours. Your patient may be on a sliding scale of insulin. You must know when insulin is given and how much if your patient is on a sliding scale. You must know the Accu-check results ***before*** you give any insulin or oral anti-diabetic medication. The sliding scale information will be located on the physician's orders, standing orders, and the MAR. Recording the information will depend on hospital policy.

e. Common nursing diagnoses associated with nutrition include, but are not limited to, **Imbalanced nutrition; Fluid volume deficit/excess, Self care deficit, feeding.**

31. Pain

a. Assessment of pain is always a skill that must be approached from a subjective and objective approach. There are many methods available. PQRST is a very popular one and easy to remember: **P**rovocation/palliation; **Q**uality of pain; **R**adiation/region; **S**everity, and **T**iming. Pain scales are available to assist in the severity of the pain: Numeric/Wong/ FLACC. Familiarize yourself with these scales and the one the institution uses where you are doing your clinical experience.

b. Any time your patient complains of pain, not only is it important to assess the pain, but you must intervene. Charting what you did and the patient's response to that intervention is required. You need to know when the last dose of pain medication was administered, how much the patient received, and what other measures helped to reduce your patient's discomfort. You will also need to know the onset, duration and peak of the medication you administer, along with possible side effects in order to know if your intervention is affective. If

not, know what you will do next. Remember the mnemonic ***AIR***: Assess, Intervene, Reassess. All this information should be documented in your nursing notes.

c. A common nursing diagnosis associated with pain is **Pain.**

32. Cognitive-Perceptual/Sleep

a. In this assessment, you should review the nursing admission form to obtain a baseline with which you can compare your assessment. This provides an opportunity to witness progress or decline. You will be assessing the patient's senses of sight, hearing, taste, smell and touch.

b. Sleep has been shown to have a devastating effect on recovery and on cognition. Assessing your patient's sleep habits/problems can cue you to needs and possible causes of some of your patient's problems that may or may not have influenced his/her admission.

33. Diagnostic tests

a. Your patient may have diagnostic tests that must be completed on the day of your clinical experience. It is imperative that you understand the test and be able to explain to your patient or family, what to expect before, during, and after the test. You also will need to know what your actions will be before, during, and after the test so that you feel more confident in caring for your patient and you can prevent harm or provide comfort as needed.

b. Tests that are being ordered will be found in the physician's order sheet.

c. You should record your patient's response and the teaching that you have down in the nurse's notes.

d. Look at the results of these tests in relation to your patient's baseline and overall health. Compare the results with previous results.

34. Medications

a. Medications are ordered by the physician and filled by the pharmacy. Pharmacy will have a form called the Medication Administration Record (MAR) that will reflect all meds that have been ordered and are being given, the time of administration and the dose. These MAR's SHOULD BE VERIFIED BY REVIEWING THE PHYSICIAN'S ORDER SHEET TO CONFIRM THE CORRECT INFORMATION.

b. Administration of medication is a nursing task and can be a legal, ethical and moral issue when not done correctly. You must know about your medication, dose, time of administration, how administered, what the mechanism of action is why it is being given, what the normal dose is, peak and duration time, nursing implications, side effects, and what you need to know to educate your patient about the medication, to name just a few.

c. If you are unable to find medication information, the hospital pharmacy may be of help. Never give a medication without knowing about it first. Also, remember that your faculty member is a good resource.

d. Know the \trade and generic name. Physicians may write one name, and the pharmacy may substitute generic drugs as a way to decrease costs and this will be reflected in a different name for the drug on the MAAR.

e. Knowing the general classification of a drug helps you to identify general information about the drug. Antibiotics are associated with the nursing diagnosis of Risk **for infection.** Antidysrhythmics and antihypertensive meds are usually associated with the nursing diagnosis of **Decreased cardiac output.** Anticoagulants and diuretics are associated with the nursing diagnosis of **Deficient fluid volume.** Corticosteroids are associated with **Ineffective protection.** Anticonvulsants are associated with **Ineffective tissue perfusion (cerebral).** Insulin and oral antidiabetic agents are associated with **Imbalanced nutrition: less than body requirements.** Medications used for pain are usually associated with the nursing diagnosis of **Pain.**

35. Lab

a. Lab tests are ordered by the physician and will be found in the physician's orders. Results of the tests will be found under the tab marked as "Lab". If using a computer-charting program, you will need to discover where diagnostic labs and other test results are located.

b. Make sure you know what tests are ordered and information about each test. As discussed under diagnostic tests, the same information is expected for lab tests. Many treatments are based on lab results. Medications such as insulin are determined based on blood glucose finger sticks and/or blood glucose results. You need to know the normal and what abnormal results mean for your patient. You also need to know what the implications of abnormal mean for you as the patient's nurse and how your plan of care needs to be modified or changed.

c. Evaluate the results of these tests based on factors that influence the results, the trend, patient's baseline and the patients overall health. ***Do not copy every diagnosis listed from your drug resource.*** This is specific to your patient.

d. Compare and contrast the results with other/past tests of this hospitalization and what is considered to be the norm for your patient.

36. Potential Nursing Diagnoses

a. This is determined by the data that you have collected. Review your prep sheet, your assessment sheet notes and data, and your day with the patient.

b. Start out by listing all the diagnoses that you think fit your patient. Then determine if you have data to support the nursing diagnoses. Then select the top two priority nursing diagnoses that pertain to your patient.

* Adapted and used from the following: Schuster, P. M. (2002). *Concept Mapping: A critical-thinking approach to care planning.* Philadelphia, PA: F.A. Davis Company

MEDICATION FORMAT

*(**minimal** amount of information to have at your fingertips in clinical)*

Medication: Brand/Generic Classification	Dose /Route/ Time/ Dose	Peak/Onset Duration	Indications/Rationale (Why I'm Giving To My Patient)	Side Effects	Nursing Considerations (what do I need to know prior to giving and monitor during/after)

Case Study Guidelines

1. Each student is required to complete a case study paper from a variety of topics.
2. Topics will be assigned during class.
3. The topic assigned will be your patient during your second simulation experience.
4. You will be expected to prepare for the second simulation day as you would any other clinical day with the same preclinical paperwork due (prep sheet, med cards, diagnostic cards) via SimChart.

Case Study Written Evaluation

The maximum points attainable for each section of the paper are listed below. **Evaluation will be based on appropriate content as well as critical thinking and clinical reasoning skills**.

Introduction/Medical Diagnosis: 15 points a. Introduce parameters of paper b. Includes current research (< 5 years) related to the medical diagnosis (prognosis, statistics, treatment options) **(**5 points) c. Includes detailed description of pathophysiology related to the disease process (5 points) d. Demonstrates understanding of disease process including risk factors (modifiable and non-modifiable) (5 points)	
Nursing Diagnosis: 10 Points a. At least three NANDA approved nursing diagnosis (three to four part diagnosis statement) (2 points) b. Nursing diagnosis should be listed in priority order (3 points) c. Includes evidence supporting choice for the three nursing diagnosis (5 points)	
Nursing Goals: 10 points a. Goals are stated in appropriate format with 2 goals for each diagnosis (5 points) b. Goals are specific to patient (based on case scenario) (5 points)	
Nursing Implementations: 20 points a. Includes assessment and intervention with rationale (10 points) b. Includes evaluation of lab values and other diagnostic testing (5 points) c. Includes additional expected physician orders discovered during research of medical diagnosis and guidelines for appropriate patient care (5 points)	
Evaluation: 10 points a. Includes how you would evaluate your patient care (2 points) b. Includes plan for change in patient care in the event your goals were not met (8 points)	
Patient/Family Education: 10 points a. Based on current research (< 5 years old) and evidence based practice (scholarly sources) (8 points) b. Includes copy of patient education tools, resources, printed information (2 points)	
Summary: 2 points Overall summary of your paper (pull it all together)	
Grammar and APA format: 3 points	
Total (80 points) (Other 20 is from Concept Map)	

Additional comments:_____

	5 points	4 points	3 points	2 points	1 point
Prep sheet, medication sheets, diagnostic cards, and assessment.	Data is relevant, accurate, and complete. Includes comparison to textbook norms.	Mostly complete, but some minor details missing.	Important data missing or lacks comparison to textbook norms.	Information presented is inaccurate.	Both inaccurate and incomplete.
Planning	Includes appropriate NANDA diagnoses and links to assessment data. Uses and prioritizes actual vs "risk for "diagnoses.	Includes appropriate diagnoses, but incorrect priority or use of format is inconsistent.	Primarily lists "risk for "diagnoses or scope of diagnoses is very limited and not clearly stated.	Identifies nursing diagnoses but lacks assessment data to support, lacks 3 part statement.	Uses 2 or more incorrect nursing diagnoses. Omits 2 or more essential nursing diagnoses
Nursing outcomes	Measurable, patient focused, appropriate to priority diagnosis. Includes short and long-term goals.	Goals limited to short term. Are narrow in focus.	Inconsistency in use of measurable, patient focused outcomes.	Outcomes are nurse focused, and/or not applicable to diagnosis.	Outcomes not measurable or applicable to nursing diagnoses.
Interventions for priority nursing diagnoses	Comprehensive; Detailed; specific; clearly related to nursing diagnosis and identified outcome criteria. Reflects collaborative care.	Specific but not comprehensive; clearly related to nursing diagnosis and identified outcome criteria. Reflects collaborative care.	Comprehensive, but not specific; clearly related to nursing diagnosis and identified outcome criteria. Minimally reflects collaborative care.	Not specific or comprehensive. Does not reflect collaborative care.	Not related to nursing diagnosis or outcome criteria.
Evaluation	Patient focused; Addresses process and outcomes; includes plan for continued care.	Patient focused; addresses outcomes but not process; includes plan for continued care.	Inconsistency in completeness. Sometimes lacks the outcomes process or plan for continued care.	Patient focused; addresses process but not outcomes. Includes plan for continued care.	Not patient focused; outcomes not addressed; no plan for continued care.
Reflection/ critical thinking	Correctly interprets findings, draws logical reasoned conclusion, supports interpretation with rationale, justifies beliefs but willing to modify.	Correctly interprets findings but not always able to support with logical reasoning. Justifies beliefs but willing to modify.	Merely repeats information; No analysis; does not draw conclusions. Omits discussion of interesting occurrences.	Provides inaccurate information. May identify principles but inappropriate application.	Lack of understanding apparent.

Department of Nursing NUR 3404: Practicum in Nursing I Weekly Clinical Grading

	5 points	4 points	3 points	2 points	1 point
Format	Well organized, proper grammar, avoids jargon and spelling errors.	Proper grammar; avoids spelling errors but not well organized.	Occasional spelling or grammar error; uses jargon.	Frequent spelling and/or grammar error. Uses jargon.	Frequent errors and difficult to understand.
Skills	Performs Independent. Standard procedure is safe and accurate; Performance quality proficient, coordinated, confident. Expedient use of time. Assistance: No direction required.	Performs at a supervised level. Standard procedures are safe and accurate. Performance quality is efficient, coordinated, and confident. Expedient use of time. Seeks assistance when appropriate. Assistance with occasional physical and verbal direction.	Performs at an assisted level. Standard procedures are mostly safe and accurate. Partial demonstration of skills. Inefficient or uncoordinated. Delayed time expenditure. Frequent verbal and/or physical direction need.	Performs at a marginal level. Standard procedures are questionably safe and accurate. Performance quality is unskilled and inefficient. Considerable and prolonged time expenditure. Continuous verbal and/or physical direction required.	Performs at a dependent skill level. Standard procedure is unsafe and inaccurate. Is unable to demonstrate procedures. Lacks confidence, coordination and efficiency. Continuous verbal and/or physical direction is required.
Professionalism	Arrives to clinical site on time. Dresses according to dress code. Brings all required materials and equipment to clinical site. Is respectful to faculty, staff, patient, family and visitors. Is truthful about clinical performance. Follows all other professionalism guidelines set forth in the syllabus or handbook.	Lacks 1 of the elements in the 5 point category.	Lacks 2 of the elements in the 5 point category.	Lacks 3 of the elements in the 5 point category.	Lacks 4 of the elements in the 5 point category.
Paper work turned in on time	Paper work is turned in on time.	Paperwork is less than 1 hour late.	Paper work is 2-3 hours late.	Paper work is 4-5 hours late.	Paper work is no more than 1 day late. (Paperwork that is more than 1 day late will receive a "0" for this element.)
Score					

NUR 3404 Weekly Clinical Grading Tool

Week	Content		Total	Comment
1 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment Planning of care plan diagnosis Nursing outcomes Interventions Evaluation of outcomes Reflections and critical thinking Format Skills Professionalism Paper work turning in on time	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	__/50	
2 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment Planning of care plan diagnosis Nursing outcomes Interventions Evaluation of outcomes Reflections and critical thinking Format Skills Professionalism Paper work turning in on time	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	__/50	
3 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment Planning of care plan diagnosis Nursing outcomes Interventions Evaluation of outcomes Reflections and critical thinking Format Skills Professionalism Paper work turning in on time	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	__/50	
4 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment Planning of care plan diagnosis Nursing outcomes Interventions Evaluation of outcomes Reflections and critical thinking Format Skills Professionalism Paper work turning in on time	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	__/50	
5 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment Planning of care plan diagnosis Nursing outcomes Interventions Evaluation of outcomes Reflections and critical thinking Format Skills Professionalism Paper work turning in on time	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	__/50	

6 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment 1 2 3 4 5 Planning of care plan diagnosis 1 2 3 4 5 Nursing outcomes 1 2 3 4 5 Interventions 1 2 3 4 5 Evaluation of outcomes 1 2 3 4 5 Reflections and critical thinking 1 2 3 4 5 Format 1 2 3 4 5 Skills 1 2 3 4 5 Professionalism 1 2 3 4 5 Paper work turning in on time 1 2 3 4 5	__/50	
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10 Date	Prep sheet, Med sheets, Diagnostic Cards and Assessment 1 2 3 4 5 Planning of care plan diagnosis 1 2 3 4 5 Nursing outcomes 1 2 3 4 5 Interventions 1 2 3 4 5 Evaluation of outcomes 1 2 3 4 5 Reflections and critical thinking 1 2 3 4 5 Format 1 2 3 4 5 Skills 1 2 3 4 5 Professionalism 1 2 3 4 5 Paper work turning in on time 1 2 3 4 5	__/50	
Final	Total score	_____/500	

Final Evaluation Sheet

Clinical strengths:

_____
_____
_____
_____

Needs improvement:

_____
_____
_____
_____

Additional comments:

_____
_____
_____
_____

Student's signature Date

_____ _____

Instructor's signature Date

_____ _____

Classroom Medication Quiz_____ Simulation Lab #1_____ #2 _____

Clinical Med Quiz #1 _____ Scenario Formal Paper _____

Clinical Med Quiz #2 _____ Scenario Concept Map _____

Research Article Presentation _____ **Final Clinical Grade** _____

Scholarly Article Critique Guidelines

1. Selection of a professional journal article.

2. Must be a nursing evidence based article about something that we do as nurses. Such as hand washing and infection prevention, this should be an evidenced based article that proves that hand washing decreases infections.
3. Must be relevant to your area of clinical practice and needs to be less than 5 years old
4. Write up
    - Article is cited correctly in APA format

      Examples of APA format citations are readily found online or in the APA book.
    - Article and write up must be submitted on the day that you are assigned
    - Identify the purpose of the article and address at least two implications for nursing clinical practice.
5. How can you use the information from the article (Do not rewrite the abstract.
6. Should be typed, 12 point font, double spaced document, should be ½ page to 1 page length. Do not share articles, as each student should present an original article.

Scholarly Article Scoring

CRITERIA	MEETS CRITERIA	DOES NOT MEET CRITERIA	COMMENTS
Selection of a professional journal article ➢ Do not select news and general interest periodicals ➢ Try to find articles written by nurses for nurses	1	0	
Article is cited correctly via APA format ➢ Examples of APA format citations are readily found online or in APA book	1	0	
Article is submitted on time and follows guidelines ➢ Due date as indicated by faculty	1	0	
Relevant to clinical area	1	0	
Identify the purpose of the article and address at least two implications for nursing clinical practice. ➢ How can you use the information from the article? ➢ Do not rewrite the abstract!!	1	0	
Score			