LOS ANGELES COUNTY COLLEGE OF NURSING AND ALLIED HEALTH
School of Nursing

Nursing 123L:

MEDICAL SURGICAL NURSING
CLINICAL

Spring 2018

COURSE TITLE:	**N123L –Medical Surgical Nursing Clinical**
PRE-REQUISITES:	Completion of Semester I Requirements
UNITS:	2.5 Units
HOURS:	15 hours per week
LENGTH:	9 weeks
PLACEMENT:	Semester 2
CONCURRENCY:	All semester theory courses are taken concurrently with the clinical courses.
COURSE DESCRIPTION:	This clinical course provides the student with opportunities to build on semester 1 and apply semester 2 theoretical content. It focuses on the application of the nursing process in the care of adult clients in the acute setting. The physiological, psychological, sociocultural, developmental and spiritual variables as identified in the Neuman Systems Model are utilized in formulation, implementation and evaluation of a plan of care. Methods of health promotion and health maintenance are applied for the adult and elderly clients in the acute care setting. The student participates as a member of the health care team and applies collaborative communication techniques, teaching-learning principles in regards to health promotion, and legal/ethical decision making in clinical practice.
COURSE OBJECTIVES:	Upon satisfactory completion of the course, the student will:

1. Apply the nursing process for safe patient-centered care of individuals with emphasis on physiological problems utilizing evidence based practice.

2. Utilize communication skills and nursing informatics in promoting and maintaining the health of individuals with common health problems.

3. Establish methods of teamwork and collaboration with other members of inter-professional healthcare teams for providing and improving patient-centered care.

4. Apply legal-ethical behaviors that reflect the value of professional accountability and provide and improve quality of care for adults with common health problems.

5. Identify nursing responsibilities in decision-making as a member of the inter-professional healthcare team in assessing, maintaining and promoting health to achieve safe, quality patient-centered care.

6. Apply teaching strategies utilizing evidence based practice to provide information to individual(s) and/or groups.

7. Integrate socio-cultural values in the provision of patient-centered care for individuals with common health problems.

STUDENT LEARNING OUTCOMES:

Students identify, apply, and safely integrate legal-ethical decisions and communication skills in providing care for culturally diverse patients in acute care settings utilizing the fundamentals of the nursing process.

TEACHING METHOD:

Skills presentations, Simulation lab participation, video presentation, pre- and post-conference discussions, bedside instruction.

METHOD OF EVALUATION:

Students achievement of all clinical Performance Evaluation criteria listed below indicates attainment of the student learning outcome:

- Receive a score of 85% or greater in the Drug Dosage Calculation Competency
- Complete clinical worksheet by 0700 each clinical day.
- Receive a grade of satisfactory on:
  - Nursing Care plan
  - Written clinical competency with a score $\geq$ 70%
  - Psychomotor skills competency
  - Implemented formal teaching plan
- Research medications and present findings at a medication conference
- Satisfactorily care for two patients by the end of the course.
- Satisfactorily meet each criterion on the Clinical Evaluation form.

GRADING SCALE:

Satisfactory/Unsatisfactory grading scale is used as the method for scoring and determining final grade in course. (See your student handbook on grading policy.

REQUIRED READING:

Berman, A., Snyder, S., and Frandsen, G. (2016). *Fundamental of nursing: Concepts, Process, and Practice (10th ed.).* New Jersey: Pearson.

BRN Nursing Practice Act. http://www.rn.ca.gov/npa/npa.htm

Kee, J., Hayes, E., & McCuistion, L. (2015). *Pharmacology: A patient-centered nursing process approach (8th ed.).* St. Louis: Elsevier.

Lewis, S., Bucher, L., Heitkemper, M., Harding, T. (2017). *Medical Surgical Nursing. 10th ed.).* St. Louis: Elsevier.

McKinney, E. James, Murray, S., (2013). *Maternal-child nursing. (4th ed.).* St. Louis: Elsevier Saunders.

RECOMMENDED READING:

Ackley, B.J., Ladwig, G.B. (2014). *Nursing diagnosis handbook: An evidenced-based guide to planning care (10th ed.).* St. Louis: Elsevier.

Alfaro-LeFevre, R. (2014). *Applying nursing process – a tool for critical thinking (8TH ed.).* Philadelphia: J.B. Lippincott.

Carpenito-Moyet, L. (2010). *Nursing diagnosis application to clinical practice (13th ed.).* Lippincott: Williams and Wilkins.

All academic policies are strictly enforced.

PROFESSIONAL STANDARDS / CLINICAL EXPECTATIONS:

Professional standards of the student are valuable qualities and necessary for your development in becoming a professional nurse. The qualities listed below are the **EXPECTED** standards at this level.

The student will demonstrate responsible, accountable and consistent behaviors in the following areas:

1. Provide safe and professional care.
2. Follow all hospital policies/procedures and accepted standards of care.
3. Be accountable for previously learned knowledge/skills.
4. Keep instructor and professional staff informed of the client's status in a timely manner.
5. Keep instructor and staff informed of whereabouts at all times.
6. Function effectively within nursing and foster open communication, mutual respect, and shared decision-making in a professional manner.
7. Prepare each day to care for their clients. Preparation includes knowledge of clients:
   - History/diagnosis
   - Expected findings
   - Current medication and effect on client
   - Diagnostic exam and rationale for exam
   - Anticipated complications
   - Rationale for plan of care
   - Cultural practices and values
   - Erickson's Developmental Stages
     - Client's expected behavior for developmental stage across the life span
     - Interventions/collaborations to promote client's growth and development
     - Priority teaching needs of client and family
8. Performs safe, and consistent total client care. Total client care includes, but is not limited to:
   - ADL
   - Medication administration
   - Daily assessment
   - Education of client/family
   - Treatment
   - Documentation
9. Observe dress code standards according to the Student Handbook.
10. Clinical evaluation is based on satisfactory completion of ALL objectives. Failure of one clinical objective will constitute an unsatisfactory grade for the course.
11. All written assignments are due at specified times. No late assignments will be accepted.
12. Students are expected to prepare the day before their clinical experience and clinical preparation sheets must be completed prior to 0700 on the day of the clinical. If students are not prepared they are deemed unsafe and will be dismissed from the clinical area and will be counted as ABSENT and student placed on academic warning. A second incident will constitute failure of a course objective.
13. Students participate actively in clinical conference.

14. The clinical competency must be completed with a passing grade. A second competency will be scheduled after notification of failure.
15. Clinical attendance is mandatory. You are responsible for the information in Policy #210 – School of Nursing Attendance for Clinical Courses.

NOTE: Failure to adhere to professional standards / clinical expectations will result in a written academic warning.

CLINICAL PERFORMANCE EVALUATION SUMMARY

Student: _____ Class: _____
Faculty: _____ Date: _____ Grade: ☐ Satisfactory ☐ Unsatisfactory

From: _____ To: _____ Midterm Grade: _____ Final Grade: _____

Clinical Outcomes

Clinical Outcome I: Nursing Process
Apply the nursing process for safe patient-centered care of individuals with emphasis on physiological problems utilizing evidence-based practice.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Utilizes the steps of the nursing process in the assessment of a patient.	1. Performs one patient-focused assessment using various variables in the assessment of: • Medical-surgical patient	1. Written documentation: Satisfactory grade consists of: a. Accurate and complete assessment according to guidelines. b. Assessment should focus on normal and abnormal data.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome I: Nursing Process (Cont'd)

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
	2. Completes one patient-focused nursing care plan utilizing the nursing process format and satisfactorily completes the following: a. Nursing assessment b. Two nursing diagnosis - NCP = 2 nursing diagnosis (physiological, psychosocial, or collaborative c. Patient outcomes for each diagnosis d. Interventions with rationale e. Implementation with patient response f. Evaluation of interventions/ implementations	2. Written documentation: a. Nursing care plan contains appropriate data related to the Neuman Model. b. Assessment focus on normal and abnormal data. c. Problem list identifies priorities in numerical order with #1 being the highest. d. Contains two nursing diagnoses. e. Appropriate patient outcome is written for each stated nursing diagnosis. f. Appropriate interventions are written in relation to each outcome. g. Evaluates effectiveness of each intervention and attainment of patient outcome.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome II: Communication
Utilize communication skills and nursing informatics in promoting and maintaining the health of individuals with common health problems.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Utilizes communication and assessment skills to develop therapeutic relationship with patients B. Utilizes communication skills in health promotion	1. Communicates with healthcare team.	1. Satisfactory grade consists of an accurate and complete assessment according to interview guidelines. 2. Instructor's Observations a. Interacts with patient on a one-to-one basis focusing on needs. b. Responds appropriately to patient's questions and needs.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome III: Collaboration
Establish methods of teamwork and collaboration with other members of inter-professional healthcare teams for providing and improving patient-centered care.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Identifies methods of developing relationships with other health care professionals.	1. Identifies situations that require collaboration in the planning of care: a. On care plan, the student will identify situations that require collaboration.	1. Written documentation a. Utilizing the Nursing Care Plan format, the student will satisfactorily identify situations that require collaboration with at least two disciplines. 2. Clinical conference Students will discuss: a. Collaborative methods utilized while interacting with other disciplines (i.e., one-on-one; group) b. Problem resolutions c. Outcomes d. Follow-Up		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome IV: Accountability
Apply legal-ethical behaviors that reflect the value of professional accountability to provide and improve quality of care for adults with common health problems.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Identifies area of nursing accountability specific to the care of patients.	1. Lists specific standards in the clinical area for which the nurse is accountable.	1. Discussion: a. Pertinent data that is documented in the following areas: • Assessment (EHR) • Care and Treatment Record (EHR) • MAR (EHR) • Protocols • Standards of Care		
B. Demonstrates legal/ethical behaviors which reflect the nursing responsibility in the care of all patients.	1. Observes nursing behavior related to the care of all patients. 2. Observes nursing activities as they relate to the nurse's role as a patient advocate.	2. Observation a. Observes caregiver interacting as a patient advocate. b. Discusses activity / outcome with instructor.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome IV: Accountability (Cont'd)

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
C. Follows legal-ethical guideline in the administration of medications and treatments. D. Demonstrates accountability for own professional behavior.	1. Observes professional decorum at all times.	1. Attends a minimum of 17days in the Med-Surg course. a. Observes standard dress code. b. Punctual for all scheduled clinical activities. c. Performs patient care activities safely • Prep sheets done prior to caring for patient • Discusses medications prior to administration		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome V: Decision-Making
Identify nursing responsibilities in decision-making as a member of the inter-professional healthcare team in assessing, maintaining and promoting health to achieve safe, quality patient-centered care.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Utilizes decision-making process in developing a plan of care in assessing/ promoting/maintaining the health of: • Medical-surgical patient	1. Lists the priority needs for assigned patient.	1. Clinical Conference: a. Discuss patient findings. b. State rationale for decisions made. c. Patient priorities are based on assessment data. d. Priorities are organized according to Maslow's Hierarchy of Needs and Erickson's Developmental Tasks.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome VI: Education
Apply teaching strategies utilizing evidence based practice to provide information to individual(s) and/or groups.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Provides health education information in health promotion. B. Provides information to meet the educational needs of individuals with problems.	1. Identifies information to be utilized in promoting health according to age-appropriate guidelines for at least two patients.	1. Discussion The student will: a. Discuss clinical findings. b. Discuss identified teaching needs. c. Identify learning needs of assigned patient. d. Discuss methods on how teaching should be done. e. Identify the level of patient's understanding. f. Identify resources for patient education. g. Discuss the effectiveness of teaching plan in meeting the needs of the patient. 2. Student will implement a teaching plan.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

Clinical Outcomes

Clinical Outcome VII: Sociocultural Sensitivity
Integrate socio-cultural values in the provision of patient-centered care for individuals with common health problems.

Objectives	Learning Activity	Evaluation Criteria	Mid S / U	Final S / U
A. Assess sociocultural considerations/variation with individuals. B. Assess sociocultural factors that impact the care of hospitalized patient and family.	1. Performs a patient-focused sociocultural assessment related to: • Medical-surgical patient	1. Clinical Conference: Be able to discuss sociocultural issues related to their patient. 2. Discussion with RN / Instructor Student will discuss with RN / instructor the sociocultural factors that impact the patient and family.		

Instructor Comments:

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Each instructor signs and dates comments.

Student Comments:

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Each student signs and dates comments

CLINICAL COMPETENCY EXAMINATION RESULTS					
Drug Dosage Calculation Competency		**Written Competency**		**Psychomotor Competency**	
Score:	**Sat / Unsat**	**Score:**	**Sat / Unsat**	**Score:**	**Sat / Unsat**

ROTATION SUMMARY

ROTATION SUMMARY: Midterm		**ROTATION SUMMARY: Final**	
Instructor Comment:	**Student Comment:**	**Instructor Comment:**	**Student Comment:**
Instructor Signature:_____	**Student Signature:**_____	**Instructor Signature:**_____	**Student Signature:**_____
Date: _____	**Date:** _____	**Date:** _____	**Date:** _____

N123L: MEDICAL SURGICAL NURSING CLINICAL

Semester 2 – Tuesdays / Wednesdays

WEEKLY CLINICAL EXPECTATIONS – SPRING 2018

WK	DATE		WEEKLY CLINICAL FOCUS	CLINICAL WORKSHEET	CLINICAL CONFERENCE
	Session 1	**Session 2**			
1	1-16-18	3-27-18	Course Orientation-Skills Lab See Skills Lab Schedule		
	1-17-18	3-28-18	Skills Lab See Skills Lab Schedule		Drug Dosage Calculation Competency 1-17-18
2	1-23-18	4-03-18	Med/Surg Clinical Orientation		DDCC Retake 1-23-18
	1-24-18	4-04-18	Nursing Process Head-to-toe assessments		
3	1-30-18	4-10-18	Collaborative Education		Collaboration Strategies
	1-31-18	4-11-18	Decision-making		Priority Decision Making
4	2-06-18	4-17-18	Sociocultural **Psychomotor Comp (Session 1)**	*Psych Comp retakes TBA*	Sociocultural sensitivity
	2-07-18	4-18-18	**Written Comp (Session 1)**	** Written Comp retake Session 1 – 2/13/18*	Med/Surg NCP (Physiological & Psychosocial; Prioritizing Nursing Diagnosis & PC)
5	2-13-18	4-24-18			
	2-14-18	4-25-18			Midterm evaluations
6	2-20-18	5-01-18	**Psychomotor Comp (Session 2)**	*Psych Comp retakes TBA*	
	2-21-18	5-02-18	**Written Comp (Session 2)**	** Written Comp retake Session 2 – 5/08/18*	
7	2-27-18	5-08-18			
	2-28-18	5-09-18	Teaching Project		
8	3-06-18	5-15-18			
	3-07-18	5-16-18			
9	3-13-18	5-22-18	Final Clinical Day		Exit Interview
	3-14-18	5-23-18	Final Evaluations		

COMPETENCY
READING ASSIGNMENT

(All Readings are from Kee – Nursing Pharmacology)

SEMESTER 2 – SPRING 2018

CHAPTER	TOPIC	PAGES / PROBLEMS
REQUIRED		
Chapter 14	Pediatric Drug Calculations	Pp. 202 – 209 No BSA Pp. 205-206, #1-8; Pp. 207-208, #1-6 ***Study Guide – Practice Problems:*** Pp. 70 – 74, #1 – 8 Pp. 76 – 78, #10 – 15
Chapter 14	Calculations of Intravenous Fluids	Pp. 190 – 197 Pp. 197 – 198, #1 – 3, 4(a,b), 6 ***Study Guide – Practice Problems:*** Pp. 63, #14 – 15, 17 Pp. 64-66, #19b, 20(a,b), 23(a,b,d) Pp. 67, #24 (a), 25(a) Pp. 68 – 70, #26 - 28, 29(a), 30 (a)
RECOMMENDED		
Review all Semester 1 material – Chapter 14 – Medications and Calculations		
Section 14A	Systems of Measurement with Conversion	Pp. 148 – 151
Section 14B	Methods for Calculations	Pp. 152 – 155 Practice Problems: Pp. 159 – 161
Section 14C	Calculations of Oral Dosages	Pp. 165 – 167 Practice Problems Pp. 168 – 171
Section 14D	Calculations of Injectable Dosages	Pp. 174 – 175, 178 Practice Problems Pp. 178 – 179, 184 – 187
Study Guide	Practice Problems	Pp. 45 – 52, Problems 1,4,5,8,11,12,13,21,22 Pp. 55 – 62 Problems 14,15,18,20,22,23,24,27,28,30,31,32

TEXTBOOK: **Kee, J.L., Hayes, E. & McCuistion, L.E. (2015). Pharmacology: A patient-centered nursing process approach. St. Louis: Elsevier.**

STUDY GUIDE: **Kee, J.L., Hayes, E. & McCuistion, L.E. (2015). Study Guide for Pharmacology: A patient-centered nursing process approach. St. Louis: Elsevier.**

NURSING 123L CLINICAL COMPETENCY

Clinical Competency Date:	**Psychomotor competency:**	**Session 1 – 2-06-18**
		Session 2 – 5-01-18
	Written competency:	**Session 1 – 2-07-18**
		Session 2 – 5-02-18

GUIDELINES

In order to assist you with the preparation for your clinical competency, please review the following information:

- The Policy and Guidelines for the "Grading for Clinical Course" of the Student Handbook.
- Refer to the content under the major categories in the "Nursing Skills Competency Checklist" in N123L Syllabus.

PSYCHOMOTOR SKILLS COMPETENCY

The skill portion of the competency will consist of actual demonstration of selected skills. These skills have been categorized into the following major concepts:

- IV (completed in the clinical setting
  - Set-up
  - Calculation
- Foley Catheter
  - Insertion
  - Maintenance
- Nasogastric Tube
  - Insertion
  - Maintenance
  - Feeding
  - Decompression

You will be required to perform one skill randomly selected from the above skills. Time for the completion of each skill will be 15 minutes. The **skill kit/bag** is **required** for competency testing.

You must be able to competently complete the skill(s) you are asked to perform according to the procedure taught in the skills labs and outlined in your textbooks, *Fundamentals of Nursing* by Berman, et.al., to the satisfaction of the instructor observing you.

If you are unable to competently complete the skills, you will be given the opportunity to repeat the competency. You must correctly complete the skills you failed before the course ends, in order to satisfactorily pass the course.

NURSING SKILLS READING LIST

TOPIC	MED-SURG Lewis	FUNDAMENTALS Berman	PHARM Kee	VISUAL AIDS
Intravenous Therapy		Chapter 35: pp. 803-811 Chapter 52: pp. 1340-1357 (Peripheral IV **only**)	pp. 223-251	DVD 1506: Taylor's IV Therapy DVD 1506: Taylor's IV Medication
Urinary Catheterization		Chapter 48: pp. 1174-1209		DVD 1506: Taylor's Indwelling Catheter DVD 1506: Taylor's Urinary Elimination
Drug Dosage Calculation				
Eternal Nutrition & Decompression Nasogastric Tube • Insertion • Maintenance • Feeding • Medicating • Decompression • Gastrostomy & Jejunostomy feeding	pp. 896-900	Chapter 47: pp. 1127-1173 Chapter 37: pp. 889-892		DVD 1506: Taylor's Nutrition Video: #1163 Delmar – Nutrition and Elimination
Diagnostic Testing • Blood Glucose Monitoring • Specimen Collection	Class Handout	Chapter 34: pp. 723-728, 728-736 (urine & stool) 736-737 (sputum & throat) Chapter 36: pp. 840-841 (wound)		
Ostomy Care		Chapter 49: pp. 1232-1240		DVD 1506: Taylor's Urinary Elimination DVD 1506: Taylor's Bowel Elimination
Enema		Chapter 49: pp. 1210-1232		DVD 1506: Taylor's Bowel Elimination

SKILLS OBJECTIVES

Colostomy Care

1. Assess and care for the peristomal skin and stoma.
2. Demonstrate proper collection of effluent and assessment of the amount and type of output.
3. Demonstrate proper management of colostomy bag for the client's comfort and self-esteem.
4. Document assessment findings; e.g. stoma color, shape, size, output in Electronic Health Record (EHR).
5. Name the various types of ostomies and describe the type of effluent.
6. Encourage expression of client's feeling and needs prior to procedure.
7. Approach the client in a professional and supportive manner throughout the procedure.
8. Demonstrate documentation of colostomy care in EHR.

Enemas

1. Demonstrate proper assessment and care for the client during enema administration.
2. Differentiate between the four different types of enemas.
3. Provide the client proper health teaching in maintaining normal defecation.
4. Discuss safety factors to be considered for enema procedure.
5. Encourage client's expressions of feelings and needs prior to the procedure.
6. Approach the client in a professional and supportive manner throughout the procedure.
7. Demonstrate knowledge of appropriate documentation of enema outcomes in EHR.

SKILLS OBJECTIVES

Specimen Collection

1. Identify the nursing responsibilities for specimen collection.
2. Explain the rationale for the collection of each type of specimen.
3. State two reasons for testing feces.
4. Demonstrate proper stool testing for occult blood.
5. Demonstrate proper urine specimen collection.
6. Demonstrate proper collection of sputum, nose, and throat specimens.
7. Approach the client in a supportive manner throughout the procedure.
8. Demonstrate documentation of specimen collection in EHR.

Blood Glucose Monitoring

1. State the purpose of performing the daily quality assurance testing for the Sure Step Pro Glucose Scan Bedside unit.
2. Navigate and program the Sure Step Pro Glucose Scanner to receive the patient information for glucose testing correctly.
3. Perform safe and proper technique for obtaining blood glucose monitoring.
4. Demonstrate proper troubleshooting techniques when problems occur with the Sure Step Pro Glucose Scanner.
5. Identify the signs and symptoms of hypo and hyperglycemia seen in patients.
6. Demonstrate correct glucose monitoring technique in skills lab environment.
8. Demonstrate proper documentation of serum glucose results in EHR.
9. Discuss LAC+USC Medical Center Insulin Management (Subcutaneous) Protocol.

MEDICATION ADMINISTRATION - INSULIN (SUBCUTANEOUS)
Performance Checklist

Performance Criteria	S	U	Comments
Check prescriber's order.			
Verbalize checking of blood glucose level prior to administering insulin.			
Determine appropriateness of administering insulin based on blood sugar reading.			
Check allergies.			
Wash hands prior to preparing medication. Sequence of hand washing may vary, but must be done prior to cleaning top of insulin vial.			
Select correct syringe for insulin administration.			
Select correct insulin vial.			
Check insulin vial for color, clarity and expiration date. If vial is opened, check for RN initials and date vial was first used.			
Clean top of vial with alcohol pad.			
Draw up correct dose of insulin in the presence of a second licensed staff.			
Obtain independent double check to verify prescriber's order matches insulin type and dose.			
Use appropriate measures to protect needle.			
Locate two correct subcutaneous injection sites that may be used for insulin administration.			
Wash hands and dons gloves prior to administering medication.			
Verify patient identity by comparing patient's name and MRUN on identification band with prescriber's order.			
Clean injection site with alcohol pad.			
Demonstrate proper technique for SQ insulin injection.			
Activate needle safety device and disposes of syringe into appropriate container, i.e., sharps container.			
Document according to documentation standards in EHR.			

SKILLS OBJECTIVES

Intravenous Therapy

1. Demonstrate the proper psychomotor skills to safely administer piggy back (IVPB) via the saline lock, continuous gravity, and intravenous infusion pump systems.

2. Discuss Intravenous Therapy Protocol and guidelines to include, but not limited to the following:
   a. An intravenous order for administration of IVPB medications
   b. Protocol for maintaining the system to include:
      1) tubing changes / management
      2) assessment of intravenous cannula site.

3. Identify the common complications seen when administering medications via IVPB and discuss the nursing responsibilities to prevent or reduce their occurrence.

4. Demonstrate the correct documentation of piggy back (IVPB) medications in the EHR.

5. Demonstrate accurate recording of intake and output of primary intravenous (IV) therapy and IVPBs in skills lab.

6. Value the significance of monitoring client's health outcomes during administration of IVPBs.

7. Value technologies (IV pumps and EHR) that support error prevention and care coordination.

Student Name: _____

Intravenous Therapy (I.V.) Skill Competency Checklist
Administration of Medications and Fluids via Peripheral Venous Access Device

	Criteria for IV Therapy Administration	S	U	Comment
1	**Assessment/Preparation**			
	Verify doctor's order			
	Wash hands			
	Identify patient and assess for allergies			
	Gather all materials and equipment • Correct Sterile IV fluid/medication/flush • Correct type of tubing • IV Pole/IV Infusion pump (if needed) • Three-way connector and one-way valves (if needed) • 3 mL syringe (if needed for flush) • Alcohol wipes or chlorohexadine (Chloroprep)/tape			
2	**Implementation and Evaluation**			
	Wear clean gloves			
	Perform all procedures observing asepsis and wearing gloves			
	Hang new IV tubing when necessary • Remove appropriate tubing from package • Clamp tubing • Spike container without damage to container or injury to self • Prime tubing, removing all large bubbles • Connect secondary tubing to primary tubing, and primary tubing to "patient"			
	Use gravity drip method to deliver therapy at the correct rate. Calculate by gravity method with various gtt factors 10/15/20/60 gtt factors			
	Use Alaris infusion pump to deliver therapy at the correct rate. • Primary rate • Secondary rate (IVPB)			
	Demonstrate correct saline lock flush technique while maintaining asepsis			
	Label all tubing and containers per IV protocol as necessary			
3	**Documentation**			
	• Type of I.V. solution and additives/IVBP medications • Condition of insertion site/patient complaints • I.V. tubing changed • I.V. discontinued and/or reinserted • Patient teaching • Nursing signature			

Student Name _____

RUBRIC: INTRAVENOUS THERAPY (I.V.) COMPETENCY
Administration of Medications and Fluids via Peripheral Venous Access Device

All of the Criteria **must** be satisfactorily met to establish competence.

Criteria	Unsatisfactory	Satisfactory	Student performance
Assessment	□ Fails to verify MDs orders □ Incorrectly identifies patient □ Fails to assess allergies □ Fails to assess / discuss: □ IV site □ Dressing & need for change □ Complications	□ Verifies MDs orders □ Correctly identifies patient □ Assesses allergies □ Accurately assesses /discusses: □ IV site □ Dressing & need for change □ Complications	
Patient Preparation	□ Fails to acknowledge patient as a core member of healthcare team □ Inadequate or no patient teaching verbalized □ Fails to encourage input/questions	□ Acknowledges patient as a core member of healthcare team □ Provides patient teaching as appropriate to given scenario □ Encourages input/questions	
Equipment	□ Incomplete gathering of equipment □ Incorrect use of equipment	□ Gathers all necessary equipment □ Correctly uses equipment	
Asepsis	□ Violates principles of asepsis	□ Maintains principles of asepsis	
Skill Performance *(any or all may be evaluated)*	□ Fails to follow the "three checks" and "eight rights" of medication administration □ Fails to administer correct amount of fluid at correct rate □ Fails to close the infusion clamp appropriately for the scenario □ Fails to wipe the appropriate port with alcohol or disinfectant swab □ Fails to complete the medication / tubing label □ Fails to discuss correct disposal of equipment and supplies	□ Follows the "three checks" and "eight rights" of medication administration □ Administers correct amount of fluid at correct rate □ Closes the infusion clamp appropriately for the scenario □ Wipes the appropriate port with alcohol or disinfectant swab □ Completes medication/tubing label and applies to the IV bag/tubing □ Discusses correct disposal of equipment and supplies	
Evaluation	□ Fails to discuss post procedure assessment and documentation	□ Discusses correct post procedure assessment and documentation	
General Competency Evaluation	□ Demonstrates inadequate nursing knowledge required to safely perform psychomotor skill. □ Neglects key elements / errors, compromising patient safety.	□ Demonstrates basic nursing knowledge to safely perform psychomotor skill. □ Performs key elements, maintaining basic patient safety.	

Comments: □ Unsatisfactory □ Satisfactory

Instructor: _____ Date: _____

Rev. 06/2016

SKILLS OBJECTIVES

Urinary Catheter Insertion

1. Discuss reasons for urinary catheterization (indwelling/straight) and external catheterization.
2. Identify factors to consider prior to catheterization.
3. Demonstrate proper technique for inserting a urinary catheter and applying an external catheter.
4. Perform aseptic technique and utilize catheter associated urinary tract infection (CAUTI) safety measures when performing catheterization.
5. Discuss nursing interventions required for maintenance of a urinary catheter system.
6. Demonstrate removal of indwelling and external catheter.
7. Discuss the LAC+USC Medical Center Indwelling Bladder Catheter Protocol.
8. Explain instructions to patient/family regarding urinary catheters.
9. Identify common nursing diagnosis associated with urinary catheterization.
10. Approach the client in a supportive manner throughout the procedure.

URINARY CATHETERIZATION COMPETENCY CHECKLIST			
Steps for Foley Catheter Insertion	**S**	**U**	**Comments**
Assessment/Preparation			
Verify doctor's order			
Wash hands			
Identify patient • Explain procedure and rationale • Assess for allergies to latex and betadine			
Gather all necessary supplies • Foley catheter tray, extra pair of sterile gloves • Check expiration date and integrity of equipment			
Provide Privacy			
Implementation			
Wash hads and don clean gloves Assist pt. to appropriate position • Expose the genitalia Set up the sterile field: Sterility MUST be maintained on all bullets in this area • Open Foley insertion kit • Place underpad under patient (shiny side down) • Provide pericare • Remove gloves • Hand gel • Open and position sterile field to patient's buttocks • Put on sterile gloves • Place fenestrated drape over patient's genitalia (optional) • Attach sterile water syringe to catheter • Remove protective catheter cover • Open betadine swabs, place on tray • Cleanse area with cotton swabs using dominant hand (Know the steps for female and male) • Male: instill lubricant into meatus • Female: squeeze lubricant onto the tray and lubricate catheter tip • Insert Foley catheter via urethra into the urinary bladder: Females – insert 3-4 inches; Males – insert 6-9 inches or until you see urine. • Observe for urine outflow and advance catheter 1-2 more inches • Move non-dominant hand to stabilize catheter while dominant hand inflates balloon • Gently retract catheter until you feel resistance (to position balloon) • Secure catheter using stat lock and skin prep as necessary • Label time and date with labels provided in kit • Hang drainage bag to non-movable part of the bed frame • Clean up and remove gloves and discard disposable trash appropriately			

Steps for Foley Catheter Insertion	S	U	Comments
Evaluation			
Reassess patient • How did pt. tolerate procedure • Examine and measure urine • Answer any questions • Provide pt. education			
Documentation			
The insertion of a Foley catheter • Type and size of Foley inserted • Inflated catheter balloon with 10ml of sterile water using sterile technique • Characteristic of urine (includes color, odor, sediment, or trauma • Amount of urine • Drainage bag to gravity • Patient teaching • Tolerated procedure well. Without complications • Sign EHR			

Student_____

RUBRIC: URINARY CATHETERIZATION

All of the criteria **must** be met satisfactorily to establish competence.

Criteria	Unsatisfactory	Satisfactory	Student Performance
Assessment	□ Fails to verify MDs orders □ Incorrectly identifies patient □ Fails to assess allergies	□ Verifies MDs orders □ Correctly identifies patient □ Assesses allergies	
Equipment	□ Fails to gather necessary supplies for urinary catheter insertion □ Fails to examine supplies for expiration date and integrity of equipment	□ Gathers necessary supplies for urinary catheter insertion □ Examines supplies for expiration date and integrity of equipment	
Patient Preparation	□ Fails to acknowledge patient as a core member of healthcare team □ Fails to explain the procedure with rationale to the patient □ Fails to encourage input questions □ Fails to provide patient privacy □ Fails to provide pericare □ Fails to position patient correctly for urinary catheter insertion □ Fails to insert catheter safely	□ Acknowledges patient as a core member of healthcare team □ Explains the procedure with rationale to the patient □ Encourages input / questions □ Provides patient privacy □ Provides pericare □ Positions patient correctly for urinary catheter insertion □ Safely inserts urinary catheter	
Skill Performance	□ Fails to implement logical sequence of procedure □ Fails to secure catheter with StatLock in the correct place □ Fails to hang drainage bag from a non-moving part of the bed □ Fails to reposition patient post insertion	□ Implements logical sequence of procedure □ Secures catheter with StatLock in the correct place □ Hangs drainage bag from a non-moving part of the bed □ Repositions patient in a comfortable position post insertion	
Asepsis	□ Violates principles of asepsis □ Fails to identify and/or correct any violations of asepsis □ Exceeds two (2) corrected violations	□ Maintains principles of asepsis □ Recognizes and corrects violations of asepsis □ Violations not to exceed two self-corrections	
Evaluation	□ Fails to discuss proper disposal of equipment □ Fails to discuss correct post procedure assessment and documentation	□ Discusses proper disposal of equipment □ Discusses correct post procedure assessment and documentation	
General Competency Performance	□ Demonstrates inadequate nursing knowledge required to safely perform psychomotor skill. □ Fails to identify errors or key elements, compromising patient safety	□ Demonstrates basic nursing knowledge and safely performs psychomotor skill. □ Performs key elements, maintaining basic patient safety.	

Comments: □ Unsatisfactory □ Satisfactory

Instructor:_____ Date:_____ Rev. 06/2016

SKILLS OBJECTIVE

Nasogastric Tube Insertion

1. State the four reasons for nasogastric tube insertion.

2. Identify proper selection of nasogastric tubes for specific clinical conditions (vented or non-vented tubes).

3. Demonstrate/discuss the proper technique for measuring, inserting, securing, checking and confirming the placement of a nasogastric tube.

4. Discuss proper documentation required after nasogastric tube insertion.

5. Discuss potential complications related to nasogastric tubes.

6. Demonstrate/discuss the proper technique for removing a nasogastric tube.

7. Encourage expression of clients' fear prior to procedure.

8. Discuss the LAC+USC Medical Center Nasogastric Tube for Decompression & Gastric Lavage Protocol.

SKILLS OBJECTIVE

Enteral Tube Maintenance/Feeding/Medication Administration

1. Discuss / demonstrate assessment, independent/dependent nursing interventions, collaboration, and documentation for the following complications of enteral (NG, PEG, PEJ) tubes:
   - Trauma
   - Sinus infection / encephalitis
   - Aspiration / pneumonia
   - Gastroenteritis and diarrhea
   - Fluid and electrolyte imbalances / re-feeding syndrome
   - Clogged tubes
   - Dislodged tube

2. Discuss / demonstrate proper technique for administering tube feeding formula according to the physician's order.

3. Discuss / demonstrate the proper technique for administering the different types of gavage and/or enteral tube feedings.

4. Discuss / demonstrate the proper technique for managing gastrointestinal suctioning.

5. Discuss / demonstrate collaborative techniques to prevent leakage of gastric contents from the nasogastric tube. (See Nasogastric Intubation for Decompression protocol.)

6. Discuss the LAC+USC Medical Center Enteral Feeding & Medical Administration Protocol.

7. Approach the client in a professional and supportive manner throughout the procedure.

8. Demonstrate documentation of enteral tube maintenance/ feeding/medication administration in EHR.

Nasogastric Tube (NGT) Insertion Competency Checklist

Steps for Nasogastric Tube Insertion	S	U	Comment
Assessment/Preparation			
Verify doctor's order			
Wash hands and put on clean gloves			
Identify patient and assess patient • Ask if pt. had nasal injury or surgery • Visualize area w/penlight • Identify largest nares • Identify nostril patency			
Gather all insertion material and equipment Know difference between the Levine and Salem Sump • 60ml catheter tip syringe • Towel • Lopez valve/multifunction port • Water soluble jelly • Tissues • Cup of water or ice chips • Emesis basin • Tape • Penlight • Rubber band and safety pin • Stethoscope • Suction equipment and tubing (if necessary)			
Implementation			
Provide privacy			
Position patient – High Fowler's			
Establish non-verbal hand signals (to indicate distress)			
Prepare tape			
Open Levine or Salem Sump packet			
Measure and mark the appropriate NGT Know anatomical landmarks for measuring tube • Tip of the nose to the tip of the earlobe to the tip of the xiphoid process [Berman, p.1285]			
Give patient cup of ice chips			
Lubricate catheter tip			
Flex head slightly (unless contraindicated)			
Insert tube			
At the Nasopharyngeal junction, rotate or turn tube 180^0 while advancing 1-2 inches to the oropharynx			
Check for tube coiling (w/penlight). For excessive coughing or gagging, pull tube back 1-2 inches and reassess			
Provide ice chips (Triggers' swallowing reflex and prevents aspiration)			
Reposition chin on chest			
Encourage swallowing Insert tube 2-4 inches (5 to 10 cm) with each swallow			
Continue to insert tube until you reach the stomach at the tape site			
Secure NGT to cheek			

Steps for Nasogastric Tube Insertion	S	U	Comment
Evaluation			
Check placement (stethoscope 2 inches down and left from xiphoid) • Insert 10-30 mL of air • Listen for gurgle or whoosh sound (if no sound, advance by 2 inches) • Aspirate gastric content (look for flash at nares) • Attach Lopez valve/multifunction port • Secure tube w/tape to nares (if X-ray not needed) • Loop the rubber band around the end of the tubing & attach the rubber band to the gown w/ a safety pin • Provide oral care • Confirm NGT placement via X-ray prior to feedings, medication administration, flushes, or irrigation. Upon confirmation, mark tube and secure w/tape to nose.			
Connect NGT to appropriate apparatus • Enteral feeding pump (cyclic, continuous, bolus) • Suction (low, intermittent or continuous)			
Reassess patient according to protocol			
Documentation			
The insertion of the tube: • How pt. tolerated the procedure • Type and size of tube placed • Left or right nare placement • Record the gastric output/characteristics • Record type of suction • Write incidental note if appropriate • Nurse Signature			

Student Name: _____

RUBRIC: NASOGASTRIC (NGT) INSERTION

All of the Criteria **must** be satisfactorily met to establish competence.

Criteria	Unsatisfactory	Satisfactory	Student performance
Assessment	□ Fails to verify MDs order □ Fails to assess nares for patency □ Fails to assess for allergies	□ Verifies MDs order correctly □ Assesses nares for patency □ Assesses for allergies	
Patient Preparation /Teaching	□ Fails to acknowledge patient as core member of healthcare team □ Fails to identify patient □ Fails to explain procedure / teaching with rationale □ Fails to encourage input/questions □ Fails to establish hand signals □ Fails to provide privacy □ Fails to position patient for NGT insertion/placement	□ Acknowledges patient as a core member of healthcare team □ Correctly identifies patient □ Explains procedure/ teaching with rationale □ Encourages input/questions □ Establishes hand signals □ Provides patient privacy □ Positions patient for NGT insertion/placement	
Equipment Preparation	□ Selects wrong tube □ Fails to gather appropriate supplies for tube insertion and/or maintenance □ Fails to identify landmarks, measure or mark tube □ Fails to lubricate tip of NGT	□ Selects appropriate tube □ Gathers appropriate supplies for tube insertion and/or maintenance. □ Identifies landmarks, then measures and marks tube □ Lubricates tip of NGT	
Asepsis	□ Fails to use medical asepsis	□ Correctly uses medical asepsis	
Skill Performance	□ Fails to correctly adjust head position □ Fails to advance NGT safely □ Fails to secure NGT □ Fails to connect Lopez valve to NGT or to appropriate apparatus correctly □ Fails to verify placement	□ Adjusts head position correctly for insertion □ Safely advances NGT □ Secures NGT □ Connects Lopez valve to NGT or to appropriate apparatus correctly □ Verifies placement	
Evaluation	□ Fails to discuss correct post-procedure assessment and documentation	□ Discusses correct post procedure assessment and documentation	
General Competency Performance	□ Student demonstrates inadequate nursing knowledge required to safely perform psychomotor skill. □ Student fails to identify errors or neglects key elements, compromising patient safety.	□ Student demonstrates basic nursing concepts required to safely perform psychomotor skill. □ Performs key elements, maintaining basic patient safety.	

Comments: Unsatisfactory □ Satisfactory

Instructor: _____ Date: _____

Rev. 06/2016

Feeding via GI Tubes Competency Checklist
Nasogastric Tube (NGT), Percutaneous Endoscopic Gastrostomy (PEG)

Criteria for NGT/PEG/PEJ	S	U	Comment
Assessment/Preparation			
Verify doctor's orders			
Wash hands			
Identify patient			
Gather all insertion material and equipment • 60 ml catheter tip syringe • Emesis basin • Towel • Kangaroo pump • Tube feeding bag with label • Tube feeding formula • Alcohol prep • Stethoscope • Drinking water			
Assess Patient • Presence of bowel sounds (minimum of Q8 hrs) • Tube placement (per hospital protocol) • Gastric residuals (NGT/PEG only) • Tolerance to formula feeding • Feeding equipment (syringe, feeding bag, date & time last changed per hospital protocol)			
Implementation and Evaluation **All steps MUST be performed in this section**			
Return aspirated residual to stomach when: • Amount is <500 mL (unless patient shows signs of intolerance) Hold feeding, notify physician and reassess patient according to protocol Continuous Feeding/Intermittent Bolus Via Kangaroo Pump • Place feeding bag/tubing in pump • Place appropriate volume in bag (not to exceed 8 hrs volume) • Label bag • Prime flush and/or feeding tube • Connect tubing to NGT, PEG tube, etc. • Select continuous or intermittent mode • Program feed rate and VTBD • Program flush volume, number and/or interval as per protocol • Run feeding pump • Use "flush now" feature following intermittent feed • Reassess patient according to protocol			

Criteria for NGT/PEG/PEJ	S	U	Comment
Documentation			
• Presence of bowel sounds • Placement of tube • Amount of residuals • HOB ≥ 30° • Type of Tube Feeding • Patient's tolerance or response to procedure • Amount of NGT feeding in Intake & Output Record • Nurse Signature			

Student Name: _____

RUBRIC: FEEDING VIA NASOGASTRIC, GASTROSTOMY OR JEJUNOSTOMY TUBE

All of the Criteria **must** be satisfactorily met to establish competence.

Criteria	Unsatisfactory	Satisfactory	Student performance
Assessment	□ Fails to verify MDs order □ Fails to assess for allergies □ Fails to assess presence of bowel sounds □ Fails to assess tube placement □ Fails to assess residual (tube patency) □ Fails to assess GI symptoms that suggest intolerance of previous feedings □ Fails to assess expiration date and temperature of the feeding	□ Verifies MDs order correctly □ Assesses for allergies □ Assesses presence of bowel sounds □ Assesses tube placement □ Assesses residual (tube patency) □ Assesses GI symptoms that suggest intolerance of previous feedings □ Assesses expiration date and temperature of the feeding	
Patient Preparation / Teaching	□ Fails to acknowledge patient as a core member of healthcare team □ Fails to correctly identify patient □ Fails to explain procedure /teaching with rationale □ Fails to encourage input/questions □ Fails to provide patient privacy □ Fails to position patient correctly for feeding	□ Acknowledges patient as a core member of healthcare team □ Correctly identifies patient □ Explains procedure /teaching with rationale □ Encourages input/questions □ Provides patient privacy □ Positions patient correctly for feeding	
Equipment Preparation	□ Fails to gather appropriate supplies prior to tube feeding.	□ Gathers appropriate supplies for tube feeding.	
Asepsis	□ Fail**s** to use medical asepsis	□ Correct use of medical asepsis	
Skill Performance *(any or all may be evaluated)*	□ Fails to follow a logical sequence of procedural implementation □ Fails to administer feeding according to the given scenario/protocol □ Fails to complete the feeding label or apply to the feeding bag □ Fails to dispose of equipment correctly	□ Implements a logical sequence of the feeding procedure □ Administers feeding according to the given scenario/protocol □ Completes the feeding label and applies to the feeding bag □ Disposes of equipment correctly	
Evaluation	□ Fails to discuss post procedure assessment and documentation	□ Discusses post procedure assessment and documentation	
General Competency Performance	□ Demonstrates inadequate nursing knowledge required to safely perform psychomotor skill. □ Fails to identify errors or key elements compromising patient safety.	□ Demonstrates basic nursing concepts required to safely perform psychomotor skill. □ Performs key elements, maintaining basic patient safety.	

Comments: □ Unsatisfactory □ Satisfactory

Instructor: _____ Date: _____ **Rev. 06/2016**

Medical/Surgical Clinical Teaching Plan Guidelines

Directions:
The instructions are designed to guide the student in systematically implementing a teaching plan according to course objective #6. Select a topic pertinent to your patient's health needs. You may use the hospital standardized teaching protocols if applicable or use the teaching guide and care plans in your Medical/Surgical text (Lewis). You will make your teaching presentation to your patient and also discuss your teaching experience during a post conference session. A copy of your teaching protocol, and any other teaching materials used during your patient presentation will be submitted to your clinical instructor.

1. Discuss the pertinent clinical findings such as medical and nursing diagnoses and stressors.
2. Identify the patient learning needs of the selected patient such as the content that needs to be taught and barriers to learning. These barriers may include health literacy, cultural and spiritual values, financial resources, social support network, and physical, psychological, cognitive and sensory factors.
3. Discuss identified instructor (student) teaching needs. For instructor teaching needs see Lewis Pg. 49-61.
4. Discuss how the teaching should be done and why the method you chose is the best for the patient, situation and goal of teaching.
5. Identify level of patient understanding such as level of education, what patient already knows, what patient wants to learn first.
6. Identify resources for patient education. Resources may include sources of information, people, and materials.
7. Discuss the effectiveness of the teaching plan in meeting the needs of the patient. Evaluate how successfully the plan helped the patient to reach the goal and how you would teach patients in future based on your experiences teaching this patient.

The following teaching and learning principles are included to provide you with further guidance for developing your teaching plan.

Teaching Principles

1. Adapt teaching to your audience (patient/family).
2. Determine audience perceptions about the subject matter before and during teaching.
3. Create an environment that is conducive to learning.
4. Involve audience throughout the learning process.
5. Make subject matter relevant to audience interest and use.
6. Ensure audience satisfaction during the teaching-learning process.
7. Provide opportunities for audience to apply material taught.

Learning Principles

1. The learning process makes use of audience experience and is geared to their level of understanding.
2. Audience is given the opportunity to provide frequent feedback on their understanding of the material taught.
3. The environment for learning is physically comfortable, offers an atmosphere of mutual helpfulness, trust, respect, and acceptance, and allows for free expression of ideas.
4. Audience actively participates. They assess their needs, establish goals, and evaluate learning progress.
5. Audience feels motivated to learn.
6. Audience sense progress toward their goals.
7. Audience integrates the learning through application

Student Name**:**_____

RUBRIC: CLINICAL TEACHING PLAN REPORT

Subject	Criteria	S	U	Comments
Introduction	Discuss patient's pertinent clinical findings: Nursing/Medical diagnosis and stressors.			
Learning need	Identify patient learning needs and barriers to patient learning.			
Student teaching/ learning needs	Identify personal teaching/learning needs encountered in the process of patient teaching.			
Patient teaching strategies	Discuss how patient teaching was done, why particular teaching methods selected were best for the patient, situation, and for the goal of teaching. Demonstrate patient/nurse collaboration.			
Level of patient understanding	Identify level of patient understanding such as level of education, what patient already knows, what patient wants to learn first.			
Resources for patient teaching	Demonstrate creativity in identifying effective patient education resources which may include people, materials and sources of information.			
Effectiveness of patient teaching	Discuss techniques and/or strategies used to evaluate patient's mastery of concepts, skills, or behavior. What would you change if anything.			
Teaching/learning principles	Demonstrate overall understanding and application of teaching/learning principles.			
Summary	Well prepared, knowledgeable, thorough, and enthusiastic.			

Comments:

Instructor's Signature: _____ Date: _____

Date _____ *Student's Name:* _____

CLINICAL WORKSHEET

CLNICAL PREPARATION WORKSHEET (ADULTS):
Estimated time on ward for preparation 30 minutes. All clinical preparation worksheets must be completed prior to administering care to your adult patients.

Patient Initials_____Age _____ Gender (circle one) M F

Room #_____Ht._____ Wt. _____Admission Date:_____

Patient's Chief Complaint(s):

Diagnosis: _____

Secondary Diagnosis (pre-existing health problems): _____

PATHOPHYSIOLOGY(cite source):
Typical signs and symptoms seen in the disease process including any abnormal labs. (Highlight those that your patient is experiencing or has experienced.)

Medical Information:

1. Allergies _____
2. Diet: _____
3. Activity Level: _____
4. Treatment(s): _____
5. IV Therapy:_____

Checklist for patient chart assessment:

1. Check physician orders: _____
2. Review brief patient history: _____
3. Lab reports:_____
4. Diagnostic Exams: _____
5. MAR (EHR): _____

Blood pressure:	SBP<_____	or	>_____	DBP<_____ or >_____
Heart rate:	<_____	or	>_____	
Respiratory rate:	<_____	or	>_____	O2 saturation < _____%
Temperature:	<_____	or	>_____	

Circle Vital Sign (s) if out of parameters and state intervention taken

Date: _____ Time: _____
Vital Signs: T _____ BP _____ HR _____ RR _____ O2sat_____
Pain_____
Intervention: _____

Date: _____ Time: _____
Vital Signs: T _____ BP _____ HR _____ RR _____ O2sat_____
Pain_____
Intervention: _____

Lab Values **Date_____** **Date_____**

Test	Normal Values	Admission Labs	Lab Results	Significance of Findings
Na^+				
K+				
Glu				
Ca+				
PO4				
Mg++				
BUN				
Cr				
Hgb				
Hct				
WBC				
RBC				
Platelets				
Others:				
_____ Peak				
_____ Trough				

Summary of Current Medical Plan (See Physician's Progress Notes):

ORGANIZATIONAL PLAN:

0700:
0800:
0900:
1000:
1100:
1200:
1300:
1400:

Priority Assessment for the Patient:

Nursing Diagnoses (NANDA):

Goals / Outcomes:
Patient will

Nursing Interventions and Rationale for the priority nursing diagnosis mentioned above:
1.

2.

3.

4.

Collaborative Problems (Potential Complications):

PC:

PC:

MEDICATIONS (LIST ALL MEDICATIONS THAT ARE CURRENT AND PROVIDE THE FOLLOWING
INFORMATION): generic and trade name, classification of drug, action, specific reason why your patient is receiving the medication (indication), recommended ranges for medication (high and low), common side effects and
nursing implications/considerations for administration. EACH DRUG IS TO BE CALCULATED OUT TO ENSURE
SAFE DOSAGES ARE BEING ADMINISTERED AND/OR ORDERED.

Time	Medication / Classification	Dose / Safe Range	Route	Indications	Side Effects	Nursing Considerations

Los Angeles County College of Nursing and Allied Health
N123L: Medical Surgical Nursing Clinical – Spring 2018

Student Name _____ Pt initials _____ Room # _____ Age _____ Gender _____ Ethnicity _____
Clinical Date_____ Admission Date _____ Height _____ Weight _____

Past Medical Hx

ALLERGIES

Medications & Schedule (attach separate medication sheet):

_____
_____
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_____

IVFluids:_____
_____

TX Ordered:_____
_____

Diet:_____
Activity:_____

Notify MD for: *HR>___or<____, BP: SBP>____or<___, DBP>____or <____, RR<____or>____,Temp>__or <____, O2sat _____*

Chief complaint

Textbook S/S
(highlight those that your patient is experiencing OR has experienced)

Pt Assessments
(complete after assessment)

Pathophysiology (cite source): _____

_____
_____
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Current Medical Dx

Abnormal Labs (highlight abnormals and give rationale):

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Diagnostic Exams & Results:

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PROBLEM #1	**PROBLEM #2**	**PC of _____:**
Goal	**Goal**	**Goal**
Interventions	**Interventions**	**Intervention**
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Summary of Current Medical Plan: (See Physician's Progress Notes in Affinity)

HEAD TO TOE ASSESSMENT CHECKLIST

NEUROLOGICAL

- ❑ WNL: Awake and alert, oriented to person, place, time and purpose. Eyes open spontaneously, speech clear, face symmetrical, sensation intact all extremities
- ❑ PERRLA
- ❑ Head tenderness? Check for lesions, nodules, depressions, symmetry
- ❑ Lymph nodes: palpable or non-palpable (watch face for any grimacing)
- ❑ Conjunctiva sac: color, lacrimal sac area: swelling? excessive tearing?- palpate gently- regurgitation?
- ❑ Sclera: color
- ❑ Note any eye pain, orbital swelling, redness
- ❑ Ptosis: (present or not)
- ❑ Palpate auricles- tenderness?
- ❑ Cerumen
- ❑ Identify odors? (coffee, alcohol?)
- ❑ Ask if any difficulty smelling
- ❑ Tremor?
- ❑ Numbness?
- ❑ Dizziness?
- ❑ Vision: glasses? contact lenses? Can count fingers at 3 ft, 4ft, and 5ft?
- ❑ Hearing: able to hear normal tone voices? Whispers? Use of hearing aids

CARDIOVASCULAR

- ❑ WNL: Skin warm and dry to touch, pulses palpable in all extremities, brisk capillary refill, no edema
- ❑ IV site, saline lock / peripheral IV? IV fluid?
- ❑ Homan's sign present?
- ❑ Edema- location, pitting (trace to 4+)
- ❑ Apical pulse (regular, irregular), rate, S1/S2 heard
- ❑ Peripheral pulses (0-4+) equal bilaterally?

RESPIRATORY

- ❑ WNL: Breathing even and unlabored on room air
- ❑ Rate, rhythm (regular vs. irregular)
- ❑ Symmetrical chest expansion
- ❑ Breath sounds: check bilaterally/ AP
- ❑ O_2 Therapy
- ❑ Oxygen saturation
- ❑ Coughing? Productive? Sputum- consistency, color, amount, frequency?
- ❑ Breast Symmetry? Swelling? Dimpling? Discharge?
- ❑ Ask if pt doing self breast exams
- ❑ Sinus- tenderness?
- ❑ Nares- patent bilaterally?

GASTROINTESTINAL

- ❑ WNL: abdomen soft, non-tender, absence of N/V/D, constipation.
- ❑ NPO?
- ❑ % of meal consumed
- ❑ Assistance needed?
- ❑ Chewing, swallowing problems?
- ❑ Diet tolerated? Type?
- ❑ Abdominal scars? drains?
- ❑ Bowel sounds- Auscultate FIRST then palpate
- ❑ Pain on palpation?
- ❑ Any nodules, masses felt on palpation?
- ❑ Abdomen (soft, hard, rigid, or tender)
- ❑ Last BM? (amount, color, consistency)
- ❑ Continent of stool
- ❑ Oral status: lips (dry/moist), Teeth (color, missing teeth, dentures)
- ❑ Any feeding tubes?

GENITOURINARY

- ❑ WNL: Urinates spontaneously w/out difficulty, clear, yellow urine.
- ❑ Note presence of catheter (indwelling or condom?)
- ❑ Any difficulty? Pain?
- ❑ Odor?
- ❑ Clarity: clear or cloudy?
- ❑ Color
- ❑ Bladder distention?
- ❑ Continent?
- ❑ Penile/vaginal discharge noted or stated

INTEGUMENTARY

- ❑ WNL: intact, warm/dry, absence of rash, blisters, bruising, lesions, pruritus, hives, wounds.
  *Note: some areas may not be visible due to dressings.
- ❑ Mucous membranes and oral mucosa moist and intact. Note color of skin
- ❑ Skin turgor: tenting? reforms immediately?
- ❑ If there are lesions: note type, size, shape, etc. Maybe more than one type.
- ❑ Hair/scalp (texture, distribution, lesions, alopecia, shaven scalp?)
- ❑ Nails (shape, texture)
- ❑ Pressure areas: decubitus (stage, size, location, odor)
- ❑ Dressings (intact, drainage?)

MOBILITY/ACTIVITY

- ❑ WNL, moves all extremities, no physical limitations, performs ADL's independently
- ❑ ROM
- ❑ Joint swelling?
- ❑ Gait
- ❑ Alignment/curvatures
- ❑ Hand-grasp bilaterally
- ❑ Leg strength-against gravity and my strength
- ❑ Orthopedic/Assistive devices
- ❑ Casts/injuries: note neurovasc checks
- ❑ Note restraints if present
- ❑ Movement: smooth and coordinated?

BEHAVIOR

- ❑ WNL: interactive, calm, cooperative
- ❑ Communication: main language spoken
- ❑ What most troubled by?
- ❑ Any recent stressful events prior to/during hospitalization?

LEARNING/TEACHING

- ❑ Learning needs:
  - ➢ Medication
  - ➢ Nutrition
  - ➢ Equipment
  - ➢ Disease Process
  - ➢ Safety
  - ➢ Pre/Post-Operative
  - ➢ Discharge instructions
  - ➢ Others
- ❑ Barriers to learning
- ❑ Readiness to learn

COMFORT

- ❑ WNL: denies pain/reports acceptable level of comfort
- ❑ Spiritual needs expressed or identified?
- ❑ Pain scale, location and characteristics?

OTHER PERTINENT DATA/ NOTES

- ❑ All prior health problems include surgeries w/approx. dates.
- ❑ All medications prior to hospitalization; pts. Reason for taking meds incl. all prescriptions and OTC meds
- ❑ List all significant family health hx.
- ❑ Allergies?
- ❑ Substance abuse
  - ➢ Alcohol? type? amount consumed? Last use?
  - ➢ Drugs? type? amount consumed? Last use?
  - ➢ Smoking?/per day
  - ➢ Caffeine?/cups per day
- ❑ Admitting dx. Discuss briefly
- ❑ Current dx.
- ❑ Summarize what has happened to the patient since being admitted to the hospital incl. all diagnostic studies
- ❑ List all medical orders (incl. all rationales for med. and tx.)
- ❑ Urinalysis
- ❑ Diagnostic test – why/what for? results?
- ❑ Predominant stressors?
  - ➢ Intra – w/health
  - ➢ Inter – w/family, other people
  - ➢ Extra – financial, job, others?

HEALTH ASSESSMENT SUMMARY

Student's Name _____ Date of Assessment_____ Location of Patient_____

Patient's Initials _____ Date of Admission _____ Primary Language_____

Summarize or briefly state what caused the patient to come to the hospital (chief complaint) (include age, sex, race)

List all prior health problems including surgeries with approximate dates:

List medications patient was taking prior to this hospitalization and patient's reason for taking medication (including prescriptions, herbs, over-the-counter).

List significant family health history:

Allergies: No ☐ Yes ☐ _____ Ht. _____ Wt._____

Substance Use/Abuse:

Alcohol	No ☐ Yes ☐	Type _____	Amount consumed/day _____	Last use: _____
Drugs	No ☐ Yes ☐	Type _____	Amount consumed/day _____	Last use: _____
Smoking	No ☐ Yes ☐	Packs per day _____		
Caffeine	No ☐ Yes ☐	Cups per day _____		

Admitting Diagnosis (discuss briefly):

Current Diagnosis (including pathophysiology):

Summarize what has happened to this patient since being admitted to the hospital (include all diagnostic tests):

List all medical orders (include all rationales for medications and treatments).

Patient's Initials_____

Routine Labs

NORMAL		ADMISSION LABS Date:	DAY #1 Date:	DAY #2 Date:	SIGNIFICANT PROBLEMS
Na					
K					
Cl					
HCO_3					
Glucose					
Ca^{++}					
PO_4^{+}					
Mg^{++}					
BUN					
Cr					
WBC					
RBC					
Hgb					
Hct					
Platelet ct.					
OTHERS					

URINALYSIS:	**SIGNIFICANCE OF FINDINGS:**
pH	
SG	
Blood	
Protein	
Bacteria	
Ketones	

DIAGNOSTIC TEST and results

1. _____

2. _____

3. _____

4. _____

N123 L - PHYSICAL ASSESSMENT

Patient Initials: _____ **Date of Assessment:** _____

Vital Signs: BP _____ **R** _____ **T** _____ **P** _____ **Pain** _____

Neurological: _____

_____

_____

Cardiovascular: _____

_____

_____

Respiratory: _____

_____

_____

Gastrointestinal: _____

_____

_____

Genitourinary: _____

_____

_____

Integumentary: _____

_____

_____

Musculoskeletal: _____

_____

_____

Psychosocial: _____

_____

_____

Developmental (Erikson):_____

_____

_____

Others: _____

_____

Other pertinent patient information:

a. Predominant stressors: (Created by the hospitalization or current illness)

- Intrapersonal
- Interpersonal
- Extrapersonal

b. Variables:

- Physiological
- Psychological
- Spiritual
- Sociocultural
- Developmental (incorporate Erikson's developmental tasks)

PROBLEM LIST – (Identify complete nursing diagnoses in order of nursing **priority** using the PRS format**).**

(Actual or Risk or PC- Alfaro)

1. _____

2. _____

3. _____

4. _____

5. _____

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
Subjective Manifestations: Objective Manifestations:	NRSG Dx: (Actual or PC Problem) Goal:	Intervention with rationale:	Include patient response to intervention:	Goal: (Include Follow-up Revision Plan *if* goal was not met or partially met)

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
Subjective Manifestations: Objective Manifestations:	NRSG Dx: (Actual or PC Problem) Goal:	Intervention with rationale:	Include patient response to intervention:	Goal: (Include Follow-up Revision Plan *if* goal was not met or partially met)

RUBRIC: NURSING CARE PLAN

Section	Description	S	U	Comments
Medical Information	Collected information (i.e. chief complaint, medical history, medical diagnoses, summary of hospitalization, and list of medical orders including drug information) was written.			
Pathophysiology	Discussion of primary diagnosis was comprehensive. Secondary diagnosis(es) was integrated and briefly discussed. Reference source(s) in APA format.			
Diagnostic tests	Lab values/test results were identified and correlated to clinical condition. Trend identified if applicable.			
Physical Assessment	Physical assessment was detailed following the N123L Assessment Documentation Guide.			
Other Variables	Brief discussion of stressors and other variables utilizing Neuman Model.			
Prioritization	List of priority nursing problems/ nursing diagnoses/ potential complications was complete.			
Nursing Care Plan	One physiologic & one psychosocial nursing diagnoses **(Session 1);** One potential complication & one physiologic nursing diagnoses **(Session 2)**			
a. Assessment	Accurate assessment data was categorized as subjective and objective.			
b. Diagnosis	NANDA diagnoses were utilized appropriately. Written in PRS/PES, PR/PE and other prescribed format.			
c. Planning	Goals were written following ROAM (Realistic, Observable, Achievable, Measurable) and with timeline. Scientific rationale per intervention was clearly written.			
d. Implementation	Intervention plans were implemented. Patient's response was written for each intervention.			
e. Evaluation	Goals were met/partially met/unmet. If goal was not met or partially met, follow up revision plan was briefly discussed.			
Spelling, Grammar & Format	Paper was neatly written with correct grammar and spelling. Prescribed format was followed.			
Accountability	**Completed Nursing Care Plan is due at date specified by Clinical Instructor.**			

Comments:

Instructor's Signature: _____ **Date: _____**