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

Nursing 233 L:

Intermediate Medical/Surgical & Psychiatric Nursing Clinical

SYLLABUS

FALL 2021

COURSE TITLE:	**N233 L - INTERMEDIATE MEDICAL/SURGICAL & PSYCHIATRIC NURSING CLINICAL – FALL 2021**
PRE-REQUISITES	Completion of course requirements for Semesters 1 and 2.
UNITS:	6 Units
HOURS:	18 Hours per week
LENGTH:	18 Weeks
PLACEMENT:	Year II: Semester 3
CONCURRENCY:	All nursing courses within a semester must be taken concurrently.
COURSE DESCRIPTION:	This clinical course provides the student with opportunities to apply semester 3 content and build on year 1 theoretical content. The application of the nursing process as a manager for group of clients in a specialized setting is implemented. Experiences allow the students to perform health promotion activities and apply concepts of legal/ethical, regulatory agencies and end-of-life issues in the clinical setting. The use of decision-making, education and sociocultural awareness are implemented in the clinical setting.
COURSE OBJECTIVES:	Upon satisfactory completion of the course, the student will:

1. Apply the nursing process for safe patient-centered care to individuals, families and groups in specialized settings utilizing evidence-based practice.
2. Integrate therapeutic communication techniques and incorporate nursing informatics to accomplish goals for individuals, families and groups with mental health and medical surgical problems.
3. Apply principles of teamwork and collaborative relationships as a member of the inter-professional healthcare teams for individuals, families and groups.
4. Apply legal and regulatory policies that influence the practice of nursing, and to provide and improve quality of care for adults with mental health and medical surgical problems.
5. Apply 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 promote health of a diverse patient population.
7. Apply transcultural nursing concepts in health promotion of individual(s), families and groups.

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STUDENT LEARNING OUTCOMES: Students incorporate concepts of professional role development through collaboration with members of the multidisciplinary health team in planning and providing safe care for individuals, families and groups with mental health problems, utilizing the nursing process, critical thinking, and therapeutic communication techniques in acute care, psychiatric and ambulatory care settings.

TEACHING METHODS:

1. Skills demonstration (video, skills lab, virtual simulation)
2. Role play (Psychiatric rotation)
3. Bedside teaching
4. Discussion (e.g. briefing, debriefing, case conferences)
5. Simulation (live and/or virtual)

METHODS OF EVALUATION:

1. Safe and competent care in clinical experience.
2. Written and psychomotor clinical competency exam (clinical application based upon client scenarios)
3. Written assignments*:
   a. Clinical Worksheets/Concept Map (1 for each planned Med/Surg client)
   b. One Nursing Care Plan and 1 Reflection Paper in the Medical/Surgical rotation
   c. Process Recording, Film Critique, Interdisciplinary Collaboration, NAMI and LA Mental Health Court Research, and Medication Research in the Psychiatric Nursing rotation
   d. Cultural Assessment Interview during the Ambulatory Care Rotation or MedSurg rotation
   e. Formal teaching project, 20 Informal Teachings, and Weekly Activities diary during the Ambulatory Care rotation
4. Drug Dosage Calculation Competency (per policy)
5. Attendance (per school and semester policy)
6. Simulation
   a. Virtual (vSims/PrepU)
   b. Live

GRADING SCALE:

1. Satisfactory
2. Unsatisfactory

Unsatisfactory grade in any clinical objective constitutes an unsatisfactory grade for the entire course.

REQUIRED READING:

BRN Nursing Practice Act for the State of California.

e-book Frandsen, G., & Pennington, S.S. (2018). *Abrams' Clinical Drug Therapy: Rationales for nursing practice.* (11th ed) Philadelphia, PA: Lippincott Williams & Wilkins.

e-book Hinkle, J., & Cheever, K.H. (2018). *Brunner & Suddarth's*

textbook of medical-surgical nursing. (14th ed.) Philadelphia, PA: Lippincott Williams & Wilkins.

e-book Taylor, C. & Lillis, C. & Lynn, P. & Lemone, P. (2019). *Fundamentals of Nursing: The Art and Science of Person-Centered Care* (9th ed.). Philadelphia: Wolters Kluwer

Morgan, K.I. & Townsend, M.C. (2021). *Psychiatric mental health nursing: Concepts of care in evidence-based practice* (10th ed.). Philadelphia: F.A. Davis.

RECOMMENDED READING:

Ackley, B.J. & Ladwig, G.B. (2019). *Nursing diagnosis handbook: An evidenced-based guide to planning care* (12th ed.). St. Louis, MO: Mosby.

* Drug Handbook.

* Laboratory Tests and Diagnostic Procedures Book.

* Medical Dictionary. Mosby or Taber's

No specific author/textbook recommended for those with an *

All academic policies are strictly enforced

For any conflict or issue, student must first meet with their respective instructor to discuss a solution. If issues are not resolved, student must adhere to the appropriate chain of command starting with the semester coordinator; Director, OES; Dean, SON; and lastly the Provost

PROFESSIONAL STANDARDS / CLINICAL EXPECTATIONS

PROFESSIONAL STANDARDS: 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. Always keep instructor and staff informed of whereabouts.
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.

CLINICAL EXPECTATIONS**:**

1. Students are advised that not all rotations have the same hours. Please follow up with your Clinical Instructor for specific clinical hours at your site.
    a. MedSurg Rotation (8 weeks) starts at 0630.
    b. Ambulatory Rotation (4 weeks) can start as early as 0600 or 0645 (depending on the facility).
    c. Psych Rotation (4 weeks) starts at 0645.
2. Clinical evaluation is based on satisfactory completion of all objectives. Failure of one clinical objective will constitute an unsatisfactory grade for the course.
3. All written assignments are due at specified times of each rotation. No late assignments will be accepted.
4. Students are expected to prepare for the Medical Surgical clinical experience. Clinical Worksheets and Concept Maps must be completed and submitted at the beginning of the clinical day on Wednesday as computer labs may not be available and research will be done on Tuesday. If students are not prepared, they are deemed unsafe and will be dismissed from the clinical area. Dismissal will be counted as absent and the student will be placed on academic warning. A second incident will constitute failure of a course objective.
5. Students in the Medical Surgical rotation need to be able to demonstrate that they can perform total care of up to 3 patients.
6. Students are expected to actively participate in clinical conference.
7. The written competency must be completed with a passing grade. A second competency will be scheduled after notification of failure.
8. Clinical attendance is mandatory. Student is responsible for the information in Policy #210 – School of Nursing Attendance for Clinical Courses.
    a. Absences cannot be taken consecutively. Absences not taken will not be rolled over to the next clinical rotation.
    b. Allowed absences/tardy are as follows:
        i. MedSurg rotation (8 weeks): 1 absence / 1 tardy
        ii. Ambulatory rotation (4 weeks): 1 absence / 1 tardy
        iii. Psych rotation (4 weeks): 1 absence / 1 tardy

N233 L - Intermediate Medical/Surgical & Psychiatric Nursing Clinical
NURSING SKILLS COMPETENCY CHECKLIST

STUDENT NAME: DATE:

Semester Three				
DEMONSTRATED COMPETENCE				
	Skills Lab (S/U) Faculty Signature	**Date**	**Clinical Area (S/U) Faculty Signature**	**Date**
Skills Lab/Ward				
Blood and Blood Products				
Central Venous Catheter Care/PICC Line				
Chest Tube Drainage Systems				
I.V. Therapy and Blood Withdrawal				
Suctioning • Artificial airway • Tracheostomy • Oral pharyngeal • Nasopharyngeal				
Basic ECG Interpretation				
Therapeutic Interventions for Psychiatric/Mental Health Client				

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MEDSURG ROTATION: NURSING CARE PLAN RUBRIC

STUDENT NAME: DATE:

CRITERIA	0	5	10	Points
Health Data	- Multiple errors noted.	- Some information is missing. - Categorization is incorrect.	- Information is complete - Clearly presented and properly categorized.	
Mechanics	- Contains many errors that blocks the reader's understanding - Does not follow APA format	- Contains several errors but does not impede overall understanding - Follows APA format	- Almost entirely free of spelling, punctuation and grammatical errors - Follows APA format	
NURSING PROCESS	**0**	**15**	**20**	**Points**
Priority Nursing Problems/ Nursing Diagnoses/ Potential Complications	- Does not meet objectives of N233L - Not supported by health data. - Not in PRS format	- Meets objectives of N233L - Prioritized based on review of health data - PRS format	- Clearly written, and meets the objectives of N233L - Prioritization is based on analysis of health data - PRS format.	
Assessment	- Data not pertinent to the client - Not supported by client information.	- Not clearly written but pertinent to the client - Supported by client information	- Clearly written and pertinent to the client. - Assessment is detailed appropriate to the client's situation	
Diagnosis / Goal	- Goal does not address nursing problem.	- Not clearly written / or lacks logic - Goal not easily identified.	- Clearly written, logical, and realistic - Goal is measurable and easily identified.	
Intervention / Implementation/ Evaluation	- Multiple errors or breach in client safety. - Does not include rationale - Goal not evaluated.	- Not completely appropriate - Rationale not clear or does not demonstrate critical thinking - Goal clearly addressed	- Interventions are clearly written and logical - Rationale appropriate and demonstrates critical thinking - Rationale for goal being met or not is clearly stated	
			TOTAL POINTS:	

NOTE:

- This assignment must be completed and submitted by the date established by the instructor.
- Assignment must be submitted as a word document (.docx). PDF files will not be accepted.
- Incomplete assignments will not be graded and result in an unsatisfactory grade.
- Assignments submitted after the due date and time will not be accepted and result in an unsatisfactory grade. An unsatisfactory in any evaluation criteria of the assignment will result in an unsatisfactory grade.
- An unsatisfactory grade for this assignment will result in an unsatisfactory grade in N233L.

Instructor Signature:_____ Date:_____

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N233L Clinical Lab: SUBSTANCE RELATED CLIENT SKILLS RUBRIC

Student name: Date:

All criteria must be met to receive a satisfactory grade.

CRITERIA	UNSATISFACTORY	SATISFACTORY
Assessment (verbal/non-verbal)	□ Does not identify risk factors □ Unable to differentiate between commonly abused substances □ Unable to identify clinical manifestations of substance withdrawal □ Does not identify evidence of substance use pattern(s) □ Does not to identify timing of last used of substance	□ Identifies at least 3 risk factors □ Differentiates between commonly abused substances □ Identifies at least 3 clinical manifestations of substance withdrawal □ Identifies evidence of substance abuse □ Identifies timing of last used of substance
Communication	□ Repeated non-therapeutic communication (verbal/non-verbal) □ Does not to identify community resources	□ Consistently uses therapeutic communication appropriately (verbal/non-verbal) □ Identifies community resources
Safety	□ Does not identify environmental hazards related to the situation □ Unable to prioritize nursing interventions based upon clinical presentation	□ Identifies environmental hazards related to the situation □ Prioritizes nursing interventions based upon clinical presentation
Collaboration	□ Solo intervention	□ Collaborated with another healthcare professional using ISBARR

Knowledge: □ Satisfactory □ Unsatisfactory
Skills: □ Satisfactory □ Unsatisfactory
Attitude: □ Satisfactory □ Unsatisfactory

COMMENTS:

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_____

Instructor: Date: _____

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N233L Clinical Lab: SUICIDAL CLIENT
SKILLS RUBRIC

Student name: Date:

All criteria must be met to receive a satisfactory grade.

CRITERIA	UNSATISFACTORY	SATISFACTORY
Assessment (verbal/non-verbal)	□ Does not identify risk factors □ Does not respond appropriately to covert statements □Does not respond appropriately to over statements □ Avoids exploration of client's feelings or probing □ Imposes personal beliefs	□ Identifies at least 3 risk factors □ Identifies covert statements and responds appropriately □ Identifies overt statements and responds appropriately □ Assess client's perception of the situation □ Utilizes facts about suicide to guide assessment
Communication	□ Repeated non-therapeutic communication (verbal/non-verbal) □ Not based upon cultural client assessment □ Non-empathetic □ Dismisses client's emotions	□ Consistently uses therapeutic communication appropriately (verbal/non-verbal) □ Based upon cultural client assessment findings □ Empathetic □ Validate emotions
Safety	□ Does not identify immediacy □ Does not identify contraband	□ Identifies immediacy of plan □ Identifies safety hazards related to the situation
Collaboration	□ Solo intervention	□ Collaborated with another healthcare professional using ISBARR

Knowledge: □ Satisfactory □ Unsatisfactory
Skills: □ Satisfactory □ Unsatisfactory
Attitude: □ Satisfactory □ Unsatisfactory

COMMENTS:

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Instructor: Date:

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Student Name:_____

Psych Rotation: PROCESS RECORDING RUBRIC

Criteria	Unsatisfactory 0 Points	Satisfactory 5 Points	Proficient 5 Points	Points
Client identification	- Incomplete client identification.	- Identifies client's initials, age, sex, cultural background, reason for admission, diagnosis and current medications.	- Identifies client's initials, age, sex, cultural background, reason for admission, diagnosis and current medications.	
Mechanics	- Multiple errors. - Errors indicate a misunderstanding of directions Multiple errors in grammar, punctuation, and spelling.	- Has a few errors in format - Contains errors in grammar, punctuation, and spelling, but does not impede understanding	- May have a few errors in format - May contain few errors in grammar, punctuation, and spelling, but does not impede understanding	
	0 Points	**10 Points**	**15 Points**	**Points**
Scenario	Does not describe physical setting of interaction.	- Describes environment in which the interaction takes place - Identifies nonverbal communication.	- Recognizes how the environment and nonverbal communication affects the interaction.	
Problem	- Does not recognize client's problem or defense mechanism(s) used by client	- Identifies client's problem(s) - Identifies defense mechanism(s) used by client	- Recognizes the client as a unique individual with consideration of values, developmental and sociocultural influences in relation to mental illness	
Goal	- Does not identify goal of interaction	- Identifies goal of interaction. that is appropriate to the client situation		
Stressors	Does not recognize interpersonal and extra-personal stressors	- Identifies interpersonal and extra-personal stressors	- Analyzes how stressors impact the client's mental health and adaptation	
Therapeutic communication techniques (TCT)	- Identifies < 5 TCT **or** - Fails to recognize communication blocks **or** - Oblivious to client's emotional state.	- Identifies 5 TCT correctly - Identifies client's feeling(s).	- Identifies >5 TCT appropriate to client's emotional state and set goal of interaction.	
Analysis	- Multiple errors **or** - Breach in safety.	- Communication safe and appropriate for client situation. - Identifies communication errors. - Gives rationale for each technique used.	- Analysis demonstrate critical thinking and depth of understanding of the process	
Summary	- Does not recognize or identify own feelings during interaction.	- Limited evidence of critical thinking relevant to the overall process. - Identifies own feelings in the process.	- Recognizes patterns and themes of the interaction process, uses critical thinking and analyzes own feelings in the process.	
			TOTAL POINTS	

NOTE:
This assignment must be completed and submitted by the date established by the instructor.
Incomplete assignments will not be graded and result in an unsatisfactory grade.
An unsatisfactory in any evaluation criteria of the assignment will result in an unsatisfactory grade.
An unsatisfactory grade for this assignment will result in an unsatisfactory grade in N233L.

CENTRAL VENOUS CATHETER CARE/MAINTENANCE

At the completion of this skills lab, the student will:

1. Demonstrate a central venous catheter dressing change.
2. Identify the complications of central venous catheters.
3. Discuss the clinical indications for a central venous catheter.
4. Discuss the management of a central venous catheter.
5. For Skills Competency, this skill will be divided into 2 parts. Part 1 = Central Line Dressing Change (40 mins), Part 2 = Central Line Dressing Removal and Central Line Valve Change (25 mins). Student must practice both parts as will be randomly tested on one of them.

TEACHING METHOD:	Skills Lab/Virtual/ Voice-over PowerPoint/Online Video recording
EVALUATION METHOD:	Demonstration (Live or virtual through MS Teams)
REQUIRED READING:	Taylor: Central Venous Access Devices pp 1581-1584, 1592 and 1593 Guidelines for Nursing Care 40-3 Removal of a PICC

CENTRAL VENOUS CATHETER VIDEOS on INTRANET*

DEPARTMENTS TAB
↓
CLINICAL SERVICES
↓
UNDER CLINICAL SERVICES CLICK NURSING SERVICES
↓
EDCOS (to the far left column)
↓
CENTRAL VENOUS CATHETER CARE
↓
VIEW EACH OF THE VIDEOS

Video	Duration
• Introduction	09:28
• CVC Protocol	16:57
• Accessing Central Line Ports	05:43
• Application of Biopatch (Play All) -Introduction -What is BIOPATCH? -Scope & Magnitude of CRBSI -CRBSI: Pathogenesis & Prevention -How is BIOPATCH Received -Application of BIOPATCH	12:14
• Central Venous Catheter Dressing Change	15:33
• Valve Change	06:58
• Troubleshooting	04:56

*Videos can be accessed at home via https://lacounty.sharepoint.com/sites/dhs-lacusc/SitePages/Home.aspx?wa=wsignin1.0
Biopatch videos may not be able to open…please watch them while at hospital as you will be tested on Biopatch application.

1) NURSING CLINICAL STANDARDS **(Central Venous Catheter & IV Therapy)**
   a. **Nursing Clinical Protocols (NCP)**: Clinical Standards
      i. 070 - Central Venous Catheter – Section 1
      ii. 069 - Central Venous Catheter – Section 2 (Care and Maintenance Guidelines)
      iii. 134 - Electrolyte Replacement: Intravenous
      iv. 278 – Intravenous Therapy
   b. **Nursing Clinical Protocols:** Procedures
      i. Proc 1415 – Central Venous Catheters: Care, Maintenance, Troubleshooting, **(DO NOT REMOVE ANY CVC)**

2) NURSING CLINICAL STANDARDS **(Intravenous)**

a. **Nursing Policy Manual :**

   i. Nur911 – Intravenous Therapy

   ii. Nur911-A – Attachment: Approved Intravenous Push Medication List-Adult

b. **Code Gold & Responsibilities https://lacounty.sharepoint.com/:v:/r/sites/dhs-lacusc-NIS/Shared%20Documents/Code%20Gold%20and%20Restraints/Code%20Gold-%20Roles%20and%20Responsibilities%202021.mp4?csf=1&web=1&e=lFOrtW**

SKILLS COMPETENCY PROCEDURE
Central Venous Catheter (CVC) Care

SUPPLIES NEEDED:

- Dressing Removal
  - Gloves
  - Chlorhexidine
  - 2 masks (clinician and client)

- Dressing Change
  - Central Line Dressing Kit
  - Statlock ® for PICCs
  - Biopatch™
  - 2 masks (clinician and client)

- Reflux Valve Change
  - Non-sterile gloves
  - 2 Positive Pressure Reflux Valves (1 per port)
  - 2 Chlorhexidine applicators (1 per port)
  - 2 4x4 gauze (1 per port)
  - 2 10mL prefilled Normal Saline Syringe (1 per port)
  - 2 Curos™ Disinfecting Caps (1 per port)

Evaluator _____Student Name_____Date_____

SKILLS COMPETENCY PROCEDURE
Central Venous Catheter (CVC) Care

	S	U	Comments
Assessment and Preparation			
1. Gathers the supplies necessary for CVC care according to facility protocol.			
2. Reviews the facility/unit specific protocol for the procedures related to CVC.			
3. Perform hand hygiene within 30 seconds of entering room. Identify client using two client identifiers and assess client's condition and readiness for procedure.			
4. Establishes privacy and assists client to an appropriate position for the CVC dressing removal.			
DRESSING REMOVAL			
5. Give a brief explanation to the client.			
6. Clean work area with facility approved wipes.			
7. Wash hands thoroughly.			
8. Applies a mask to the client or asks the client to keep his/her head turned away from the insertion site during the procedure to reduce the risk of infection.			
9. Don clean gloves.			
10. Carefully tear the white adhesive that anchors Tegaderm™ and remove.			
11. Remove Tegaderm™ dressing by gently pulling the edges and client's skin down. Carefully peel off the dressing in the direction of the catheter site.			
12. Unlock Statlock®. Gently lift ports and lay them on the surface of the arm.			
13. Use Chlorhexidine as needed to remove Statlock® adhesive dressing.			
14. Assess site for evidence of infection or leaking. If PICC, note number of centimeters exposed.			

	S	U	Comments
15. Remove gloves and discard them.			
DRESSING CHANGE			
16. Set up sterile field, open and drop Statlock® and Biopatch™ onto sterile field.			
17. Don sterile gloves.			
18. Pick up 4x4 gauze in the middle with non-dominant hand and place it on top of the catheter hub.			
19. Take sterile disposable drape with dominant hand and place it under the catheter or the arm.			
20. Open chlorhexidine applicator. Clean the catheter exit site and surrounding skin with chlorhexidine. • Use back-and-forth strokes with sponge for 30 seconds • Completely wet area with antiseptic • Allow to air dry for 30 seconds			
21. Clean exposed length of catheter (starting at insertion site) and Statlock™ connector site with chlorhexidine applicator and allow to air dry for 30 seconds.			
22. Apply Statlock® to PICC lines with directional arrows towards insertion site.			
23. Apply Biopatch™ with the shiny blue side facing up. The disc slit must be aligned with catheter and the edges of the radial slit must be pushed together and remain in contact.			
24. Apply sterile occlusive dressing (Tegaderm™) covering insertion site, Biopatch™, and Statlock®.			
25. Securely tape catheter. Apply foam dressing to anchor Tegaderm™ dressing.			
26. Label the dressing with initial, date and time of dressing change.			
REFLUX VALVE CHANGE			
27. Don clean gloves.			
28. Open reflux valves packaging and attach NS syringe to prime valves. Leave NS syringe connected and proceed to cleaning central line ports.			
29. Lift catheter and hold catheter downwards.			
30. Remove old reflux valve/port			

	S	U	Comments
• Ensure catheter is clamped			
31. Clean hub opening and sides of lumen of catheter vigorously, for 15 - 30 seconds with one chlorhexidine applicator.			
32. Allow to dry for 15 seconds.			
33. Inspect hub for debris. Continue cleaning as needed until debris is cleared.			
34. Replace with new sterile reflux valve and flush gently using positive pressure ("push-stop" method).			
35. Apply Curos™ Disinfecting Caps to end of valve.			
36. Repeat steps 30-36 for second port.			
37. Label the dressing with initial, date and time of dressing change (if not done after dressing change).			
38. Ensure client safety.			
39. Disposes of used materials, valves, and gloves in proper receptacles.			
40. Performs hand hygiene.			
Evaluation			
41. Assess how the client tolerated the procedure.			
42. Document procedures in EHR.			
43. Entire procedure should take no more than 40 minutes			

N233L Clinical Lab: CENTRAL LINE CARE – RUBRIC

STUDENT NAME: _____

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

Criteria	**Unsatisfactory**	**Satisfactory**	Student Performance
Knowledge of Standard of Care	□ Fail to verbalize essential elements of central line care standards per textbook and/or institutional protocol	□ Correctly verbalizes essential elements of central line care per textbook and/or institutional protocol	
Assessment	□ Incomplete or inaccurate assessment of Central Venous Line Site	□ Complete and accurate assessment of Central Venous Line Site	
Skill Performance	□ Incorrect selection of central line care equipment **OR** □ Incorrect use of equipment **OR** □ Does not follow a logical sequence of procedural implementation **OR** □ Violates principles of asepsis and does not recognize and/or corrects violation **OR** □ Does not explain the procedure to the client	□ Correct selection of central line care equipment **AND** □ Correct use of equipment **AND** □ Implements logical sequence of procedure **AND** □ Maintains principles of asepsis and/or recognizes violation **AND** □ Explains the procedure to the client	
Documentation	□ Fail to verbalize correct procedural documentation	□ Verbalizes correct procedural documentation	

□ Unsatisfactory □ Satisfactory

Comments:

Instructor:_____ Date:_____

AIRWAY SUCTIONING

At the completion of this skills lab, the student will:

1. Demonstrate safe and effective airway suctioning.

    a. Select appropriate equipment for suctioning a client
    b. Describe the correct position and method for suctioning a client safely

2. Discuss the nursing responsibilities before, during, and after suctioning.

3. Suctioning skill should take no longer than 20 minutes to complete.

TEACHING METHOD:	Skills Lab/Virtual/ Voice-over PowerPoint/Online Video recording
EVALUATION METHOD:	Demonstration (Live or virtual through MS Teams)
REQUIRED READING:	Taylor, pp 1517-1518 Tracheostomy, Providing Trach Care, Tracheal Suctioning. Click on the Watch & Learn Video 17-04 on page 1518. Also, pp 1542-1547 Skill 39-6 Suctioning a Tracheostomy: Open System

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Evaluator _____Student Name_____Date_____

SKILLS COMPETENCY PROCEDURE
Suctioning a Tracheostomy Tube

	S	U	Comments
Assessment and Preparation			
1. Check order for tracheostomy (also size) and 02 amount			
2. Check nursing documentation o see when the last time the procedure was performed on the client.			
3. Perform hand hygiene within 30 seconds of entering room.			
4. Identify client using two client identifiers, assess client's condition (especially respiratory system) and readiness for procedure.			
5. Establish communication via hand signals			
6. Conduct a room assessment and is able to point out the following: Obturator, extra boxed trach or inner cannula, O2 wall/tank set up with tubing, bag valve mask, suction setup including suction canister and tubing, O2 Sat machine (especially if 02 Sat is low)			
7. Clean bedside table with facility approved wipes, establishes privacy and assists client to an appropriate position for Suctioning Tracheostomy Tube.			
8. Gathers the supplies necessary for Suctioning Tracheostomy Tube according to facility protocol: • Suction Catheter Kit (select by appropriate size) • If kit comes in a plastic tray it will have a pair of sterile gloves and a suction catheter with a thumb suction control valve. The tray itself is used for NS. - If kit is flat it will have a pop-up cup to use for NS, a pair of gloves and a suction catheter with a thumb suction control valve. • 1bottle Normal Saline [NS] (initial, date & time if new), loosen cap • 1 towel			

	S	U	Comments
Implementation			
9. Give a brief explanation to the client.			
10. Wash hands thoroughly.			
11. Put on a face shield, or goggles and mask if necessary.			
12. Don clean gloves. Place a towel across client's chest. Have suction tubing close and working.			
13. Have bag valve mask nearby. If client has a low O2, then preoxygenate by giving 2-3 breaths with bag valve mask bag. Replace O2 mask.			
14. Carefully open the Suction Catheter Kit as contents are sterile. Taking care not to contaminate the contents, remove the sterile gloves package.			
15. Apply the sterile gloves. If kit is flat and comes with a pop-up cup, then carefully remove it and open it. With non-dominant (dirty) hand, pop cap of NS and fill the cup. • If the kit is a plastic tray then with sterile gloves on, take the catheter with dominant sterile hand and with nondominant (dirty) hand, pop cap of NS and fill the tray.			
16. Remove client's trach mask and or pull it to the side of the neck (always checking the O2Sat for desaturations).			
17. Hold catheter in dominant hand and the suction tubing in nondominant hand, attach suction catheter to suction tubing.			
18. Using dominant hand, place catheter tip in sterile NS to flush line and lubricate catheter by occluding the thumb suction control valve to give it proper suction • The NS should move up the catheter and tubing into the collection canister on the wall when suction is placed by your thumb (dirty hand)			
19. With nondominant thumb OFF the suction control valve, quickly but gently insert the catheter into trachea through the trach tube 4-5 inches past the distal end of the trach tube OR until the client coughs • Once you feel resistance, withdraw the catheter 1 inch before applying the suction with your thumb.			
20. Apply suction for 5-10 seconds by placing nondominant thumb over the thumb port			

	S	U	Comments
21. Rotate the catheter by rolling it between thumb and forefinger while slowly withdrawing it and applying intermittent suction controlled by thumb • Observe the color and consistency of secretions in catheter and in suction tubing as it travels to canister.			
22. Reassess client's O2 Sat, if low then hyperoxygenate. Observe respirations, skin color, and pulse. If normal, then repeat suctioning. • Encourage client to breathe deeply and cough between suctions • Allow 2-3 minutes with O2 on between suctions if needed • Flush catheter with clean NS			
23. When done suctioning trach, you may suction nose then mouth if needed, to clear of secretions (flush catheter with NS if secretions are thick)			
24. If at any time secretions to trach are VERY thick and tenacious, you may lavage with 3-5 mL of NS inserted directly down trach prior to each suction • Use caution when lavaging as this may stimulate the client's cough reflex and may spew the NS and secretions out of trach...use goggles if lavaging for your eye safety.			
25. Provide comfort and safety for client.			
26. Assist to a comfortable position that aids in breathing			
Evaluation			
27. Assess how the client tolerated the procedure.			
28. Listen to breath sounds again as should be clearer than prior to suctioning.			
29. Document procedure in EHR as well as color, consistency, and amount of secretions.			
30. Also document the O2 Sat during procedure.			
31. Procedure should take no more than 20 minutes to complete.			

N233L Clinical Lab: AIRWAY SUCTIONING – SKILLS RUBRIC

Student name: _____

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

Criteria	Unsatisfactory	Satisfactory	Student performance
Equipment	□ Incomplete gathering of equipment □ Incorrect use of equipment	□ Gathers all equipment necessary □ Correct use of equipment	
Assessment	□ Does not identify indications for airway suctioning	□ Correctly identifies indications for airway suctioning	
Preparing the client	□ Does not position the client correctly for procedure	□ Positions the client appropriately for the given scenario	
Asepsis	□ Does not recognize or does not self-correct violation of aseptic technique	□ Correct use of aseptic technique □ Self corrects violation of asepsis	
Skill Performance	□ Does not lubricate catheter OR lubricates catheter with wrong solution □ Advances catheter incorrectly □ Fails to apply suction control correctly □ Fails to rinse the catheter □ Fails to dispose the catheter correctly	□ Lubricates catheter with appropriate solution □Advances suction catheter at correct depth □ Applies suction control correctly □ Rinses catheter □ Disposes of the catheter correctly	
Evaluation	□ Fails to discuss post-procedure assessment and documentation	□ Discusses post procedure assessment and documentation	
Communication	□ Does not communicate with client	□ Introduce self and procedure, establish a mode of non-verbal communication	

□ Unsatisfactory □ Satisfactory

Comments:

Instructor:_____ Date:_____

TRACHEOSTOMY CARE

At the completion of this skills lab the student will be able to

1. Demonstrate suctioning via an artificial airway.
2. Demonstrate tracheostomy care.
3. Tracheostomy care skill should take no longer than 20 minutes to complete.

* **Note:**
1. Goggles or face shield should be used in standard precautions.
2. Check ward/area protocols before pre-oxygenating clients.

TEACHING METHOD:	Skills Lab/Virtual/ Voice-over PowerPoint/Online Video recording
EVALUATION METHOD:	Demonstration (Live or virtual through MS Teams)
REQUIRED READING:	Taylor, pp 1538-1542 Skill 39-5 Providing Care of a Tracheostomy Tube

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Evaluator _____Student Name_____Date_____

SKILLS COMPETENCY PROCEDURE
Care of a Tracheostomy Tube

*Normally we do not clean a Disposable Inner Cannula only Nondisposable Inner Cannulas. We would just open a new pack and apply it while still cleaning the site and changing the ties. If there is not a new Cannula available and the client seems to be in distress d/t a clogged Cannula, then we would have no choice but to clean it. For practicing purposes, we will go ahead and clean the Disposable Inner Cannulas of our manikins.

	S	U	Comments
Assessment and Preparation			
1. Check order for tracheostomy(also size) and 02 amount			
2. Check nursing documentation to see when the last time the procedure was performed on the client.			
3. Perform hand hygiene within 30 seconds of entering room.			
4. Identify client using two client identifiers, assess client's condition (especially respiratory system) and readiness for procedure.			
5. Establish communication via hand signals.			
6. Conduct a room assessment and is able to point out the following: • Obturator, extra boxed trach or inner cannula • O2 wall/tank set up with tubing, bag valve mask • Suction setup including suction canister and tubing • O2 Sat machine (especially if 02 Sat is low)			
7. Clean bedside table with facility approved wipes, establishes privacy and assists client to an appropriate position for the Tracheostomy Tube Care.			
8. Gather the supplies necessary for Tracheostomy Tube Care according to facility protocol: • Tracheostomy Clean and Care Tray • Tray consists of tray(with 3 sections), vinyl sterile gloves, drape, 2 pipe cleaners, 2 4x4 gauze, 5 cotton tip swabs, trach dressing 4x4 gauze, brush, twill trach tie			

	S	U	Comments
• 1bottle Normal Saline [NS] (initial, date & time if new), loosen cap • 1bottle Hydrogen Peroxide [H2O2] (initial, date & time if new), loosen cap			
Implementation			
9. Give a brief explanation to the client.			
10. Wash hands thoroughly.			
11. Put on a face shield, or goggles and mask if necessary.			
12. Don clean gloves.			
13. Carefully open the Tracheostomy Clean and Care Tray as contents are sterile. • *Taking care not to contaminate the contents, remove the sterile gloves and put aside if it is on top. If it is not, then carefully pull out sterile drape by the edges, open it and apply it to the length of the bedside table with shiny side down. Sterile gloves package should be put aside if it was under the sterile drape.*			
14. Put supplies inside the tray onto the sterile field from a height of 6 inches above the field. (**DO NOT** put the Tracheostomy tray itself in the sterile field) it goes adjacent to the field closest to the client.			
15. Remove client's trach mask (always checking the O2Sat for desaturations). • Take off the old 4x4 Trach gauze. Assess it for color and consistency of drainage as well as foul odor. • Assess the site for color, inflammation, maceration or infection and take note of the tube size that is in place. (If there are any sutures, be sure that they are intact)			
16. Dispose of old gauze and gloves properly.			
17. May apply new vinyl gloves if preferred but not mandatory.			
18. Pour about 50 mL of each bottle into the **large** compartment of the tray. (This is a 1:1 ratio of NS to H2O2)			
19. Then fill NS only to both smaller compartments of the tray to the top but do not overfill.			

	S	U	Comments
20. *Stabilize the outer cannula and the base plate (flange) of trach with one hand, rotate lock of the inner cannula and with a counterclockwise motion with your other hand, release it from the outer cannula. ** Continue to hold the base plate and gently remove the inner cannula and stick it in the larger compartment of the tray that has the 1:1 solution.*			
21. Apply sterile gloves. Place all cotton tipped applicator sticks in one of the smaller NS compartments.			
22. Pick up the inner cannula soaking in the 1:1 solution (by the cuff only), moisten brush to insert it into the inner cannula *Use a back and forth motion to loosen and remove any secretions that have accumulated in the inner cannula.*			
23. Agitate inner cannula in one of the NS compartments to rinse off the H2O2, then tap it against the inner surface of the compartment to shake off moisture.			
24. Reinsert inner cannula and lock in place with dirty hand touching ONLY the cuff portion of cannula. Student is done with sterility.			
25. Cleanse tracheostomy site. • Clean by using applicator sticks to clean skin beneath base plate (student's sterile hand can get the swabs and dirty hand to lift plate). A clean swab to clean each side of trach, and above and below trach. One swab can be used to clean base plate. • Each swab should be used only once, work in a circular motion, clean from the stoma site outward.			
26. Sterile hand can retrieve 4x4 to pat dry, then place tracheostomy dressing and slide it underneath the base plate and around the trach tube.			
27. Change tracheostomy ties, supporting the outer cannula at all times (may need a second person to assist). Do not remove soiled tie until the new one is in place. *Trach tie should be twice the circumference of the neck plus 4 inches. Velcro ties may also be used.*			
28. Insert trach tie through the opening of the base plate alongside the old tape, pull it all the way through until both ends are even, then slide both			

	S	U	Comments
sides of the ties under the client's neck and insert one through the remaining opening on the other side of the base plate. • Pull the tape snuggly and tie the ends using a double square knot. Tie should be loose enough so you can fit one finger between the neck and the ties. • During this, student should also examine neck for sores, erythema, or skin breakdown.			
29. Once new tie is secure, carefully remove the old one.			
30. Put trach mask 02 back on.			
31. Remove gloves, assist client to a comfortable position, place bed in lowest position.			
Evaluation			
32. Assess how the client tolerated the procedure.			
33. Document procedure in EHR as well as color, consistency, and amount of secretions.			
34. Also document the O2 Sat during procedure.			
35. Procedure should not take longer than 20 minutes to complete.			

N233L Clinical Lab: TRACHEOSTOMY CARE – SKILLS RUBRIC

Student name:

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

Criteria	Unsatisfactory	Satisfactory	Student performance
Equipment	□ Incomplete gathering of equipment □ Incorrect use of equipment	□ Gathers all equipment necessary □Correct use of equipment	
Assessment	□ Does not identify rationale for Trach care	□ Correctly identifies rationale for Trach care	
Preparing the client	□ Does not position the client correctly for procedure □ Does not recognize safety precautions	□ Positions the client appropriately for the given scenario □ Considers safety measures and precautions	
Asepsis	□ Does not recognize or does not self-correct violation of aseptic technique	□ Correct use of aseptic technique □ Self corrects violation of asepsis	
Skill Performance	□ Does not remove and / or replace inner cannula □ Soaks and / or rinses inner cannula incorrectly □ Does not clean incision site and tube flange □ Unsafe application of trach ties and dressing	□ Removes and replaces inner cannula correctly □ Soaks and rinses inner cannula in correct solutions □ Cleans incision site and tube flange □ Safe application of trach ties and dressing	
Evaluation	□ Fails to discuss post-procedure assessment and care	□ Discusses post-procedure assessment and care	
Communication	□ Does not communicate with client	□ Introduce self and procedure, establish a mode of non-verbal communication	

□ Unsatisfactory □ Satisfactory

Comments:

Instructor: _____ Date:_____

CHEST TUBE DRAINAGE SYSTEMS

At the completion of this skills lab, the student will:

1. Describe the purpose, methods, and nursing responsibilities related to chest tubes.
2. Discuss the pathophysiological conditions in which a chest tube is required:
   a. Pleural effusion
   b. Hemothorax
   c. Pneumothorax
   d. Empyema
3. Discuss the common placement/location of chest tubes.
4. Identifies the components of a chest tube drainage system.
   a. Name the three chambers of a chest tube drainage system
5. List the requirements in the management and care of a chest tube.
6. List the steps in troubleshooting problems with chest tubes.
7. The Chest Tube skill should not take longer than 20 minutes to complete.

TEACHING METHOD:	Skills Lab/Virtual/ Voice-over PowerPoint/Online Video recording
EVALUATION METHOD:	Demonstration (Live or virtual through MS Teams)
REQUIRED READING:	Taylor, pp 1512-1514 (pg 1512 Managing Chest Tubes, pg 1513 Table 39-5, & pg 1514 Guidelines for Nursing Care 39-3

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Evaluator _____Student Name_____Date_____

SKILLS COMPETENCY PROCEDURE CHECKLIST
Care of a Chest Tube

These are the expectations needed / required to take care of a client with a chest tube. You will be required to know this for future test questions and for skills competency. The procedure should not take longer than 20 minutes.

	S	U	Comments
Assessment and Preparation			
1. Identify client using two client identifiers, assess client's condition (especially respiratory system) and readiness for procedure			
2. Discuss 4 conditions in which a chest tube is required			
3. Name the 2 cavities in which these tubes are inserted into			
4. Name the rib numbers in which these tubes are inserted			
5. Explain an upper vs lower insertion site			
6. Explain all of the parts of a Pleurovac Device			
7. Explain what a chest tube looks like and what purpose the ends of the tube serve			
8. Equipment needed to set up a chest tube: a. Sterile gloves b. Suction and tubing c. Chest Tube: confirm right size d. Pleurovac Device: practice setting it up e. Lidocaine (to numb injection site)			
9. Clean bedside table with facility approved wipes, establish privacy and assist client to an appropriate position for chest tube insertion			
10. Estimate a drainage amount within a time frame before calling the Healthcare provider			
11. Explain nursing actions if chest tube becomes disconnected/dislodged from Pleurovac connector tube			
12. Explain nursing actions if the chest tube gets pulled out from thoracic cavity			

13.	Describe the 3 types of fluid draining: Serous / Sanguineous / Serosanguineous			
14.	Correlate the importance of wall suction (whether to have high or low) when order calls for 20cm suction on Pleurovac Device			
15.	Knowledge of taping two ends together between chest tube and Pleurovac Device.			
16.	Explain how to determine the location of an air leak and what to do about it. Air leak may be from: a. Pleurovac Device b. Pleurovac Hose / tube c. Chest Tube d. Chest tube insertion site			
	Evaluation			
17.	Evaluate the chest tube: a. Initial insertion b. Every 8 hours c. On admission or transfer to another department			
18.	Evaluation includes: a. HOB 30 – 45% degrees elevated b. Vital signs c. Pain score d. Occlusive dressing condition: dry, intact, dated e. Intact chest drainage system f. Lung sounds g. Water levels h. Marked collection chamber at the level of drainage i. Any dependent loops			
19.	Teaching includes: a. Cough and deep breath Q2h b. Use incentive spirometer 10 consecutive times Q1h while awake c. Explain the purpose of a chest tube to your client d. Precautions to prevent dislodgement or disconnection e. Report any sudden difficulty breathing f. Request pain medication as needed			

N233L Clinical Lab: CHEST TUBE – SKILLS RUBRIC

Student name: _____

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

Criteria	Unsatisfactory	Satisfactory	Student performance
Equipment	□ Incomplete gathering of equipment □ Incorrect use of equipment	□ Gathers all equipment necessary □ Correct use of equipment	
Indications	□ Does not identify indications for chest tube(CT) **OR** □ Does not discuss the difference between mediastinal and pleural CT	□ Correctly identifies indications for chest tube **AND** □ Correctly discusses the difference between mediastinal and pleural CT	
Assessment	Fail to discuss assessment of CT: □ Types (mediastinal VS pleural) □ Dressing and need for change □ Complications	Discusses assessment of CT: □ Types (mediastinal VS pleural) □ Dressing and need for change □ Complications	
Positioning	□ Does not position the client correctly	□ Positions the client appropriately for the given scenario	
Asepsis	□ Does not recognize or does not self correct violation of aseptic technique	□ Correct use of aseptic technique **OR** □ Self corrects violation of asepsis	
Skill Performance ***(any or all may be evaluated)***	□ Incorrect set up the chest tube according to physician orders □ Does not identify CT drainage system air leakage □ Does not take action in case of an air leak □ Incorrect dressing change □ Incorrect action in chest tube emergencies	□ Correctly sets up the chest tube according to physician orders □ Identifies CT drainage system air leakage □ Takes appropriate action in the case of air leak □ Correct dressing change □ Correctly intervenes in CT emergencies	
Evaluation	□ Fails to discuss post-procedure assessment and documentation	□ Discusses post procedure assessment and documentation	
Communication	□ Does not communicate with client □ No client teaching verbalized	□ Introduce self and provide client teaching as appropriate to given scenario	

□ Unsatisfactory □ Satisfactory

Comments:

Instructor:_____ Date:_____

BLOOD AND BLOOD PRODUCTS

At the completion of this skills lab the student will:

1. Discuss the nursing responsibilities in the administration of blood and blood products
   - Prior to transfusion
   - During transfusion
   - After transfusion

2. Select the appropriate equipment required in a blood transfusion.

3. Discuss the signs and symptoms of a blood transfusion reaction
   - Febrile non-hemolytic
   - Allergic
   - Hemolytic transfusion reactions

4. Discuss nursing responsibilities when a blood transfusion reaction occurs (or suspected).

TEACHING METHOD:	Skills Lab/Virtual/ Voice-over PowerPoint/Online Video recording
EVALUATION METHOD:	Demonstration (Live or virtual through MS Teams)
REQUIRED READING:	Blood and Blood Products Hospital Protocol Taylor, pp 1593-1597 Administering Blood & Blood Products

BASIC ECG INTERPRETATION

At the completion of this skills lab, the student will:

1. Identify normal electrocardiogram pattern.

2. Identify two (2) methods to calculate the heart rate.

3. Measure:

   - P-R interval
   - QRS complex
   - QT interval

4. Identify common dysrhythmias:

   - Sinus bradycardia
   - Sinus tachycardia
   - Atrial flutter
   - Atrial fibrillation
   - Premature ventricular contractions (PVC)
   - Ventricular tachycardia (V-tach)
   - Ventricular fibrillation (V-fib)
   - Asystole
   - First degree AV block
   - Second degree AV block
   - Third degree AV block
   - Paroxysmal Supraventricular Tachycardia (PSVT)

5. Demonstrate correct ECG lead placement.

6. Identify ST segment elevation.

TEACHING METHOD:	Skills Lab/Virtual/ Voice-over PowerPoint/Online Video recording
EVALUATION METHOD:	Demonstration (Live or virtual through MS Teams)
REQUIRED READING:	Hinkle, et. al., Medical-Surgical Nursing, Chapter 25 pp 695-699 and Chart 25-5 Nursing Research Profile
RECOMMENDED READING:	Introduction to Dysrhythmia Recognition (Self-study module) – in library

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AMBULATORY CARE FORMAL TEACHING - RUBRIC

Student name(s):_____ Date:_____

All criteria must be met to receive a satisfactory grade.

CRITERIA	UNSATISFACTORY	SATISFACTORY
Client learning objectives	□ Lists learning objectives inappropriate to target audience □ Does not use objective terms	□ States 3 client learning objectives appropriate for the target audience □ Uses objective terms
Teaching strategies	□ Teaching strategies not appropriate for target audience □ No teaching aid used in presentation □ Teaching aid(s) inappropriate for the target audience □ Teaching aid(s) utilized is/are not standard or pre-approved	□ Teaching strategies selected with careful consideration of target audience □ Teaching aid(s) selected is/are appropriate for the target audience □ Teaching aid(s) selected is/are standard or pre-approved
Evaluation tool	□ Evaluation tool is not based upon objectives	□ Evaluation tool is based upon objectives
Presentation	□ Presentation is disorganized □ Presentation does not engage the audience	□ Presentation is well organized □ Presentation engaged the audience □ Presentation delivered within set time frame

NOTE:
This assignment must be completed and submitted by the date established by the instructor.
Incomplete assignments will not be graded and result in an unsatisfactory grade.
Assignments submitted after the due date will not be accepted and result in an unsatisfactory grade.
An unsatisfactory in any evaluation criteria of the assignment will result in an unsatisfactory grade.
An unsatisfactory grade for this assignment will result in an unsatisfactory grade in N233L.

COMMENTS:

Instructor:_____ Date:_____

LAC School of Nursing
N233 L – Intermediate Medical / Surgical & Psychiatric Nursing Clinical – FALL 2021 - II

Student: _____ **Class:** **SPRING 2022 - I**

Faculty: _____ Date: _____ Rotation: Grade: ☐Satisfactory ☐Unsatisfactory
Faculty: _____ Date: _____ Rotation: Grade: ☐Satisfactory ☐Unsatisfactory
Faculty: _____ Date: _____ Rotation: Grade: ☐Satisfactory ☐Unsatisfactory

Midterm: ☐ Satisfactory ☐ Unsatisfactory ☐ Needs Improvement **Final Grade**: ☐ Satisfactory ☐ Unsatisfactory

Grading Guidelines

- Clinical performance criteria utilizing core competencies are evaluated on a Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U) basis using the following criteria:
  Satisfactory: Student is consistently meeting measurement criteria at the expected achievement level.
  Needs Improvement: Performance level is inconsistent. The student must demonstrate consistent performance at the expected achievement level by the end of the term to pass clinical.
  Unsatisfactory: Student is not meeting criteria – core competencies and course objectives at expected level of achievement
  N/A: Not applicable
- Student must receive Satisfactory during the final clinical evaluation to pass the course.

Clinical Performance Evaluation Tool

Clinical Course

Core Competencies	Midterm				Final	
	S	NI	U	N/A	S	U
1. **Patient-Centered Care**: Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values and needs. **(Course Objectives 1, 2, 5 & 6)**						
a. Completes an individualized nursing care plan utilizing the nursing process and comprehensive assessment skills in Medical Surgical (MedSurg) rotation						
b. Documents appropriately on all MedSurg clients						
c. Conducts an observed comprehensive physical assessment on a client in MedSurg within the first 2 weeks of rotation						
d. Provides care of up to 3 patients in MedSurg						
e. Completes a Written Competency						
f. Submits a Clinical Worksheet by 0600 the first 2 weeks of MedSurg rotation (Tuesday's clinical worksheet must be submitted on the following day at 0600 and Wednesday's clinical worksheet must be submitted the following Tuesday at 0600). After the first 2 weeks, you may be progressed by your instructor to a concept map.						
g. Maintains a written account of at least 20 Informal Teaching Sessions in Ambulatory Care rotation						
h. Completes a Process Recording in psychiatric (psych) setting						
i. Demonstrates sociocultural sensitivity in providing patient care in: Med-Surg						
Ambulatory						
Psych						
2. **Teamwork and Collaboration**: Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect and shared decision making to achieve quality patient care. **(Course Objectives 1, 2, 3 & 7)**						
a. Utilizes therapeutic communication skills (verbally, non-verbally, and though EHR documentation) with patients, family, and health care team members in: Med-Surg						
Ambulatory						
Psych						
b. Presents a Case Study of an assigned Psychiatric Disorder with a peer group						

Core Competencies	Midterm				Final	
	S	NI	U	N/A	S	U
c. Collaborates with or researches a NAMI (National Alliance of Mental Illness) Chapter during the Psych rotation						
d. Discusses the communication process and dynamics of a NAMI meeting in Psych						
e. Completes an Interdisciplinary Collaboration Sheet in Psych						
f. Conducts a Cultural Interview with a client in MedSurg or Ambulatory setting						
3. **Evidence-Based Practice**: Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health. **(Course Objective 1 & 6)**						
a. Utilizes evidence-based literatures and practice in written assignments, nursing care plans and clinical activities while in MedSurg rotation						
b. Presents client's psych medication research for a medication post conference						
c. Presents a Formal Teaching Project utilizing an evidence-based practice visual aid while in Ambulatory Care						
4. **Quality Improvement**: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems. **(Course Objective 4)**						
a. Provides care in a timely and effective manner while in MedSurg						
b. Recognizes that nursing and other health care professions are parts of systems of care and care processes that affect outcomes for patients and families in: MedSurg						
Ambulatory						
Psych						
c. Values own contributions to outcomes of care while in: MedSurg						
Ambulatory						
Psych						
5. **Safety**: Minimize risk of harm to patients and providers through both systems effectiveness and individual performance. **(Course Objectives 1 & 5)**						
a. Demonstrates knowledge, skills and attitudes in provision of quality and safe care of all assigned clients during: MedSurg						
Ambulatory						
Psych						
b. Demonstrates competency in a skills practicum						
c. Implements strategies discussed in psych lectures to reduce risk of harm to self or others in: MedSurg						
Ambulatory						
Psych						
d. Provides a Reflection Paper on patient care safety and improvement in MedSurg						
e. Demonstrates safe, timely administration of medications with verbalization of pharmacologic implications and considerations to assigned patient(s) in MedSurg						
6. **Informatics**: Use information and technology to communicate, manage knowledge, mitigate error, and support decision-making. **(Course Objective 1 & 4)**						
a. Documents clear and concise assessment and responses to care in the electronic health record in MedSurg						
b. Examines an assigned film online in Psych and submits a summary						

Core Competencies	Midterm				Final	
	S	NI	U	N/A	S	U
c. Protects confidentiality of electronic health records and adheres to HIPAA while in : MedSurg						
Ambulatory						
Psych						
d. Participates in vSims and/or live simulations						
7. **Professionalism**: Demonstrate professional behavior towards patients, families, inter-professional team members, faculty, and fellow students. **(Course Objectives 2 & 4)**						
a. Maintains professional behavior and appearance in Psych						
b. Researches the LAC Superior Mental Health Court while in Psych						
c. Maintains a weekly diary of Ambulatory Care activities						
d. Arrives to each clinical site at assigned times prepared to receive report and perform patient care MedSurg						
Ambulatory						
Psych						
e. Accountable for absences not to exceed 3 clinical days for entire semester (1 per each rotation) and 2 for clinical conferences.						
f. Accountable for punctual clinical experiences with no more than 4 tardies for entire semester (1 per each rotation and 1 for clinical conferences)						

Methods of Evaluation	Satisfactory	Unsatisfactory
Drug Dosage Calculation Competency	☐	☐
Written Competency	☐	☐
Skills Competency	☐	☐
All written assignments for each rotation: MedSurg	☐	☐
Ambulatory	☐	☐
Psych	☐	☐

Attendance Summary	Midterm			Final		
Rotation	**Number and dates of Absences**	**Number and dates of Tardies**	**Student Signature**	**Number and dates of Absences**	**Number and dates of Tardies**	**Student Signature**
Medical Surgical:						
Psychiatric Care:						
Ambulatory Care:						

MIDTERM Evaluation Summary

	Rotation: Medical/Surgical Care	**Rotation: Ambulatory Care**	**Rotation: Psychiatric Care**
Faculty Comment: **(Address strengths and opportunities for improvement)** **Plan for improvement (Required for any "Needs Improvement" and "Unsatisfactory" areas** **Signature/date**			
Student Comment: **Plans for improvement** **Signature/date**			

FINAL Rotation Summary

Rotation: MEDICAL/SURGICAL CARE	
Faculty Comment: Signature / Date:	Student Comment: Signature / Date:

Rotation: AMBULATORY CARE		Rotation: PSYCHIATRIC CARE	
Faculty Comment: Signature / Date:	Student Comment: Signature / Date:	Faculty Comment: Signature / Date:	Student Comment: Signature / Date: