NUR 230 Nursing Care of the Acute and Chronically Ill Adult II   **Spring 2019**

Instructor:

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Course Description

This is a hybrid course is a sequence to NUR 229. Additional emphasis will be placed on preparing students to assume greater responsibility for organizing, managing, and delivering care to a larger group of clients. In order to progress in the Nursing Program, a grade of 75% or above must be achieved on all exams and a 75% or above must be attained on all course requirements. A grade of 90% or above must be attained on a dosage calculations exam in this course. Total of 41 hours of lecture, 18 hours of simulation exercises, and 52 hours of clinical. Laboratory fee required. Prerequisites: NUR 126 and NUR 226.   Semesters offered: Fall, Spring. 4 Credits

Required Textbooks and Technology:

- Doenges, M.,Moorhouse, M, Murr, A. Nurses Pocket Guide Diagnoses, Prioritized Interventions, and Rationales. 13th edition, F.A. Davis, 2013.
- Lewis, S.L., Dirkesen, S.R., Heitkemper, M.M., & Bucher, L. (2017) 10th Ed. Elsevier.
- McCuistion, L.E., Vuljoin-Dimaggio, K., Winton, M.B., & Yeager, J.J. (2018). Pharmacology: A patient-centered nursing approach.(9th ed). Philadelphia: Saunders. ISBN: 978-0-323 -39916-6
- Pagana & Pagana. Mosby's Manual of Diagnostic and Laboratory Tests.   4th edition. Elsevier, 2010.
- Perry and Potter, Clinical Nursing Skills & Techniques, 8th edition, Elsevier, 2014.

End of Course Student Learning Outcomes:

1. Utilize critical thinking in application of the nursing process to provide care for individuals in a variety of settings that promotes health throughout the lifespan. (1-3)
2. Adhere to quality of care and safety standards in both acute and community based environments. (1-6)
3. Facilitate the continuity of care for individuals in various acute and community settings. (1-6)
4. Practice within the ethical and legal framework of the nursing profession and maintain professional standards of conduct. (1-6)
5. Provide compassionate care and serve as advocates for individuals and families, respecting their diverse cultures, values, and belief systems. (1,4)
6. Employ written and therapeutic communication skills. (3-5)
7. Collaborate with the individual, family, and interdisciplinary health   professionals to promote, maintain, or restore health, and comfort the dying. (1-3)
8. Exercise leadership skills in the management of care. (2, 3, 5)

Course Outcomes:
- Incorporate the nursing process to establish a plan of care for clients and their families in acute care settings.(1-3)
- Demonstrate safe practice and correct application of acquired skills in lab and clinical settings. (1-6).
- Plan care for clients from admission to discharge in acute and community settings across the healthcare continuum. (1-6)
- Integrate ethical, legal, and professional standards when providing care to adult clients and their families. (1-6)
- Integrate nursing care, which demonstrates knowledge of culture and belief system when providing care to clients in the acute care setting. (1, 6)
- Utilize effective verbal and written communication skills to promote therapeutic interactions between client and caregiver in an acute care setting. (3-6)
- Collaborate on a plan with the healthcare team that assists individuals and families to positively adapt to changes in health or achieve a peaceful death. (1-3)
- Demonstrate personal leadership styles that contribute to effective patient care management. (2, 3, 6)

QSEN Competencies
1. Patient Centered Care
2. Teamwork & Collaboration
3. Evidence-based Practice
4. Quality Improvements
5. Safety
6. Informatics

Total Hours of Coursework:
To earn one academic credit at Hagerstown Community College, students are required to complete a minimum of 37.5 clock hours of coursework per semester.

Assignment/Assessment	Clock Hours	Explanation
In-class instruction	41	Time spent in class- lecture & Select Online Lectures.
Assigned readings	35	Reading, projects, quizzes, studying, etc.- minimum
Clinical Simulation	18	
Clinical	52	Time spent on site at MMC and other clinical activities
Projects	7	
Exams	8	To complete exams
Lab Prep and ATI	19	
Total hours	**180**	

Services for Students with Disabilities: Students may receive reasonable accommodations if they have a diagnosed disability and present appropriate documentation. Students seeking accommodations are required to contact the Disability Support Services (DSS) office as early as possible. Students may contact a DSS staff member for an appointment at dss@hagerstowncc.edu or at 240-500-2530.

☐ **UTI** (tutorials ⟶ Real Life RN Medical Surgical ⟶ UTI) _____

☐ **Target Renal/Urinary** (Practice Assessment ⟶ Targeted Med Surg 2013: Renal/Urinary)_____

☐ **Kidney Disease** (Tutorials⟶ Real Life RN Medical Surgical ⟶ Kidney Disease)

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☐ **Practice Test Renal/Urinary** (Tutorials ⟶ Learning Systems RN ⟶ Practice Tests ⟶ Renal/Urinary)_____

☐ **Urinary Catheterization Skill Module** 2.0(Tutorials⟶ Skills Module⟶ Urinary Catheter Care)_____

☐ **Pharm Made Easy Repro/GU** (Tutorials ⟶ Pharm Made Easy3.0 ⟶ The Repro and GU System)_____

☐ **Nurse Logic Priority Setting** (Tutorials ⟶ Nurse Logic 2.0 ⟶ Priority Setting)_____

☐ **Target GI** (Practice Assessment ⟶ Targeted Med Surg 2013: Gastrointestinal)_____

☐ **Pharm Made Easy/GI** (Tutorials ⟶ Pharm Made Easy 2.0 ⟶ The Gastrointestinal System)_____

☐ **GI Bleed** (Tutorials ⟶ Real Life RN Medical Surgical ⟶ GI Bleed)_____

☐ **C-Diff** (Tutorials ⟶ Real Life RN Medical Surgical ⟶ C-Diff)_____

☐ **Practice Test GI** (Tutorials ⟶ Learning Systems RN ⟶ Practice Tests ⟶ Gastrointestinal)_____

☐ **N/G Tube Skill Module 2.0** (Tutorials⟶ Skills Module⟶ Nasogastric Intubation)_____

☐ **Ostomy Care Skill Modul 2.0e** (Tutorials⟶ Skills Module⟶ Ostomy Care)_____

☐ **Target Neuro/MS** (Practice Assessment ⟶ Targeted Med Surg: Neurosensory/Musculoskeletal)_____

☐ **Pharm Made Easy/Muscular skeletal system-**(Tutorials→Pharm Made Easy 3.0→The M/S system_____

☐ **Practice Test M/S** (Tutorials ⟶ Learning Systems RN ⟶ Practice Tests ⟶ Musculoskeletal _____

- ☐ **Practice Test Neuro** (Tutorials ⟶ Learning Systems RN ⟶ Practice Tests ⟶ Neurosensory) _____

- ☐ **Transfusion Skill Module** (Tutorials ⟶ Skills Module ⟶ Blood Administration)_____

- ☐ **Pharm Made Easy/Hematological** (Tutorials-----→ Pharm Made Easy 3.0--→Hematological System)

- ☐ **Practice Test Dermatological** (Tutorials--------→Learning Systems RN------→Practice Tests------→ Dermatological

- ☐ **Pharm Made Easy/Pain & Inflammation** (Tutorials--→Pharm Made easy 3.0 – Pain and Inflammation

- ☐ **Pain Management** (Tutorials ⟶ Skill Modules)_____

- ☐ **Pharm A & B Practice Sessions** _____

Community Health Fair

Purpose

To provide students with the opportunity to plan a community health fair according to the population served, and to identify and address specific health teaching needs using a team approach.

Objectives

At the end of this project students will be able to:

- Design a health fair for the specific population you are working with in the community.
- Complete individual client assessments to identify health-teaching needs.
- Plan and implement an individualized health-teaching plan with each client.
- Evaluate all aspects of the health fair to determine its effectiveness and success.
- Evaluate the clinical group's ability to function as a team with one another, with clients and others in the community, and the ability of the team to successfully meet its goals for the health fair.

Guidelines

- Each clinical group will be assigned to a community Facility/Event where the health fair will take place. Clinical groups will work independently and collaboratively with one another. Members of each clinical group will work together as a team to assess, plan, implement, and evaluate the health fair.
- Each health fair will have the following stations: blood pressure assessment, blood glucose checks, pulse ox checks, vital signs, general health history, and medication management.
- Each group will be responsible for:
    - Group will meet with a representative(s) to plan, organize, and set up the health fair at least 4 weeks before event.(representation of each group to meet and disseminate the information). This is non-applicable for the Hispanic Festival , the representatives' will meet with course coordinator.
    - Organizing and setting up the health fair to include meeting with facility for planning appropriate resources to include space, and privacy. Each group will meet with the Lab coordinator at least 2 weeks before the event to review needed supplies, how to utilize machinery and to plan for pickup.
    - Documentation of communication between groups and within groups.
    - Setting outcomes and objectives for the health fair. Remember, outcomes must be measurable.
    - Developing client assessment and data gathering tools.
    - Developing and/or compiling educational materials. This can include information developed by the group such as learning boards and handouts, as well as information from other sources such as texts, other organizations, manufacturers, books, videos, etc.
    - Ensuring that all clients are evaluated and provided with health teaching, educational materials, and any documentation relevant to their problems. For example, a person on a new anti-hypertensive would need to know his blood pressure so he can report it to his physician. He should also leave knowing about his medication and perhaps a handout to help him remember.
    - Evaluating the success of the health fair.
    - Evaluating one's participation, and each group member's participation as a team member.
- After the health fair is completed, each clinical group must meet to review and evaluate the health fair and its success. The evaluation must be based on the outcomes and objectives that were established by each group for their individual health fair. It should include data about your clients, feedback from your clients, and feedback from each member of the clinical group about the assessment, planning, and implementation of the event, their roles, impact on the clients, etc. What were the positive aspects of the fair? What were the negative? How would you have done things differently? These are just some of the questions that you should consider as part of your evaluation. The team should write the evaluation together.

    The format for the evaluation should include the following and be typed in correct APA format:

- o Introduction: should be descriptive and explain the setting, clients and students involved
- o Goals and Outcomes
- o Client Data: e.g.: numbers served, ages, gender, services provided, problems identified, why they came to the health fair, types of health problems, number of people having more than one medical problem (comorbidities), etc.
- o Client Feedback
- o Success of the Health Fair: from the perspective of the entire clinical group. The seven Criteria found in the Grading Rubric should be addressed for this section of the evaluation. Should include positive aspects and challenges faced by the team. It should also include whether goals and outcomes were met.
- o Group Process: discuss group consensus about positive aspects and challenges of assessing, planning, and implementing the health fair as a team.
- o Summary and Recommendations
- o Keep a journal recording attempts made to communicate and meetings setup and results.
- ▪ Each clinical group must submit in a folder the written team evaluation of the health fair, each student's self evaluation, and the evaluation of their team members to the NUR 227 course coordinator. Note for events such as the Hispanic Festival one notebook will be created.

Grading

- ▪ The clinical group will receive one grade for the team on observations made by the clinical instructor on the day of the health fair according to the attached rubric. 50%
- ▪ The clinical group will receive one grade for its written evaluation of the health fair. 35%
- ▪ Each member of the clinical group will complete a self evaluation on his or her part of the whole experience. 10%
- ▪ Each member of the clinical group will receive an individual evaluation from other group members on his or her collaboration as a team member. 5%

Health Fair
Grading Rubric

Criteria	14.28 points	12 points	11 points	3.57 points
Teamwork	The group provides evidence that group members helped one another, shared ideas, developed and evaluated their finished product(s). The project is clearly a group effort. A journal will be kept by the group demonstrating meeting time and correspondence. The team will present in a fluid manner with each participating.	The group documents how members divided tasks, shared the workload and managed problems in a way that advanced the group goal.	The group occasionally helped one another but required professor assistance to resolve differences. Individuals report that he/she did most of the work and/or problems were not managed in a way that advanced the group goal.	The group required professor assistance with dividing tasks and resolving differences. Few people contributed their fair share of work.
Set up and organization of the health fair	The set up is aesthetically pleasing and contributes to the organization of the event and the willingness of potential clients to attend.	The set up is complete and fairly well organized but lacks client appeal.	The set up shows some organization, but appears cluttered and busy or distracting.	The set up is cluttered and confusing. There are no signs or directions for clients to follow.
Assessment skills and tools	Client assessments are performed skillfully and accurately. Assessment tools make data collection easy and non-stressful for clients. Assessment tools assist the student to easily identify client teaching needs.	Most assessments are performed skillfully and accurately. Assessment tools helpful in identifying most client teaching needs.	Instructor help is needed to perform some assessments. Students need some assistance to interpret data collection and identify client teaching needs.	Students do not know how to perform assessments and very dependent on instructor help.
Assessment of client needs	Client needs are identified by asking questions and listening actively. Educational plans identified for each client. Clients acknowledge identified teaching needs.	Most teaching needs identified. Clients acknowledge identified teaching needs	Some teaching needs identified. Client reminds students about teaching needs.	Client does not acknowledge identified teaching needs.

Client education	All clients received verbal teaching and/or appropriate educational materials based on their initial nursing assessment. Teaching was understandable and supported with facts and examples. Client's understanding of teaching and/or educational materials was evaluated.	Most clients received verbal teaching or appropriate educational materials based on their initial nursing assessment. Teaching and educational material somewhat difficult to understand. Students attempt to clarify teaching and answer client questions.	Some clients received verbal teaching or appropriate educational materials based on their initial nursing assessment. Teaching and educational material difficult to understand. Students have difficulty clarifying teaching and answering client questions.	Few clients received verbal or written educational materials. No attempt to evaluate clients' understanding of teaching or educational materials.
Professional behavior	All clients greeted in a polite and friendly manner. Appropriate and understandable language used.	All clients greeted in a polite and friendly manner. When providing information, occasionally use language or terms not understood.	Not all clients receive a greeting. Students have to be reminded to speak to clients using understandable terms.	Most clients allowed to walk through fair without interaction with students. Clients have difficulty understanding terminology. Students talk amongst themselves and ignore clients. **(0 points earned for this criterion only)**
Evaluation	Clients seemed very satisfied during their interactions with students. Compliment students on their efforts.	Clients seemed generally satisfied during their interactions with students.	Clients seemed somewhat dissatisfied during their interactions with students.	Clients dissatisfied with their experience and verbalize their concerns. **(0 points earned for this criterion only)**

Grading Rubric for Students

Instructions

To evaluate your teammates, write their names in the first column "Name of Group Member." Read the description of the rating criteria for "Poor," "Fair," "Good," and "Excellent" and select **only one** that best describes your evaluation of each team member. Enter the corresponding numerical score in the score column beside each name. Follow the same rating procedure when completing your self evaluation at the bottom of the page. You may enter any comments as desired. Comments must be written in a professional manner. Place your evaluation in a sealed business sized envelope in order to maintain confidentiality.

Name:_____

Collaboration with Peers		Poor (1)	Fair (2)	Good (3)	Excellent (4)
Name of Group Member	**Score**				
_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	Rarely listens to, shares with, and supports the efforts of others in the group. Is not a good team member. Contributes little or no effort to project.	Often listens to, shares with, and supports others in the group but sometimes is not a good team member. Does not contribute much effort to project.	Usually listens to, shares with, and supports the efforts of others in the group. Participates in team effort. Contributes to team effort when asked. Maintains positive attitude.	Almost always listens to, shares with, and supports the efforts of others in the group. Contributes to team efforts without being asked. Tries to keep other team members working well together.
Self Evaluation _____	_____	Did not work well with other team members. Late in completing assignments. Contributed little to presentation.	Sometimes worked well with others. Needed many reminders to complete work. Sometimes late in completing assigned tasks. Minimal help with presentation.	Mostly worked well with other team members. Completed assigned tasks with some reminders. Helped prepare presentation.	Worked well with the team. Supported group efforts. Consistently helped prepare presentation. Always completed tasks on time.

Additional Comments

Purpose

To provide students the opportunity to participate in the multidisciplinary care of a surgical patient or patient in a specialty care unit (Ie woundcare unit, Emergency Care, or Intensive care unit.

Objectives

At the end of this experience, the student will be able to:

- Discuss the individual roles as well as the team roles of the nurse:
  1. in utilizing evidenced based care of the surgical/ specialty client(if surgical then the preop care, intra-operatively and post anesthesia recovery. Identify the safety needs of the client preoperatively, intra-operatively, in post recovery(PACU), on the in-patient or out-patient unit.
- Plan and Implement care for a postoperative client on the first post-operative day or post-operative care in PACU and discharge teaching needs of patient going home post-operatively from same day surgery.
- Explain the roles and responsibilities of the various health care team members who provide care to clients before, during, and after surgery.

Required Reading

- **<u>Lewis Chapters 18, 19, 20</u>**
- Review Care of the Surgical Patient lecture from Fundamentals.

Guidelines for In-Patient:

- Each week a student(s) from every clinical group will be assigned to a patient who is scheduled for surgery.
- The student will report to the pre-operative holding room on the morning of the surgery to greet the patient and assist the registered nurse in assessing and preparing the client for the surgical procedure.
- The student will accompany the client to the operating room to observe the surgical procedure.
- When the surgery is completed the student will accompany the client to post anesthesia recovery and assist the registered nurse in providing care to the recovering client. Students will be able to complete assessments, provide general nursing care, and document appropriately. Students **<u>may not</u>** do invasive procedures or any other procedures for which there has not been any previous instruction. Students may assist the registered nurse in transferring the client to the in-patient unit.
- On the second day of the clinical experience the student will provide nursing care to the postoperative client from day one.

Grading:

This assignment is to be typed and placed in a **three ring binder or Folder**. It is to be handed in to the Course Coordinator **one week** after the surgical/specialty experience.

- APA Format. 15- Rough Draft may be addressed with coordinator
    1. Title page- see apa format
    2. Reference page and siting in paper(Minimal of 3 resources)
    3. Abstract : be clear what are your objectives < 200 words
    4. Body of paper : Split up long paragraphs in to 2 or more
- In narrative format provide a history of the client.(utilize EMR information as able and interview information at admission)= 10%
- Provide a comprehensive explanation of the operative procedure i.e.: total hip replacement (**compare and contrast procedure with text description**) or explanation of primary diagnosis or procedure. 3%
- Provide a detailed explanation of the role of **each** nurse who provided care to the client during the surgical / specialty experience. 15%(Define individual and team roles and focus on evidenced based care).
- Provide an explanation of the roles and responsibilities for each of the other health care team members who provided care for the client during the surgical experience. 10%
- **List** actual and potential safety issues for the client throughout the surgical/ Specialty area experience from preop, intrasurgery and postop, and how they were addressed. 5%
- Complete a data base on the client. 2%
- Develop a comprehensive plan of care for the client including pertinent **prioritized** nursing diagnoses(ABC's), goals, outcomes, nursing care, rationale, and evaluation of outcomes. Care plan should include education needs related to post-care at home, anxiety or other emotional health issues. 40%. ,

Nursing Care Plan

Client initials: **Age:**   **Diagnoses:**

Assessment *Diagnosis*	Plan *Goals/Outcomes*	Interventions *Nursing Orders*	Rationale	Evaluation

Nursing Care Plan

Assessment *Diagnosis*	Plan *Goals/Outcomes*	Interventions *Nursing Orders*	Rationale	Evaluation

Clinical Experience – Care of the Client in the Emergency Department, ICU specialty, wound care unit or other specialty experience.

Purpose

To provide students the opportunity to participate in planning and providing care to clients in selected areas of the emergency department).

Objectives

At the end of this experience the student will be able to:

- Compare and contrast the purpose and type of care provided to clients on your home unit to the specialty unit.
- Discuss the role of the nurse on your home unit verses the specialty unit.
- Discuss the nursing care priorities for clients in the different settings.
- Identify the teaching needs of clients and how those needs are addressed.
- Identify how the discharge planning needs may differ for clients in each settings.
- Explain how nursing care in the specialty area differs from nursing care on an in-patient med-surg unit or your home unit.

Guidelines

- Select student(s) will rotate to the specialty area for one clinical day.
- Students will be assigned to provide care to selected clients with a nurse preceptor in each of the patient care areas.
- Students will be able to complete assessments, provide general nursing care, and document if appropriate. Students may not do invasive procedures or any other procedures unless the clinical instructor is present.

Evaluation

- Each student will write a journal of their experience which will include:
  - A paragraph for each objective (listed above).
- This journal will be handed into the course coordinator.

Report Sheet(For use with every patient cared for and handed in with clinical paperwork)

Patients Initials _____   Age _____ Allergies _____

Code Status _____

Primary Dx _____

Secondary Dx _____, _____,
_____,

_____

Activity Status _____

Diet _____

PO Med Times _____

IV Med Times _____

Your primary focus for care of this patient to include assessments – physical, labs, txs/response, ect.

Top three Dx: before report: 1   2

3. At the end of day?

Treatment goals per team for patient to be d/c?

HAGERSTOWN COMMUNITY COLLEGE – Nursing 230 Data Base

Student   **Date**   **Pt. Dx.**

Patient Diagnosis: **Allergies:**   **Age:**   **Code:**   **Religion:**

Diet: **Hygiene:** **Activity:** **Invasive Devices:** **IV size and location** **Solution:** **Rate:** **Respiratory Care/ 02:** **Specimens Needed:** **Isolated:**	**Treatments/Nursing Interventions** **Risk for Falls** _____ Previous Falls _____ Impaired Mobility _____ High Risk Diagnosis _____ Altered Mental Status _____ Sensory Deficit _____ Language Barrier _____ Orthostatic Hypotension _____ >65 years old	**Medication & Dose:**

Test	Patient Result	Significance to Pt.	Test	Lab Significant to Pt.'s Condition (maybe not listed on chart)	Significance to Pt.

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ASSESSMENT	DAY 1	Focus Assessment (unless change in condition)	PSYCHOSOCIAL
NEUROLOGICAL Alert, Oriented, LOC, PERRLA, Behavior appropriate, Speech, Gait steady, Swallowing ability, Purposeful & equal movement			
RESPIRATORY Rate, Rhythm, Effort, Dyspnea, Breath sounds, Oxygen, Pulse Ox., Sputum color			
CARDIOVASCULAR Rate, Rhythm, Apical & peripheral pulses, Extremity temperature & color, Capillary refill, Edema, BP			**DISCHARGE PLANNING**
GASTROINTESTINAL Abdomen soft, non-tender, non-distended, Bowel sounds, flatus, last BM			
GENITOURINARY Urine color, Continence, Catheter, Bladder distended, Voiding pattern, Genitalia- no redness, itching, drainage, lesions			
NEUROVASCULAR Skin color, Extremity temperature, Distal pulses Sensation, Movement Capillary refill, Pain			**TEACHING**
MUSCULO-SKELETAL Movement, ROM, Joint swelling, redness or tenderness, Strength, Gait smooth, Limitations			
INTEGUMENT Color, Temperature, Moisture, Mucous membranes, Turgor, Scars, Hyperemia, Skin Breakdown/Stage ___			
MISCELLANENOUS IV site – Pain – Surgical Incision Status Assistive Devices			

Clinical Prep Card

Condition/Disease _____

Description

Pathophysiology

Clinical Manifestations

Signs	Symptoms

Diagnostic Tests

Collaborative Care

POSSIBLE Nursing Diagnoses and Interventions

Diagnosis	Interventions

Psychosocial Implications

Discharge Planning

Teaching Needs: Acute illness and home care

Prevention/Health Promotion

Trade name: Generic name: Pt. weight:

Classification:

Indications:

- Why is your patient receiving this drug?

Standard dose and routes:

Patient dose:

Adverse Reactions and side effects: Patient/Family Teaching

Contraindications:

Nursing implications:

Lab test considerations

Final Clinical Evaluation   NUR 230 Instructor/Student (circle)

Student_____Date_____ Unit_____

S = Satisfactory = 3 points   NI = Needs Improvement = 1 point   U = Unsatisfactory = 0 points

One "U" in a critical behavior (starred items) will result in counseling and advisement with instructor. A second "U" in the same critical behavior will result in a meeting with instructor and course coordinator and an action plan will be initiated. Failure to meet identified objectives by specific dates on the individual action plan will result in a clinical failure and subsequent failure for the course.

OUTCOMES	S	NI	U
1. Analyze the application of the nursing process throughout all care modalities.			
Collects data from appropriate resources.			
Accurately performs physical assessment on assigned patients.			
Identifies appropriate areas for client reassessment.			
Immediately reports deviations from baseline assessments.			
Establishes appropriate nursing diagnoses based on client data.			
Integrates nursing theory when establishing a plan of care.			
Verbalizes plan of care to instructor after shift report.			
Implements care according to established plan and desired outcomes.			
Completes care identified in the kardex.			
Prioritizes client needs.			
Evaluates client's response to care and revises plan as needed.			
Communicates nursing interventions not completed to instructor and health care team.			
Completes drug cards, patient data base, and clinical prep cards for every patient.			
Provides complete care for a minimum of three patients.			
Writes a comprehensive plan of care.			
2. Demonstrates safe practice and correct application of acquired skills in lab, clinical, and community settings.			
Identifies patients with safety risk.			
*Accurately and safely performs skills according to established standards.			
*Observes standard precautions.			
*Provides safe care according to established standards of nursing practice and facility protocols.			
Incorporates safety in nursing care plan for patients and their families.			

3. Plan care for clients from admission to discharge in acute and community settings across the healthcare continuum.			
Regularly updates instructor / health care team regarding changes in the client's status or condition			
Participates in shift reports.			
Identify learning needs and implement appropriate patient and family teaching.			
Performs care for patients in varying health care settings.			
4. Integrates responsibility, accountability, and advocacy into one's own practice.	**S**	**NI**	**U**
*Prepares adequately to care for clients.			
*Adheres to HIPAA guidelines regarding client confidentiality/privacy.			
*Maintains ethical and legal accountability for nursing practice in accordance with the Maryland Nurse Practice Act and the ANA Code of Ethics			
*Provides safe care according to established standards of nursing practice and facility protocols.			
Adheres to the HCC honor code.			
5. Implements nursing care which demonstrates knowledge and sensitivity of diverse cultures, values and beliefs.			
*Respects client rights in regard to their dignity and human worth.			
Individualizes care based on the client's culture, values, beliefs or gender.			
Integrates assessment of cultural, values or beliefs into the plan of care.			
6. Analyze and modify effectiveness of both written and verbal communication skills.			
Demonstrates effective therapeutic communication techniques.			
Documents care accurately on patient record.			
Documents all nursing care accurately according to legal and professional guidelines.			
7. Formulate a plan with the healthcare team that assists individuals and families to positively adapt to changes in health or achieve a peaceful death.			
Participates in patient care conferences. (if available)			
Collaborates actively with staff nurse when planning care of assigned patients.			
Identifies the need for ancillary support services.			
8. Integrates concepts of resource management to provide comprehensive and cost effective care.			

Completes care by end of scheduled shift.			
Applies organizational techniques to complete patient care.			
Plans for efficient use of supplies.			
Incorporates the use of various physical and technological resources into the plan of care.			
9. Recognizes opportunities that promote personal and professional development.			
*Demonstrates accountability and responsibility for own actions.			
Performs self-evaluation and communicates learning needs to instructor.			
Uses time wisely, seeks learning opportunities			
Maintains appropriate collegial relationships.			
Adheres to dress code.			
10. Identify personal leadership styles that contribute to effective patient care management.			
Participates actively in post conference and presents at least one patient for discussion.			
Reports to clinical on time.			
Attendance.			
Demonstrates initiative in assists peers and staff.			
Complete clinical resource project.			

The starred (*) items are critical behaviors that require a satisfactory ("S") score on the final evaluation

Total Points Possible: 156   **Passing Score: 150**   **Student's Score:_____**

Additional Comments:

_____   _____
   Student Signature   **Instructor Signature**

10.27.07:11.5.07