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CLINICAL FACILITIES: PHONE NUMBERS

Fundamentals/Geriatrics

- Allegany Health Nursing & Rehab 301 777 5941
- Hampshire Health Center 304 822 7527
- Lion’s Center 301 722 6272
- Piney Valley (formerly Heartland) 304 788 3415

Med-Surg

- Hospice of the Panhandle 304 822 8813
- Potomac Highlands Regional Jail 304 496 1275
- Potomac Valley Hospital: WVU Medicine
  - Cardiopulmonary Rehabilitation 304 597 3565
  - Diabetes Clinic 304 597 3774
- Ray of Hope 301 722 4560 or 3334
- Western Maryland Health System 240 964 7000
  - Cancer Center 240 964 1400
  - Cardiovascular Unit 240 964 1500
  - Emergency Department 240 964 1200
  - Nursing Units
    - 6 West 240 964 6600
    - 7 North 240 964 7100
    - 7 South 240 964 7300
  - Outpatient Dialysis Unit 240 964 8600
  - Outpatient/GI Department 240 964 8111
  - Same Day Surgery 240 964 3222
  - Surgery 240 964 3200
  - Wound Clinic 240 964 8711

Obstetrics

- Western Maryland Health System 240 964 7000
  - 6A Obstetrics 240 964 6400

Pediatrics

- Burlington Primary School 304 289 3073
- Keyser Middle School 304 788 4220
- Keyser Primary School 304 788 4508
- Potomac State College Student Health 304 788 6913
- WV Schools for the Deaf & the Blind 304 822 3521

Behavioral Health

- Thomas B. Finan Center and Willowbrook 301 777 2405
- Western Maryland Health System 240 964 2200
- Western Maryland Recovery Services 301 724 1144
CONFIDENTIALITY POLICY & AGREEMENT

In the performance of your duties as a practical nursing student, you will have access to patient records and other protected health information (PHI). Patient information from any source and in any form, including paper records, oral communications, audio recordings, and electronic display (computerized), is strictly confidential. Access to confidential patient information is permitted on a need-to-know basis only.

It is the policy of our school that students shall respect and preserve the privacy and confidentiality of patient information, regardless of the agency to which the student is assigned. Examples of violation (breach) of this policy include, but are not limited to:

1. discussing PHI outside the scope of practice, such as in the agency elevator or cafeteria;
2. accessing information that is not within the scope of your patient assignment;
3. misusing, disclosing without proper authorization, or altering patient or personnel information;
4. disclosing to another person your sign-on code and/or password for accessing electronic or computerized records;
5. using another person’s sign-on code and/or password for accessing electronic or computerized records;
6. leaving a secured application unattended while signed on;
7. attempting to access a secured application without proper authorization.

Safeguarding confidentiality also applies to e-mail, internet communication, and social network sites (e.g. Facebook, Twitter, MySpace, and other internet journals). Students must not post any information about any patient on any social media site. Students must not discuss any information about patients via texting, e-mailing, or messaging of any type. Not only must the student safeguard confidentiality of patients, but also school and clinical agencies, staff, classmates, and instructors.

Violation of this policy will result in immediate dismissal from the nursing program. Unauthorized release of confidential information may also result in personal, civil, and/or criminal liability and legal penalties in accordance with agency, state, and federal regulations, including penalties outlined in the Health Insurance Portability and Accountability Act (HIPAA).

Written 12/03
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Revised 12/04; 12/06; 12/07; 09/10; 10/16
TO DO THESE THINGS, A NURSE MUST UNDERSTAND AND APPLY THE FOLLOWING CONCEPTS OF PROFESSIONAL BOUNDARIES:

As a health care professional, a nurse strives to inspire the confidence of clients, treat all clients and other health care providers professionally, and promote the clients’ independence. Clients can expect a nurse to act in their best interests and to respect their dignity. This means that a nurse abstains from obtaining personal gain at the client’s expense and refrains from inappropriate involvement in the client’s personal relationships.
**Professional boundaries are the spaces between the nurse’s power and the client’s vulnerability.**

The power of the nurse comes from the professional position and the access to private knowledge about the client. Establishing boundaries allows the nurse to control this power differential and allows a safe connection to meet the client’s needs.

**Boundary violations can result when there is confusion between the needs of the nurse and those of the client.**

Such violations are characterized by excessive personal disclosure by the nurse, secrecy or even a reversal of roles. Boundary violations can cause distress for the client, which may not be recognized or felt by the client until harmful consequences occur.

**Boundary crossings are brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a special therapeutic need.**

Boundary crossings can result in a return to established boundaries but should be evaluated by the nurse for potential client consequences and implications. Repeated boundary crossings should be avoided.

**Professional sexual misconduct is an extreme form of boundary violation and includes any behavior that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the client.**

Professional sexual misconduct is an extremely serious violation of the nurse’s professional responsibility to the client. It is a breach of trust.
A Continuum of Professional Behavior

Every nurse-client relationship can be plotted on the continuum of professional behavior illustrated above.

A zone of helpfulness is in the center of the professional behavior continuum. This zone is where the majority of client interactions should occur for effectiveness and client safety. Over-involvement with a client is on the right side of the continuum; this includes boundary crossings, boundary violations and professional sexual misconduct. Under-involvement lies on the left side; this includes distancing, disinterest and neglect, and it can also be detrimental to the client and the nurse. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead, it is a gradual transition or melding.
This continuum provides a frame of reference to assist nurses in evaluating their own and their colleagues’ professional-client interactions. For a given situation, the facts should be reviewed to determine whether or not the nurse was aware that a boundary crossing occurred and for what reason. The nurse should be asked: What was the intent of the boundary crossing? Was it for a therapeutic purpose? Was it in the client’s best interest? Did it optimize or detract from the nursing care? Did the nurse consult with a supervisor or colleague? Was the incident appropriately documented?

SOME GUIDING PRINCIPLES FOR DETERMINING PROFESSIONAL BOUNDARIES AND THE CONTINUUM OF PROFESSIONAL BEHAVIOR

• The nurse’s responsibility is to delineate and maintain boundaries.

• The nurse should work within the zone of helpfulness.

• The nurse should examine any boundary crossing, be aware of its potential implications and avoid repeated crossings.

• Variables such as the care setting, community influences, client needs and the nature of therapy affect the delineation of

• Actions that overstep established boundaries to meet the needs of the nurse are boundary violations.

• The nurse should avoid situations where the nurse has a personal or business relationship, as well as a professional one.

• Post-termination relationships are complex because the client may need additional services and it may be difficult to determine when the nurse-client relationship is truly terminated.
Q | REGARDING PROFESSIONAL BOUNDARIES AND SEXUAL MISCONDUCT | A
What if a nurse wants to date or even marry a former patient? Is that considered sexual misconduct?

The key word here is former, and the important factors to be considered when making this determination are:

- What is the length of time between the nurse-client relationship and the dating?

- What kind of therapy did the client receive? Assisting a client with a short-term problem, such as a broken limb, is different than providing long-term care for a chronic condition.

- What is the nature of the knowledge the nurse has had access to, and how will that affect the future relationship?

- Will the client need therapy in the future?

- Is there risk to the client?

Variables such as the care setting, community influences, client needs, nature of the therapy provided, age of the client and degree of involvement affect the delineation of behavioral limits.

All of these factors must be considered when establishing boundaries, and all contribute to the complexity of professional boundaries.

The difference between a caring relationship and an over-involved relationship is narrow. A professional living and working in a remote community will, out of necessity, have business and social relationships with clients. Setting appropriate standards is very difficult.

If they do not relate to real life, these standards may be ignored by the nurse or simply may not work. However, the absence of consideration of professional boundaries places the client and nurse at risk.

Do boundary violations always precede sexual misconduct?

Boundary violations are extremely complex. Most are ambiguous and difficult to evaluate. Boundary violations may lead to sexual misconduct, or they may not. In some cases, extreme sexual misconduct, such as assault or rape, may be habitual behavior, while at other times, it is a crime of opportunity. Regardless of the motive,
extreme sexual misconduct is not only a boundary violation, it is criminal behavior.

**Does client consent make a sexual relationship acceptable?**

If the client consents, and even if the client initiates the sexual conduct, a sexual relationship is still considered sexual misconduct for the health care professional. It is an abuse of the nurse-client relationship that puts the nurse’s needs first. It is always the responsibility of the health care professional to establish appropriate boundaries with present and former clients.

**How can a nurse identify a potential boundary violation?**

Some behavioral indicators can alert nurses to potential boundary issues, for which there may be reasonable explanations. However, nurses who display one or more of the following behaviors should examine their client relationships for possible boundary crossings or violations.

**Excessive Self-Disclosure** – The nurse discusses personal problems, feelings of sexual attraction or aspects of his or her intimate life with the client.

**Secretive Behavior** – The nurse keeps secrets with the client and/or becomes guarded or defensive when someone questions their interaction.

**“Super Nurse” Behavior** – The nurse believes that he or she is immune from fostering a nontherapeutic relationship and that only he or she understands and can meet the client’s needs.

**Singled-Out Client Treatment or Client Attention to the Nurse** – The nurse spends inappropriate amounts of time with a particular client, visits the client when off-duty or trades assignments to be with the client. This form of treatment may also be reversed, with the client paying special attention to the nurse, e.g., giving gifts to the nurse.

**Selective Communication** – The nurse fails to explain actions and aspects of care; reports only some aspects of the client’s behavior or gives “double messages.” In the reverse, the client returns repeatedly to the nurse because other staff members are “too busy.”
**Flirtations** – The nurse communicates in a flirtatious manner, perhaps employing sexual innuendo, off-color jokes or offensive language.

**“You and Me Against the World”**
**Behavior** – The nurse views the client in a protective manner, tends not to accept the client as merely a client or sides with the client’s position regardless of the situation.

**Failure to Protect Client** – The nurse fails to recognize feelings of sexual attraction to the client, consult with supervisor or colleague, or transfer care of the client when needed to support boundaries.

**What should a nurse do if confronted with possible boundary violations or sexual misconduct?**

The nurse needs to be prepared to deal with violations by any member of the health care team. Client safety must be the first priority. If a health care provider’s behavior is ambiguous, or if the nurse is unsure of how to interpret a situation, the nurse should consult with a trusted supervisor or colleague. Incidents should be thoroughly documented in a timely manner. Nurses should be familiar with reporting requirements, as well as the grounds for discipline in their respective jurisdictions, and they are expected to comply with these legal and ethical mandates for reporting.

**What are some of the nursing practice implications of professional boundaries?**

Nurses need to practice in a manner consistent with professional standards. Nurses should be knowledgeable regarding professional boundaries and work to establish and maintain those boundaries. Nurses should examine any boundary-crossing behavior and seek assistance and counsel from their colleagues and supervisors when crossings occur.

**THE NURSE’S CHALLENGE**

- Be aware.
- Be cognizant of feelings and behavior.
- Be observant of the behavior of other professionals.
- Always act in the best interest of the client.

**For More Information**

For additional information about boundary issues and professional sexual misconduct, call the National Council of State Boards of Nursing (NCSBN ®) at 312.525.3600.
SOCIAL MEDIA POLICY

Introduction
The use of social media and other electronic communication is increasing with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Nursing students often use electronic media both personally and professionally. Instances of inappropriate use of electronic media by nurses have been reported to boards of nursing (BONs) and, in some cases, reported in nursing literature and the media. This document is intended to provide guidance to practical nursing students using electronic media in a manner that maintains patient privacy and confidentiality.

Social media can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with patients and family members, and educating and informing consumers and health care professionals.

Nursing students are increasingly using blogs, forums, and social networking sites to share clinical experiences, particularly events that have been challenging or emotionally charged. These outlets provide a venue for the nursing student to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified as effective tools in nursing practice. Without a sense of caution, however, these understandable needs and potential benefits may result in the nursing student disclosing too much information and violating patient privacy and confidentiality.

Health care organizations that utilize electronic and social media typically have policies governing employee use of such media in the workplace. Components of such policies often address personal use of employer computers and equipment, and personal computing during work hours. The policies may address types of websites that may or may not be accessed from employer computers. Health care organizations also maintain careful control of websites maintained by or associated with the organization, limiting what may be posted to the site and by whom.

Confidentiality and Privacy
To understand the limits of appropriate use of social media, it is important to have an understanding of confidentiality and privacy in the healthcare context. Confidentiality and privacy are related, but distinct, concepts. Any patient information learned by the nursing student during the course of treatment must be safeguarded by that nursing student. Such information may only be disclosed to other members of the health care team for health care purposes. Confidential information should be shared only with the patient’s informed consent, when legally required or where failure to disclose the information could result in significant harm. Beyond these very limited exceptions the nursing student’s obligation to safeguard such confidential information is universal.

Privacy relates to the patient’s expectation and right to be treated with dignity and respect. Effective nurse-patient relationships are built on trust. The patient needs to be confident that their most personal information and their basic dignity will be protected by the nursing student. Patients will be hesitant to disclose personal information if they fear it will be disseminated beyond those who have a legitimate “need to know.” Any breach of this trust, even inadvertent,
damages the particular nurse-patient relationship and the general trustworthiness of the profession of nursing.

Federal law reinforces and further defines privacy through HIPAA regulations. HIPAA regulations are intended to protect patient privacy by defining individually identifiable information and establishing how this information may be used, by whom, and under what circumstances. The definition of individually identifiable information includes any information that relates to the past, present or future physical or mental health of an individual, or provides enough information that leads someone to believe the information could be used to identify an individual.

Breaches of patient confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. Nursing students may breach confidentiality or privacy with information he or she posts via social media. Examples may include comments on social networking sites in which a patient is described with sufficient detail to be identified, referring to patients in a degrading or demeaning manner, or posting video or photos of patients. Additional examples are included at the end of this document.

**How to Avoid Problems**

It is important to recognize that instances of inappropriate use of social media can and do occur; but with awareness and caution, nursing students can avoid inadvertently disclosing confidential or private information about patients.

The following guidelines are intended to minimize the risks of using social media. These are our expectations:

- First and foremost, nursing students must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.

- Nursing students are strictly prohibited from transmitting, by way of any electronic media, any patient-related image. In addition, nursing students are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.

- Nursing students must not share, post, or otherwise disseminate any information, including images, about a patient or information gained in the nurse-patient relationship with anyone unless there is a patient-care related need to disclose the information or other legal obligation to do so.

- Nursing students must not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.

- Nursing students are not permitted to use their cell phone for any reason in any patient care area of any healthcare facility. Do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.

- Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nursing student has the obligation to establish, communicate, and enforce professional boundaries with patients in the online environment. Do not have an online social contact with patients, former patients, their family members, and/or
instructors. Online contact with these individuals blurs the distinction between a professional and personal relationship. The fact that a patient or his/her family member may initiate contact with the nursing student does not permit the student to engage in a personal relationship with them.

- Consult school, program, and clinical agencies’ policies, and/or an appropriate leader within the facility, for guidance regarding facility-related postings.
- Promptly report any identified breach of confidentiality or privacy.
- Be aware of and comply with clinical agencies’ policies regarding the use of facility-owned computers, cameras, and other electronic devices, and the use of personal devices within the facility.
- Do not refer to patients in a disparaging manner, even if the patient is not identified. Do not make disparaging remarks, in any format, about peers, instructors, the nursing program, clinical agencies, or clinical staff members. Do not make, in any format, threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic, or other offensive comments.

Conclusion
Social and electronic media possess tremendous potential for strengthening personal relationships and providing valuable information to health care consumers. Nursing students need to be aware of the potential ramifications of disclosing patient-related information via social media. Nursing students must be mindful of school policies, clinical agencies’ policies, relevant state and federal laws, and professional standards regarding patient privacy and confidentiality and its application to social and electronic media. By being careful and conscientious, nursing students may enjoy the personal and professional benefits of social and electronic media without violating patient privacy and confidentiality.

Consequences
VIOLATION OF THIS POLICY WILL RESULT IN IMMEDIATE DISMISSAL FROM THE PRACTICAL NURSING PROGRAM. SEE DISCIPLINARY PROCESS AND DISMISSAL PROCEDURE/POLICY.


Written 08/12
Reviewed 10/13; 10/14; 10/15; 10/16

Illustrative Cases
The following cases, based on events reported to BONs, depict inappropriate uses of social and electronic media. The outcomes will vary from jurisdiction to jurisdiction.

SCENARIO 1
Bob, a licensed practical/vocational (LPN/VN) nurse with 20 years of experience used his personal cell phone to take a photo of a resident in the group home where he worked. Prior to taking the photo, Bob asked the resident’s brother if it was okay for him to take the photo. The brother agreed. The resident was unable to give consent due to her mental and physical condition. That evening, Bob saw a former employee of the group home at a local bar and showed him the photo. Bob also discussed the resident’s condition with the former coworker. The administrator of the group home learned of Bob’s actions and terminated his employment. The matter was also reported to the BON. Bob told the BON he thought it was acceptable for him to take the resident’s photo because he had the consent of a family member. He also thought it was acceptable for him to discuss the resident’s condition because the former employee was now employed at another facility.
within the company and had worked with the resident. The nurse acknowledged he had no legitimate purpose for taking or showing the photo or discussing the resident’s condition. The BON imposed disciplinary action on Bob’s license requiring him to complete continuing education on patient privacy and confidentiality, ethics and professional boundaries. This case demonstrates the need to obtain valid consent before taking photographs of patients; the impropriety of using a personal device to take a patient’s photo; and that confidential information should not be disclosed to persons no longer involved in the care of a patient.

**SCENARIO 2**

Sally, a nurse employed at a large long-term care facility arrived at work one morning and found a strange email on her laptop. She could not tell the source of the email, only that it was sent during the previous nightshift. Attached to the email was a photo of what appeared to be an elderly female wearing a gown with an exposed backside bending over near her bed. Sally asked the other dayshift staff about the email/photo and some confirmed they had received the same photo on their office computers. Nobody knew anything about the source of the email or the identity of the woman, although the background appeared to be a resident’s room at the facility. In an effort to find out whether any of the staff knew anything about the email, Sally forwarded it to the computers and cell phones of several staff members who said they had not received it. Some staff discussed the photo with an air of concern, but others were laughing about it as they found it amusing. Somebody on staff started an office betting pool to guess the identity of the resident. At least one staff member posted the photo on her blog.

Although no staff member had bothered to bring it to the attention of a supervisor, by midday, the director of nursing and facility management had become aware of the photo and began an investigation as they were very concerned about the patient’s rights. The local media also became aware of the matter and law enforcement was called to investigate whether any crimes involving sexual exploitation had been committed.

While the county prosecutor, after reviewing the police report, declined to prosecute, the story was heavily covered by local media and even made the national news. The facility’s management placed several staff members on administrative leave while they looked into violations of facility rules that emphasize patient rights, dignity and protection. Management reported the matter to the BON, which opened investigations to determine whether state or federal regulations against “exploitation of vulnerable adults” were violated. Although the originator of the photo was never discovered, nursing staff also faced potential liability for their willingness to electronically share the photo within and outside the facility, thus exacerbating the patient privacy violations, while at the same time, failing to bring it to management’s attention in accordance with facility policies and procedures. The patient in the photo was ultimately identified and her family threatened to sue the facility and all the staff involved. The BON’s complaint is pending and this matter was referred to the agency that oversees long-term care agencies.

This scenario shows how important it is for nurses to carefully consider their actions. The nurses had a duty to immediately report the incident to their supervisor to protect patient privacy and maintain professionalism. Instead, the situation escalated to involving the BON, the county prosecutor and even the national media. Since the patient was ultimately identified, the family was embarrassed and the organization faced possible legal consequences. The organization was also embarrassed because of the national media focus.

**SCENARIO 3**

A 20-year-old junior nursing student, Emily, was excited to be in her pediatrics rotation. She had always wanted to be a pediatric nurse. Emily was caring for Tommy, a three-year-old patient in a major academic medical center’s pediatric unit. Tommy was receiving chemotherapy for leukemia. He was a happy little guy who was doing quite well and Emily enjoyed caring for him. Emily knew he would likely be going home soon, so when his mom went to the cafeteria for a cup of coffee, Emily asked him if he minded if she took his picture. Tommy, a little “ham,” consented immediately. Emily took his picture with her cell phone as she wheeled him into his room because she wanted to remember his room number.

When Emily got home that day she excitedly posted Tommy’s photo on her Facebook page so her fellow nursing students could see how lucky she was to be caring for such a cute little patient. Along with the photo, she commented, “This is my 3-year-old leukemia patient who is bravely receiving chemotherapy. I watched the nurse administer his chemotherapy today and it made me so proud to be a nurse.” In the photo, Room 324 of the pediatric unit was easily visible.

Three days later, the dean of the nursing program called Emily into her office. A nurse from the hospital was browsing Facebook and found the photo Emily posted of Tommy. She reported it to hospital officials who promptly called the nursing program. While Emily never intended to breach the patient’s confidentiality, it didn’t matter. Not only was the patient’s privacy compromised, but the hospital faced a HIPAA violation. People were able to identify Tommy as a “cancer patient,” and the hospital was identified as well. The nursing program had a policy about breaching patient...
confidentiality and HIPAA violations. Following a hearing with the student, school officials and the student’s professor, Emily was expelled from the program. The nursing program was barred from using the pediatric unit for their students, which was very problematic because clinical sites for acute pediatrics are difficult to find. The hospital contacted federal officials about the HIPAA violation and began to institute more strict policies about use of cell phones at the hospital.

This scenario highlights several points. First of all, even if the student had deleted the photo, it is still available. Therefore, it would still be discoverable in a court of law. Anything that exists on a server is there forever and could be resurrected later, even after deletion. Further, someone can access Facebook, take a screen shot and post it on a public website.

Secondly, this scenario elucidates confidentiality and privacy breaches, which not only violate HIPAA and the nurse practice act in that state, but also could put the student, hospital and nursing program at risk for a lawsuit. It is clear in this situation that the student was well-intended, and yet the post was still inappropriate. While the patient was not identified by name, he and the hospital were still readily identifiable.

**SCENARIO 4**
A BON received a complaint that a nurse had blogged on a local newspaper’s online chat room. The complaint noted that the nurse bragged about taking care of her “little handicapper.” Because they lived in a small town, the complainant could identify the nurse and the patient. The complainant stated that the nurse was violating “privacy laws” of the child and his family. It was also discovered that there appeared to be debate between the complainant and the nurse on the blog over local issues. These debates and disagreements resulted in the other blogger filing a complaint about the nurse.

A check of the newspaper website confirmed that the nurse appeared to write affectionately about the handicapped child for whom she provided care. In addition to making notes about her “little handicapper,” there were comments about a wheelchair and the child’s age. The comments were not meant to be offensive, but did provide personal information about the patient. There was no specific identifying information found on the blog about the patient, but if you knew the nurse, the patient or the patient’s family, it would be possible to identify who was being discussed.

The board investigator contacted the nurse about the issue. The nurse admitted she is a frequent blogger on the local newspaper site; she explained that she does not have a television and blogging is what she does for entertainment. The investigator discussed that as a nurse, she must be careful not to provide any information about her home care patients in a public forum.

The BON could have taken disciplinary action for the nurse failing to maintain the confidentiality of patient information. The BON decided a warning was sufficient and sent the nurse a letter advising her that further evidence of the release of personal information about patients will result in disciplinary action.

This scenario illustrates that nurses need to be careful not to mention work issues in their private use of websites, including posting on blogs, discussion boards, etc. The site used by the nurse was not specifically associated with her like a personal blog is; nonetheless the nurse posted sufficient information to identify herself and the patient.

**SCENARIO 5**
Nursing students at a local college had organized a group on Facebook that allowed the student nurses’ association to post announcements and where students could frequently blog, sharing day-to-day study tips and arranging study groups. A student-related clinical error occurred in a local facility and the student was dismissed from clinical for the day pending an evaluation of the error. That evening, the students blogged about the error, perceived fairness and unfairness of the discipline, and projected the student’s future. The clinical error was described, and since the college only utilized two facilities for clinical experiences, it was easy to discern where the error took place. The page and blog could be accessed by friends of the students, as well as the general public.

The students in this scenario could face possible expulsion and discipline. These blogs can be accessed by the public and the patient could be identified because this is a small community. It is a myth that it can only be accessed by that small group, and as in Scenario 3, once posted, the information is available forever. Additionally, information can be quickly spread to a wide audience, so someone could have taken a screen shot of the situation and posted it on a public site. This is a violation of employee/university policies.

**SCENARIO 6**
Chris Smith, the brother of nursing home resident Edward Smith, submitted a complaint to the BON. Chris was at a party when his friend, John, picked up his wife’s phone to read her a text message. The message noted that she was to “get a drug screen for resident Edward Smith.” The people at the party who heard the orders were immediately aware that Edward Smith was the quadriplegic brother of Chris. Chris did not want to get the nurse in trouble, but was angered that personal information about his brother’s medical information was released in front of others.
The BON opened an investigation and learned that the physician had been texting orders to the personal phone number of nurses at the nursing home. This saved time because the nurses would get the orders directly and the physician would not have to dictate orders by phone. The use of cell phones also provided the ability for nurses to get orders while they worked with other residents. The practice was widely known within the facility, but was not the approved method of communicating orders.

The BON learned that on the night of the party, the nurse had left the facility early. A couple hours prior to leaving her shift she had called the physician for new orders for Edward Smith. She passed this information onto the nurse who relieved her. She explained that the physician must not have gotten a text from her co-worker before he texted her the orders.

The BON contacted the nursing home and spoke to the director of nursing. The BON indicated that if the physician wanted to use cell phones to text orders, he or the facility would need to provide a dedicated cell phone to staff. The cell phone could remain in a secured, private area at the nursing home or with the nurse during her shift.

The BON issued a warning to the nurse. In addition, the case information was passed along to the health board and medical board to follow up with the facility and physician.

This scenario illustrates the need for nurses to question practices that may result in violations of confidentiality and privacy. Nurse managers should be aware of these situations and take steps to minimize such risks.

**SCENARIO 7**

Jamie has been a nurse for 12 years, working in hospice for the last six years. One of Jamie’s current patients, Maria, maintained a hospital-sponsored communication page to keep friends and family updated on her battle with cancer. Jamie periodically read Maria’s postings, but had never left any online comments. One day, Maria posted about her depression and difficulty finding an effective combination of medications to relieve her pain without unbearable side effects. Jamie knew Maria had been struggling and wanted to provide support, so she wrote a comment in response to the post, stating, “I know the last week has been difficult. Hopefully the new happy pill will help, along with the increased dose of morphine. I will see you on Wednesday.” The site automatically listed the user’s name with each comment. The next day, Jamie was shopping at the local grocery store when a friend stopped her and said, “I didn’t know you were taking care of Maria. I saw your message to her on the communication page. I can tell you really care about her and I am glad she has you. She’s an old family friend, you know. We’ve been praying for her but it doesn’t look like a miracle is going to happen. How long do you think she has left?” Jamie was instantly horrified to realize her expression of concern on the webpage had been an inappropriate disclosure. She thanked her friend for being concerned, but said she couldn’t discuss Maria’s condition. She immediately went home and attempted to remove her comments, but that wasn’t possible. Further, others could have copied and pasted the comments elsewhere.

At her next visit with Maria, Jamie explained what had happened and apologized for her actions. Maria accepted the apology, but asked Jamie not to post any further comments. Jamie self-reported to the BON and is awaiting the BON’s decision.

This scenario emphasizes the importance for nurses to carefully consider the implications of posting any information about patients on any type of website. While this website was hospital sponsored, it was available to friends and family. In some contexts it is appropriate for a nurse to communicate empathy and support for patients, but they should be cautious not to disclose private information, such as types of medications the patient is taking.

**References**


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National Council of State Boards of Nursing
111 E. Wacker Dr., Suite 2900 Chicago, IL 60601
312.525.3600 | Fax: 312.279.1032
### CLINICAL SKILLS CHECKLIST

**Student Name ________________________________    SS#__________________**

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PROCEDURE FOLLOWING POTENTIAL EXPOSURE TO BLOODBORNE PATHOGENS

Even with adherence to all prevention practices and standard precautions, exposure incidents can occur. As a result, procedures have been established for post-exposure evaluation and follow-up should exposure to bloodborne pathogens occur. Mineral County School Policy shall apply and be strictly followed. In the clinical setting, the facility’s policies will also be followed.

The Occupational Safety and Health Administration (OSHA) regulations require employers to tell employees what to do if an exposure incident occurs. OSHA also mandates medical follow-up and counseling for any employees who are exposed. Practical nursing students are at risk for exposure to bloodborne pathogens, yet are not considered employees of any of the health facilities utilized for clinical experience. While OSHA standards require employers to provide free medical evaluation and treatment to employees who experience an exposure incident, the Mineral County Board of Education cannot assume similar responsibilities for practical nursing students; the medical evaluation and follow-up is the responsibility of the adult student.

*Exposure incident* is defined by OSHA as a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood, or the inhalation or ingestion of potentially infectious materials that results from the performance of clinical tasks. The following procedure will be followed after a potential exposure incident:

1. The student will immediately notify the instructor.
2. A facility staff member will work with the student and instructor to complete an incident report.
3. According to the policy of the respective facility, the source individual’s blood will be tested as soon as possible (after consent is obtained) in order to determine infectivity. If consent is not obtained, the medical facility shall establish that the legally required consent cannot be obtained.
4. Information will remain confidential and every action will be taken to protect the privacy of the individuals involved.
5. The following medical evaluation (at the student’s expense) is recommended to be taken in the follow-up of the exposed student:
   a. Appropriate laboratory testing
   b. Post-exposure prophylaxis
   c. Counseling
   d. Follow-up as prescribed by the student’s healthcare provider

Note: This policy is based on information in the *Exposure Control for Blood and Other Potentially Infectious Material: A Protocol Document for Health Occupations Education Programs in West Virginia* published by the West Virginia Department of Education, 1992.
PROCEDURE FOR SAFETY OF PREGNANT STUDENTS

Nursing students who are pregnant need to notify the Coordinator as soon as pregnancy is suspected. Students will be advised that the nature and exposure to a variety of illnesses in the clinical experience included in practical nursing could pose a potential threat to an unborn baby. The student must have written approval of her physician to continue in the program. Nursing students who are pregnant and choose to continue in the program are required to:

1. Notify the Coordinator immediately when pregnancy is suspected.
2. Sign a form that indicates the student:
   a. Has been counseled by the Coordinator of the school of nursing regarding the pregnancy policy of the school;
   b. Has been made aware that the nature and exposure to a variety of illnesses in the clinical experience included in the practical nursing program could pose a potential threat to the unborn baby;
   c. Has the option to withdraw from the program until after the birth of the baby, and then return to the class at the appropriate quarter to complete the program, according to the Readmission Policy; and
   d. Releases the school and clinical agencies from liability should activities relating to the educational program be detrimental to the pregnant female or the unborn baby.
3. Provide the Coordinator with a statement from her physician authorizing continuation in the program following each prenatal visit.
4. During pregnancy and if delivery occurs during the school year, the absenteeism policy of the school shall apply.
EVALUATION OF STUDENT’S CLINICAL PERFORMANCE

These objectives represent the expected minimal outcomes for the student upon completion of the clinical components of the nursing program and reflect the program concepts and threads. Outcomes are based on the student’s ability to apply the nursing process to clinical practice and reflect continuing growth and improvement both within and among courses. During each course’s orientation to the clinical experience, the evaluation process is reviewed both programmatically and in relation to specifics of the course. Students are evaluated at mid-rotation (M) to document progress to that point, and receive a final (F) evaluation at the end of the clinical course.

EVALUATION CRITERIA

4. Pass – Self-directed Independent Level
3. Pass – Moving toward independent Level
2. Unsatisfactory – Needs Improvement (requires completion of a Performance Improvement Plan)
1. Failure – Dependent Level (requires completion of a Performance Improvement Plan)

Each of the above areas is defined on the next page, specifically in relation to the stated outcome.

OUTCOMES

A student must receive a “Pass” (3 or 4) criteria rating on ALL objectives identified for the current clinical rotation by the end of the course to pass the course. An “Unsatisfactory” or “Failure” (1 or 2) criteria rating on any one clinical course objective means an unsatisfactory grade regardless of the ratings on other items. All objectives identified as 1 or 2 at mid-rotation must improve to a criteria rating of 3 or 4 to successfully pass the clinical course.

Reminder:
Satisfactory clinical performance: 3 or 4 rating in ALL areas of final evaluation
Unsatisfactory clinical performance: 1 or 2 rating in ANY ONE area of final evaluation
DEFINITIONS FOR EVALUATION CRITERIA

4. Pass – Self-directed Independent Level
   1. Performs safely and accurately during the performance* and without* supportive cues from the instructor
   2. Demonstrates dexterity* and coordination,* while performing the skill
   3. Completes the skill in minimal amount of time*
   4. Focuses on the patient* while giving care
   5. Appears relaxed and confident during performance
   6. Applies knowledge of the principles of the skill accurately*

3. Pass – Moving toward Independent Level
   1. Performs safely and accurately during the performance* with occasional directive cues* from the instructor
   2. Demonstrates coordination and dexterity*, but uses some unnecessary energy* to complete the skill
   3. Generally appears relaxed and confident most of time with occasional display of anxiety
   4. Completes the skill within a reasonable time* frame
   5. Focuses on the patient initially, but as the skills progresses, focuses on the task*
   6. Applies knowledge of the principal of the skill accurately with occasional cue from the instructor*

2. Unsatisfactory – Needs Improvement
   1. Performs safely and accurately with frequent direction or cues from the instructor* during the performance
   2. Requires frequent direction or cues* from the instructor
   3. Demonstrates partial lack of dexterity*; is awkward
   4. Takes a longer time* to complete the skill
   5. Wastes energy* due to poor planning/anxiety
   6. Focuses primarily on the task, not on the client*
   7. Needs direction in application of the principles of the task*

1. Failure – Dependent Level
   1. Performs the skill in an unsafe* manner
   2. Requires constant supportive and directive cues* from the instructor
   3. Takes an unreasonable length* of time to complete the skill
   4. Lacks organization* due to poor planning
   5. Wastes energy* due to disorganization or incompetence
   6. Focuses entirely on the skill or own behavior*
   7. Unable to identify or apply the principles of the skill*

*Distinctive Criteria for Competency Level
# EVALUATION OF CLINICAL PERFORMANCE

**STUDENT NAME:** ____________________________ **STUDENT ID#:** ____________________________

<table>
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<tr>
<th>Date</th>
<th>FUND</th>
<th>GERI</th>
<th>MS</th>
<th>Critical to all Courses</th>
<th>NURSING PROCESS – The Student Will</th>
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</table>
| M    |      |      |    | A. Demonstrate biopsychosocial assessment skills in collection and analysis of data to identify the needs of the client. | 1. Has difficulty in observing and assessing data despite guidance and supervision from instructor.  
2. Needs frequent direction in order to assess needs of client.  
3. Observes and assesses data with minimal assistance from the instructor.  
4. Independently observes and assesses data. |
| F    |      |      |    | B. Formulate goals based on data. | 1. Has difficulty formulating patient behavioral objectives.  
2. Requires frequent input in order to formulate client behavioral objectives.  
3. Formulates patient behavioral objectives with minimal assistance from the instructor.  
4. Independently formulates patient behavioral objectives correctly based on data. |
| M    |      |      |    | C. Use critical thinking to formulate a plan of care based on client oriented behavioral objectives. | 1. Unable to use critical thinking to formulate a plan of care.  
2. Requires frequent direction from instructor to use critical thinking to formulate a plan of care.  
3. Applies critical thinking while formulating a plan of care with occasional support from instructor.  
4. Applies critical thinking while formulating a plan of care. |
| F    |      |      |    | D. Write a plan of care based on patient-oriented behavioral objectives. | 1. Has difficulty identifying priority nursing diagnosis, planning nursing actions, identifying scientific rationale, and evaluating the plan, despite guidance and supervision of instructor.  
2. Needs frequent direction in order to write a plan of care based on client behavioral objectives.  
3. Identifies priority nursing diagnosis, plans nursing actions, identifies scientific rationale, and evaluates the plan with minimal assistance from instructor.  
4. Independently identifies priority nursing diagnosis, plans nursing actions, identifies scientific rationale, and evaluates the plan. |
| M    |      |      |    | E. Implement nursing measures to meet prioritized client need. | 1. Some planning but does not take into consideration patient data and/or is not able to establish priorities.  
2. Wastes energy due to poor planning in order to implement nursing measures to meet prioritized client need.  
3. Assignment planned, priorities established, and usually carried through as intended except for unexpected circumstances.  
4. Assignment planned and organized so as to afford patient and family maximum comfort. |
### MCSPN Clinical Syllabus

#### Date  FUND  GERI  MS

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| **F.** | **Evaluate the effectiveness of nursing interventions and adapts plan of care accordingly.**  
1. Requires constant support to evaluate effectiveness of interventions.  
2. Requires frequent support to evaluate effectiveness of interventions.  
3. Requires minimal assistance to evaluate effectiveness of interventions.  
**M**  
**F** |
| **G.** | **Report and record nursing process.**  
1. Has difficulty in observing and recording data, despite guidance and supervision from instructor; database is incomplete.  
2. Needs frequent direction from instructor during reporting and recording of nursing process.  
3. Able to observe and record data, with minimal assistance from instructor; database is complete, descriptive, and accurate.  
4. Independently observes and records data; database is complete, descriptive, and accurate.  
**M**  
**F** |
| **H.** | **Perform technical aspects of care.**  
1. Makes errors, recognizes and corrects a few of them, requires much supervision and/or prompting from instructor.  
2. Demonstrates partial lack of dexterity while performing technical aspects of care.  
3. Makes minimal errors or omissions, recognizes and corrects most of them; requires little supervision and/or prompting from instructor.  
4. Consistently performs skills accurately and efficiently without requiring prompting from instructor.  
**M**  
**F** |
| **I.** | **Explain rationale for performing basic nursing skills and technical procedures.**  
1. Seldom applies previously learned principles; requires much guidance.  
2. Occasionally applies previously learned principles; requires frequent guidance.  
3. Usually applies previously learned principles; requires minimal guidance.  
4. Consistently and independently applies previously learned principles.  
**M**  
**F** |
| **J.** | **Secure, calculate, prepare, and administer medications accurately.**  
1. Makes errors in securing correct medications, calculating dosages, and/or preparing and administering medications; and requires prompting to correct errors.  
2. Performs safely and accurately with frequent direction or cues from the instructor during the performance.  
3. Makes minimal errors in securing correct medication, calculating dosages, and preparing and administering medications; and recognizes and corrects errors with minimal assistance.  
4. Is accurate and efficient in securing correct medication, calculating dosages, and preparing and administering medications.  
**M**  
**F** |

#### Date  FUND  GERI  MS
| Critical to all Courses | K. Discuss relevant data regarding medications.  
1. Unable to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.  
2. Needs frequent direction from instructor in order to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.  
3. Usually able to state physiologic action of drugs, recognize behavior and physiologic changes due to drugs, and adapt nursing care according to effects of drugs.  
4. Is accurate and efficient in stating physiologic action of drugs, recognizing behavior and behavioral changes to drugs, and adapting nursing care according to effects of drugs. |

| Critical to all Courses | TEACHING-CLIENT/FAMILY – The Student Will:  
L. Perform appropriate teaching with clients and/or families applying principles of learning and teaching.  
1. Rarely able to apply principles of teaching and learning; requires much guidance.  
2. Sometimes able to apply principles of teaching and learning; requires frequent guidance.  
3. Usually able to apply principles of teaching and learning; requires minimal guidance.  
4. Consistently and independently able to apply principles of teaching and learning. |

| Critical to all Courses | COMMUNICATION – The Student Will:  
M. Collaborate effectively with other members of the health team to promote continuity of care.  
1. Communication is rarely effective and requires much guidance.  
2. Communication is occasionally effective and requires frequent guidance.  
3. Communication is usually effective and requires minimal guidance.  
4. Communication is consistently effective and is done independently. |

| Critical to all Courses | N. Present appropriate and therapeutic responses to patient situations, including appropriate facial expressions, body language, and responses.  
1. With guidance, unable to adapt to patient ‘s circumstances; little insight into personal behaviors and responses; no change in behaviors.  
2. With frequent guidance, is able to adapt to patient ‘s circumstances; occasional insight into personal behaviors and responses; occasional change in behaviors.  
3. With minimal guidance, able to adapt to patient ‘s circumstances; insight into personal behaviors and responses; shows change in behavior.  
4. Adapts readily to patient circumstances; good insight into personal behaviors. |
Critical to all Courses

O. Establish purposeful interpersonal relationships and demonstrate effective communications with clients and/or family members.
1. Communication is rarely effective and requires guidance.
2. Communication is occasionally effective but requires guidance.
3. Communication is usually effective and requires minimal guidance.
4. Communication is effective and independent.

P. Perform nursing measures with respect to client’s dignity, safety, and confidentiality.
1. Client’s dignity, safety, and confidentiality over-looked; error(s) made were actually or potentially dangerous to the welfare of the patient.
2. Client’s dignity, safety, and confidentiality occasionally over-looked; error(s) made were not actually or potentially dangerous to the welfare of the patient.
3. Client’s dignity, safety, and confidentiality usually considered and demonstrated; error(s) made were not dangerous to the welfare of the patient.
4. Client’s dignity, safety, and confidentiality consistently considered and demonstrated.

Q. Display judgment and objectivity in situations and make decisions that reflect both knowledge of fact and sound judgment.
1. Has difficulty functioning after initial direction; needs repeated explanations.
2. Requires frequent directions; occasionally demonstrates acceptable use of judgment and objectivity in some situations.
3. Able to follow initial directions; demonstrates acceptable use of judgment and objectivity in most situations.
4. Rarely needs direction; is consistently able to make judgments independently and with objectivity.

R. Meet established criteria (as stated in course and clinical syllabi/policies) for oral, written, and electronic assignments.
1. Preparations/assignments contain spelling and grammar errors, lack depth, and are incomplete and unsatisfactory.
2. Preparations/assignments are occasionally done that meet established criteria.
3. Preparations/assignments are usually complete and satisfactory.
4. Preparations/assignments display consistent, in-depth content and usually go beyond the requirements for the assignment.

S. Accept and profit from constructive criticism.
1. Rarely accepts and profits from constructive criticism.
2. Occasionally accepts and profits from constructive criticism.
3. Usually accepts and sometimes profits from constructive criticism.
4. Accepts and profits from constructive criticism.
| Critical to all Courses | M | T. Actively participate in clinical pre- and post-conferences.  
1. Seldom participates in conferences or displays inappropriate behavior.  
2. Occasionally participates in conference with frequent cues from instructor.  
3. Usually participates in conferences.  
4. Consistently contributes to conferences. |
|------------------------|---|-----------------------------------------------------------------|
|                        | F | U. Correlate classroom theory to clinical practice.  
1. Shows little or no knowledge beyond immediately defined nursing care.  
2. Occasionally correlates theory to clinical practice to implement care.  
3. Usually correlates theory to clinical practice to implement care.  
4. Consistently correlates theory to clinical practice to implement care. |
|                        | M | V. Demonstrate self-direction and assume responsibility for his/her growth and learning.  
1. Lacks initiative; is non-assertive and does not follow through with responsibility.  
2. Needs direction in order to move toward assuming responsibility for his/her own growth and learning.  
3. Usually demonstrates initiative and assertiveness, and usually follows through with responsibility.  
4. Consistently demonstrates initiative, assertiveness, self-direction and creativity; goes beyond required tasks. |
|                        | F | W. Organize patient care assignment so that completed in the specified amount of time.  
1. Does not complete assignment on time.  
2. Occasionally completes assignment on time.  
3. Usually completes assignment on time.  
4. Consistently completes assignment on time. |
|                        | M | X. Prepare for skill/assignment by gathering all necessary items/supplies for care.  
1. Consistently forgets items/supplies and/or does not gather appropriate items/supplies for care.  
2. Occasionally forgets items/supplies and/or does not gather appropriate items/supplies for care.  
3. Usually remembers and gathers appropriate items/supplies for care.  
4. Consistently remembers and gathers appropriate items/supplies for care. |
|                        | F |                                                                                   |

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### Critical to all Courses

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<tr>
<th>M</th>
<th>Critical to all Courses</th>
<th>Y. Utilize an appropriate, assertive approach to clients, family, healthcare team, visitors, classmates, and faculty.</th>
</tr>
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<tbody>
<tr>
<td>F</td>
<td></td>
<td>1. Approach is often inappropriate and passive.</td>
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<tr>
<td></td>
<td></td>
<td>2. Approach is occasionally appropriate and assertive.</td>
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<tr>
<td></td>
<td></td>
<td>3. Approach is usually appropriate assertive.</td>
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<tr>
<td></td>
<td></td>
<td>4. Uses appropriate assertive approach.</td>
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<th>M</th>
<th>Critical to all Courses</th>
<th>Z. Adhere to all LPN program and facility standards regarding professional appearance, behavior, and conversation.</th>
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<tbody>
<tr>
<td>F</td>
<td></td>
<td>1. Does not adhere to these standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Occasionally adheres to these standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Usually adheres to these standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Consistently adheres to standards.</td>
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FUNDAMENTALS OF NURSING CLINICAL

Course Description: The beginning student will integrate content from classroom learning activities and skills lab to practice in the clinical setting. The student will provide care to selected clients. The focus is on assessment of needs, maintaining a safe environment while meeting the physical and psychosocial needs, and promoting wellness.

Course Learning Outcomes:
1. Provide care to all assigned clients in a professional manner, demonstrating awareness of legal/ethical principles.
2. Utilize critical thinking skills, Maslow’s Hierarchy of Human Needs, and knowledge of holistic assessment of the client to implement the nursing process.
3. Maintain a safe environment during all aspects of client care.
4. Use therapeutic communication with all assigned clients and colleagues.
5. State the rationale for all aspects of care administered to assigned clients including laboratory, nutritional, and medication orders.
6. Assist all assigned clients with activities of daily living, based on the assessment of the client’s developmental level.
7. Demonstrate the use of the “six rights” of medication administration.
8. Administer medications to assigned clients, after dosages are verified by clinical instructor with 100% accuracy.
9. Perform basic nursing skills in the clinical setting upon availability. These skills may include providing personal hygiene, physical assessment, documentation, catheterization, tube feeding, medication administration, dressing changes, maintaining oxygen therapy, assisting clients with ambulation, and assisting clients with nutritional needs.
10. Document the client care and teaching provided.
11. Discuss client care priorities and goal attainment issues in relation to the nursing process during clinical post conference.
12. Integrate Maslow’s and developmental theories in all nursing process related assignments.
13. Safely manage all aspects of care for one or two assigned clients.
Instructor’s Expectations
Each clinical group has a faculty member responsible for planning and supervising the activities of the clinical group. The faculty has a strong clinical background and desire to share their expertise and professionalism. In addition to clinical responsibilities, clinical instructors are responsible for evaluating each student’s clinical performance and written assignments, and are available for consultations to meet individual student’s needs.

One goal of the instructor is to promote student learning from each clinical experience through planned individual and group activities. The instructor expects students to be prepared for each clinical experience and to demonstrate personal and professional effort in meeting the demands of the course clinical objectives.

Method of Instruction
Methods suitable for adaptation and implementation to the clinical area include:

- Hands-on clinical application of theory with facilitation by clinical instructor;
- Pre-Conference: An organized focused time prior to beginning clinical facilitated by the clinical instructor, which “grounds” the student’s clinical activities;
- Directed observation of procedures by staff;
- DVD and electronic learning as/if available at clinical site; and
- Post-Conference: An organized, focused time after the day’s clinical experience to support the integration of experiences and to debrief from the day.

Evaluation Methods

- Attendance and participation
- Verbal evaluation of clinical performance
- Evaluation of written assignments
- Written evaluation of clinical performance at end of clinical rotation

Confidentiality
Confidentiality is a strict must! Any breach of confidentiality is grounds for immediate dismissal from program.
PRE-/POST-CONFERENCE GUIDELINES

Pre-Conference
Prior to student providing direct client care, a clinical pre-conference will be held. The time and location of the pre-conference is at the discretion of the clinical instructor. The focus will be reviewed, goals for the day established, and learning needs identified.

Pre-Conference is intended to be a brief, but important, review of the day’s activities. The clinical instructor will assist the clinical group in identifying care priorities, learning opportunities, and organizational needs. Nursing care plans and other written assignments for each client may also be randomly chosen for discussion.

Post-Conference
Post-conference is intended to discuss nursing care challenges of interest for the benefit of all the students in the group, to share ideas for meeting these challenges, and to debrief. The location and time for clinical post-conferences will be scheduled by the clinical instructor.

The clinical instructor will facilitate the post-conference discussion. Each student is expected to participate in evaluating the day’s goals and learning experiences. Activities relevant to the clinical focus will be discussed with emphasis on expected and actual outcomes of care, alternative interventions, and staff nurse responsibilities in the overall management of care for the client.

Student Objectives
The student will:
- Identify the client;
- State client needs;
- Describe pertinent observations in a review of systems manner;
- Report situation and potential or actual problems experienced;
- Discuss nursing approach/solution to these problems;
- List the drugs administered, and state the action, dose, desired effect, side/adverse effects, and methods of administration for each;
- List treatments, and state the purpose of and the client’s response to each;
- Labs pertinent to patient; and
- Client teaching

Student Guide for Discussion
1. Who is my client? (For example, age, marital status, psychosocial history, medical conditions and mental status).
2. Significant events of this admission (admitting diagnoses, surgery, emotion crises, fracture).
3. Client’s needs TODAY? (Describe the situation, your observations, potential or actual problems and your approach).
   a. Basic daily needs
   b. Needs requiring special attention
4. What medications were administered, or is your client receiving?
   a. Why?
   b. What were the positive and negative effects?
   c. What safety measures were used?
5. What treatments were done?
   a. Why were these done?
   b. What special principles or safety measures were involved?
6. Did I meet my client’s needs? Explain.
7. What could I do to improve my nursing care of this client?
8. What were my feelings about taking care of this client?
9. Presentation of special topics

**Week One: Clinical Orientation**

The student will:

1. Learn the physical layout of the clinical area.
2. Review and be familiar with the OSHA guidelines regarding standard precautions as related to the clinical setting; knowing where to find protective equipment, sharps disposal boxes and infection control manuals located on the unit.
3. Discuss the ethical and legal issues involved in the nursing care of the clients.
4. Discuss the issue of confidentiality related to the clinical site.
5. Be oriented to clinical assignments, time of clinical experience, location and time of pre- and post-conferences and other scheduled clinical experiences in this rotation.
6. Identify the role of the licensed practical nurse as provider of care, manager of care, and member of the profession.
7. Identify the chain of command as it relates to the clinical area.
8. Maintain confidentiality.
9. Be familiar with usual routines for the unit.
   a. Vital signs
   b. Meal times
   c. Visiting hours
10. Review the clinical evaluation tool.

In post-conference, the student will be prepared to discuss:

1. Experience and personal feelings
2. Preview objectives for clinical experience next week

**Week Two:**

The student will:

1. Demonstrate his/her ability to locate client care items.
2. Demonstrate and continuously practice proper handwashing techniques.
3. Demonstrate and continuously practice principles of proper body mechanics.
4. Demonstrate use of bed controls and call light system.
5. Identify environmental risk factors for client’s safety.
6. Institute principles of fall prevention.
7. Assist staff in providing care according to client’s care plan.
8. Turn and position clients to maintain correct body alignment and to prevent pressure sores.
9. Practice therapeutic communication techniques.
In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings
2. Importance of good rapport with client to promote a trusting nurse/patient relationship
3. Client care needs
4. Documentation of care provided
5. Identify own learning needs
6. Preview objectives for clinical experience next week

Week Three
The student will continue to meet the previous objectives and:
1. Set up a client for an independent bath
2. Assist a client with a partial bed
3. Make an unoccupied bed
4. Provide AM care
5. Assist client with elimination needs per bedpan
6. Assist client to transfer to chair
7. Assist client to ambulate with assistive devices
8. Document according to agency policy

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next week
2. Safety guidelines to follow during client care
3. Observation of skin and common abnormalities and treatments for common conditions

Week Four
The student will continue to meet the previous objectives and:
1. Provide a complete bed bath
2. Assist client with a shower
3. Assess the integrity of client’s skin
4. Make an occupied bed
5. Feed a client
6. Become familiar with the sections of a client’s chart

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next week
2. The importance of mobility and skin integrity

Week Five
The student will continue to meet the previous objectives and:
1. Demonstrate the ability to care for the incontinent client
2. Provide perineal care
3. Demonstrate prevention techniques for pressure sores
4. Position client properly using appropriate body mechanics
5. Perform passive and active range of motion exercises on clients

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next week
2. Medical and surgical asepsis practices when implementing care

Week Six
The student will continue to meet the previous objectives and:
1. Demonstrate proper care of a urinary catheter
2. Provide care for a client in isolation
3. Demonstrate safe use of client lifts per agency policy
4. Administer an enema to a client
5. Provide PEG tube care per agency protocol

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next week
2. Fluid balance
3. Prevention and treatment of pressure sores
4. Alternative feeding methods

**Week Seven**
The student will continue to meet the previous objectives and:
1. Maintain accurate intake and output on assigned client
2. Demonstrate ability to check placement of PEG tube and flush device per agency protocol
3. Demonstrate treatment to pressure sores and other wounds using clean technique

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next week
2. Signs and symptoms of hypoxia

**Week Eight**
The student will continue to meet the previous objectives and:
1. Complete a physical assessment on assigned client
2. Document findings of the physical assessment and identify client problems
3. Accompany assigned client to various therapies and activities
4. Identify one nursing diagnosis for assigned client with at least three defining characteristics
5. Develop a list of three nursing interventions related to the identified nursing diagnosis along with a rationale for each of the interventions

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next clinical day
2. Client problems and potential nursing diagnoses

**Week Nine**
The student will continue to meet the previous objectives and:
- Review assigned client’s chart
- Discuss potential for and plans for discharge for assigned client
- Terminate your relationship with assigned client and staff

In post-conference, the student will be prepared to discuss:
1. Experience and personal feelings and objectives for next clinical day
2. Evaluation of clinical instruction, clinical site, and self
GERIATRICS CLINICAL

Course Description
Application of nursing process will focus on common and select biopsychosocial health concerns for older adults. Emphasis will be on health promotion, risk assessment, and prevention of illness and injury. Clinical experiences will occur in the nursing home and community settings.

Course Objectives
During this course, the student will:

1. Apply knowledge from liberal arts, nursing science, and related disciplines for health promotion and risk reduction in the care of older adults.
2. Apply the nursing process of assessment, diagnosis, outcome identification, planning, intervention and evaluation for health promotion and risk reduction in the care of older adults.
3. Demonstrate critical thinking attitudes, skills, and abilities in clinical decision-making and in evaluating nursing practice with older clients.
4. Integrate technological and relationship-centered nursing interventions to promote the health of older adults in clinical and community settings.
5. Use communication and collaboration skills to develop partnerships with older individuals and their social systems (families, community, and healthcare resources) to promote healthy aging.
6. Demonstrate commitment to self-evaluation, life-long learning, professional behaviors, service, diversity, and social justice in the care of the elderly and their families.

Student Responsibilities in Long Term Care Facility
Students will provide basic care to older clients, including basic hygiene, ambulation, and nutrition. Emphasis will be placed on targeted assessments relevant to older adults including evaluating sensory changes, functional status, cognitive and mood changes, fall risk, nutrition status, environmental hazards, and pain. Students will prepare and administer medications. Other skills will include dressing changes, glucometry readings, and other skills based on availability of opportunities and faculty discretion. The general clinical focus will be to:

a. Conduct elderly client assessments and interviews (see weekly assignments on following pages)
b. Provide basic care, including bathing, dressing, feeding, and transferring
c. Measure vital signs
d. Complete head-to-toe assessments
e. Administer medications
   a. Follow the six rights of medication administration
   b. Know the classification, action, purpose, side and adverse effects, and normal dose range of each medication
f. Perform treatments as assigned/available, including dressing changes, oxygen therapy, suctioning, catheterization, and tracheostomy care
g. Document care and medication administration as provided
Clinical Experience in the Community Setting
Each student will visit one older person (age 65 or older) weekly over the rotation for purpose of promoting health in well elders. Students will practice interviewing, communicating, and collaborating with clients/families. Assignments will include targeted assessments relevant to older adults including evaluating sensory changes, functional status, cognitive and mood changes, fall risk, nutrition status, environmental hazards, and pain (see following pages for weekly assignments).

Focused Geriatric Assessments
You will complete comprehensive geriatric assessments which will include several tools. Due dates for these assessments are shown on the weekly clinical schedule (see following pages).

- **Instrumental Activities of Daily Living**: This assessment tool is used for community-based residents.
- **Katz Index of Independence in Activities of Daily Living**: This assessment is based on your knowledge and observation of the resident and his ability to perform each task. Indicate the level that reflects your assessment of your resident’s abilities. It may be appropriate to add a specific description of what the resident can and cannot do.
- **Sensory Assessment**: This tool examines vision and hearing needs and issues.
- **Pain Assessment**: A pain assessment should be done for each resident each day. For residents without dementia, use the Verbal Descriptor scale. For patients with dementia, use the Checklist of Nonverbal Pain Indicators or the FLACC Scale.
- **Nutritional Assessment**: The DETERMINE form will be available for assessing your community-based client’s nutritional needs.
- **Oral Health Assessment**: This tool examines oral care needs and issues.
- **Fall Risk Assessment**: Check the items that apply to your resident, and total the score. A score of ≥ 15 indicates that fall precautions should be implemented.
- **Environmental/Safety Assessment**: This tool is to be used with your community client to identify environmental risks.
- **Braden Scale for Risk for Skin Breakdown Assessment**: Assess each category for your resident and total the numeric score. A score of ≥ 16 indicates a risk for skin breakdown.
- **Folstein Mini-Mental State Examination (MMSE)**: This screening tool for cognitive impairment is appropriate for all residents in long-term care facilities, but may not be possible for those who are severely cognitively impaired. Your instructor or the nursing staff can assist you to identify a resident with whom to complete this assessment if your resident is not able to do so.

Evaluation Methods
Attendance and participation
Verbal evaluation of clinical performance
Evaluation of written assignments
Written evaluation of clinical performance at end of clinical rotation
# Geriatrics Clinical: Week One Packet

**Assignments Due: 8 am on**

## Long-Term Care Resident

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<thead>
<tr>
<th>Nursing Care</th>
<th>Assignments to be Submitted</th>
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<tbody>
<tr>
<td>Meet assigned resident, get permission to work with them, and develop rapport; prepare for termination</td>
<td>Medication summaries in SimChart for all meds actually given during shift</td>
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<tr>
<td>Provide personal care</td>
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<tr>
<td>Administer medications as assigned</td>
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<tr>
<td>Complete treatments as assigned</td>
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<tr>
<td>Complete “Admission Assessment: Comprehensive Holistic Assessment Tool” (CHAT)</td>
<td>CHAT</td>
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<tr>
<td>Complete “Katz Index of Activities of Daily Living”</td>
<td>Katz</td>
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<td>Begin “Life History” questions</td>
<td>Discuss in post-conference</td>
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## Community Resident

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<tr>
<th>Nursing Care</th>
<th>Assignments to be Submitted</th>
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<tbody>
<tr>
<td>Read entire Week One Packet: Focus is on Communication and Growth &amp; Development</td>
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<tr>
<td>Select and meet community resident, explain assignment/schedule to them, and develop rapport; prepare for termination</td>
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<tr>
<td>Complete “Instrumental Activities of Daily Living” (IADL)</td>
<td>IADL</td>
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<tr>
<td>Complete “Functional Status Questionnaire” (FSQ) *Only ask questions; complete final scoring at home – requires quiet/quality time to score accurately</td>
<td>FSQ</td>
</tr>
<tr>
<td>Begin “Life History” questions</td>
<td>Take notes; to be discussed in post-conference week 3</td>
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<tr>
<td>Complete Summary of Visit Forms</td>
<td>Summary of Visit Forms</td>
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Admission Assessment: Comprehensive Holistic Assessment Tool (CHAT)

Client Initials: _______  DOB: _______  Age: _______  Wt: ___________
Diagnosis: ________________________________________________________________

**attach daily assessment
Patient Admission Information:

I. PERCEPTUAL/SENSORY/COGNITION

Communicating: pattern involving sending messages
Name preferred: __________________________________________ Sex: ______ Age: ______
Date: ___________________________________________________________
Informant: Patient    Parent    Spouse    Other _______________ Admitted from: Home   ED   OR
Other ___________________________________________________________
At time of interview patient is: alert  appropriate  relaxed  agitated  anxious  tearful  sleepy  other _____
Primary language: __________________________________________ Interpreter needed: _____________

Relating: pattern involving established bonds
Role: marital status, children, parents, siblings: __________________________
Significant others/Primary caregiver: ______________________________________
Lives with: _____________________________________________________________
Recent changes in family:  No   if Yes, explain: _______________________________
History of physical/sexual/emotional abuse: _______  Do you feel safe at home?________
Are you in a relationship in which you or your child have been hurt or threatened?__________________
In the past year, has someone close to you hit, kicked, punched, slapped, or shoved you or your child?
________________________________________________________________________________
Occupation/Educational experience: __________________________________________
Patient/parent concern related to role responsibilities (school, work, financial, caregiver): __________
___________________________________________________________________________________
Socialization/support systems: _________________________________________________

Valuing: pattern involving spiritual growth
Religious preference: __________________________    Spiritual needs:______________________
Cultural preferences/needs: ________________________________________________________

Knowing: pattern involving the means associated with information
Medical History:
Chief complaint: _________________________________________________________________
_________________________________________________________________________________
Previous/Ongoing Health problems (symptoms, length of illness, treatment)____________________
___________________________________________________________________________________
Previous Hospitalizations/Surgery ________________________________________________________
___________________________________________________________________________________
Immunizations: Up to date

Infectious Disease Exposure: None  Chicken Pox  Rubella  Measles  Mumps  TB  Hepatitis

List all medications in use (prescription, OCT, herals) – see attached medication sheet

List all allergies (medications, food, environment and reaction)

<table>
<thead>
<tr>
<th>Medication/Food/Environment</th>
<th>Reaction</th>
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Risk factors: (smoking, family history, etc.): ____________________________________________________________

Substance use: Alcohol (type) ____________ drinks/day  Cigarettes: ____________ per day

Illicit drug use: ___________________________ Rx drug use: ___________________________

Perception/Knowledge of Health/Illness:

Readiness to learn (ready, willing, and able): __________________________________________________________

Comprehension: Ability to grasp concepts and respond to questions: HIGH  MEDIUM  LOW

Motivational Level: asks questions  eager to learn  anxious  uninterested  uncooperative  disinterested
denies need for education

Memory: No problem  Limited short term memory  Limited long term memory

Learning Barriers: None  Language  Cultural/Religious  Emotional  Hearing  Vision  Dexterity

Describe: _______________________________________________________________________________________

Feeling: pattern involving the subjective awareness of information

Comfort/Pain: (Is patient in pain? Chronic? Acute? What methods relieve pain, provide comfort?): _____

Emotional Integrity: (lonely, sad, depressed, angry, joy): __________________________________________________

Perceiving: pattern involving the reception of information:

Sensory Perception: (Able to receive information via all senses? Deficits noted?): ________________________

Visual: __________________ Contacts: __________________ Eyeglasses: __________________

Hearing: __________________ Earaches: __________________ Hearing Aids: __________________

Choosing: pattern involving the selection of alternatives

Coping/Stress Management Measures: _______________________________________________________________

Support systems: ________________________________________________________________________________
II. MOBILITY
Moving: pattern involving activity
See daily assessment for physical assessment component
Functional ability: (independent, if not specify deficits and needs): ________________________________
____________________________________________________________________________________
Assistive devices required: _______________________________________________________________
Orthopedic equipment: ________________________________________________________________
Physical Therapy: _________________________________________________________________
Age related hazards of mobility: __________________________________________________________
Fall Risk: ______________________________________________________
Recreation/Play: _______________________________________________________________________
Self care: _____________________________________________________________________________

III. OXYGENATION
See daily assessment for physical assessment component
Home nebulizer/O₂/CR monitor: _____________________________________________________________________

IV. CELLULAR INTEGRITY
See daily assessment for physical assessment component
Skin integrity risk factors: none  obesity incontinent urine/feces emaciated immobility prematurity altered LOC altered sensation breakdown present  Home treatment plan: _____________________________

V. REGULATION
Exchanging: pattern involving mutual giving and receiving
See daily assessment for physical assessment component
Recent weight loss or gain: _______________________________________________________________
Therapeutic diet: _______________________ Dietary restrictions: _____________________________
Suck quality: ___________ Loose teeth: ___________ Dentures: ___________ Problems: __________
Sleep patterns: __________________________
Sexually active: ________ Sexual preference: ________ Birth Control: ________ Problems: __________
LMP: ___________ Menarche (age): ______ Menopause (age): ________ BSE: _____________
Difficulties: __________________
Reproductive History: # of pregnancies: ______ # of births: ______ # of living children: ______#
Problems: ___________________________________________________________________________
Testes: ___________ TSE: ___________ Circumcised: ___________ Problems: _________________

Additional comments: ______________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Discharge Plan: __________________________________________________________________________
Katz Index of Activities of Daily Living

Abbreviations: I, independent; A, assistance; D, dependent

1. Bathing (sponge, shower, or tub):
   I: receives no assistance (gets in and out of tub if tub is the usual means of bathing)
   A: receives assistance in bathing only one part of the body (such as the back or a leg)
   D: receives assistance in bathing more than one part of the body (or not bathed)

2. Dressing:
   I: gets clothes and gets completely dressed without assistance
   A: gets clothes and gets dressed without assistance except in tying shoes
   D: receives assistance in getting clothes or in getting dressed or stays partly or completely undressed

3. Toileting:
   I: goes to “toilet room,” cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying it in the morning)
   A: receives assistance in going to “toilet room” or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode
   D: doesn’t go to room termed “toilet” for the elimination process

4. Transfer:
   I: moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)
   A: moves in and out of bed or chair with assistance
   D: doesn’t get out of bed

5. Continence:
   I: controls urination and bowel movement completely by self
   A: has occasional “accidents”
   D: supervision helps keep urine or bowel control; catheter is used, or is incontinent

6. Feeding:
   I: feeds self without assistance
   A: feeds self except for getting assistance in cutting meat or buttering bread
   D: receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids
Based upon the results of the client’s functional assessment, write the communications/directions that you would give the UAP who have not given care to this client previously.
STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
WEEK ONE

CHILDHOOD – GROWING UP:
1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
6. What did you used to do in the evening, before the days of radio and television?
7. What kinds of chores did you have to do as a child?
8. What social events and/or occasions did you look forward to?
9. What do you remember about going to school?
10. How did your family take care of you when you were ill?

YOUNG ADULTHOOD:
1. What was life like as a young adult who was dating? What kinds of things did you do on a date?
2. Who was the 1st president you voted for? Do you remember why you voted for him?
3. (If married) What do you remember best about your wedding ceremony or wedding day?
4. How many children?
5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
    A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

LATER ADULTHOOD:
1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you’ve ever received?
16. What is the most extravagant thing you’ve ever done?
17. What are you most proud of having done?
18. What is the most important rule you’ve lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven’t done yet?
21. Something amusing in life experiences?
22. Best advice for today’s youth?
OBJECTIVES FOR GERIATRIC CLIENTS IN INDEPENDENT SETTING

WEEK ONE
General Guidelines:
1. Follow an independent individual who is 65 years of age or older and living in the community.
2. Make three weekly visits lasting 60 minutes utilizing guidelines related to a specific area of focus.
3. Summarize each visit using the “Summary of Visit with Elder” form.
4. Contact faculty for problems that arise or whenever assistance is needed.

Week One
Topic: Communication

Objectives: Completing this clinical experience will enable the learner to:
1. Demonstrate therapeutic communication and interpersonal skills.
2. Recognize the value of attentive listening (since not all problems of the elderly can be alleviated).
3. Discuss special considerations for communicating with the elderly.
4. Evaluate his/her own communication patterns.
5. Share experience with clinical group at post conference.

Preparation Activities:
1. Review the following:
   1. Practical Pointers for Student
   2. Interview Format
   3. Caring Nursing Behaviors
   4. Caring Communication
   5. Life History Tool
   6. Summary of Visit with Elder Forms

Student Learning Experience:
1. Explain purpose, length, and duration of visits. Prepare for termination.
2. Ask individual for a verbal agreement to meet 6 times with you.
3. Practice therapeutic communication skills.
4. Begin life history interview.

Student Guides:
   Practical Pointers for Student
   Interview Format
   Caring Nursing Behaviors
   Caring Communication
   Life History Tool
   Summary of Visit with Elder Forms

Discussion Guidelines for use in summary following first interview:
1. Discuss impressions, general reactions and feelings to your first visit.
2. Identify at least one communication barrier.
3. Identify at least one therapeutic communication skill utilized.
4. Describe your perspective of client’s response to interview.
5. Identify the practical pointers you utilized when communicating with your client.
STUDENT GUIDELINES FOR INTERVIEWS

Introduce self and purpose of the interview.

Obtain permission from individual to be interviewed.

Be aware of yourself and the interviewee:
- Gestures
- Posture
- Voice tone and rate of speech
- Distance between you and interviewee
- Hearing deficit
- Vision deficit.

1. Questions concerning what, how, when, and where sustain the interview; those asking “why” may be difficult to answer.

2. Questions requiring a “yes” or “no” answer may inhibit flow of conversation, e.g., “Are you satisfied with your health care? Instead you might ask, What has your health care been like?”

3. Avoid judgment, e.g., “That is good” or “That is bad.” Rather, Did you feel that was O.K. (or) not O.K.?

4. When you feel it is time to bring closure to the interview, state “I have only a few more minutes, is there anything else you would like to talk about?”

5. Always give feedback about what you have learned in the interview and ask in what way the interview has been useful or helpful to the interviewee.

6. Thank the person for sharing their time and their views.

7. Set up a specific time for the next interview and inform them of the focus of the next interview.

8. Do not share addresses or phone numbers or go to the home of a stranger.

9. If the person is willing ask them to sign a contract (in syllabus) for the next nine interviews. If they seem reluctant explain that it is for their protection but they have a right not to sign. It will be necessary in that case to explain that you are not capable at this time of giving advice related to health but if they have a specific problem you will find a resource for them.

10. Summarize the interview according to guidelines on “Summary of Visit with Elder” form.

11. In the event an immediate problem is encountered with the interviewee contact your lab instructor as soon as possible for assistance.
1. Always assess the elder’s visual and hearing abilities and arrange with direct eye contact your sitting/distance, 12 inches to 2 feet, so that you are most comfortable and the outcome is successful.

2. Because the elderly person has decreasing energies to cope with the tasks of everyday living, the visitor may have to invest proportionately more energy into the visit.

3. The visitor needs to pace the visit according to the elderly person’s fluctuating energy levels and physical conditions.

4. The use of appropriate touch can be a meaningful communication bridge.

5. Avoid information overload by: speaking slowly; using short sentences; dealing with one thought at a time; and asking for feedback to be certain meaningful communication has taken place. The elderly person needs 15% more time to respond.

6. Enhance the aged feelings of self-esteem by both encouraging his maximum participation and acknowledge his role of being an authority on aging. He is the product of his total life experiences and he is the only one who knows what these experiences have been. His past plays a significant part in current functioning.

7. Importance of choices – express confidence in the person’s ability to make choices and follow through.

8. Motivation to participate in an activity will be increased if:
   A. an older person is intrigued by a task rather than perceiving it as “just busy work”;
   B. the role or activity conveys the message “you are important”;
   C. there is a possibility of forming meaningful relationships.

9. The use of reminiscence is an effective tool in linking relevant past events to present situation.

10. Some elderly do not have the strength to cope with the confusion of bureaucracies. So if necessary, be an advocate. Connect the elderly person with appropriate resources in the community.
LEARNING GUIDE
SENSORY/PERCEPTION/COGNITION
DO’S AND DON’TS OF THERAPEUTIC COMMUNICATIONS

DO’S

1. Be Honest!
2. Maintain Confidentiality!
3. Listen to what the client is saying and doing as though you were attending a concert – that is – note variations and themes or verbal messages, non-verbal gesture, and symbolic messages.
4. BE AWARE OF YOUR RESPONSE to what the client is “saying”; what is your “gut-level” feeling – empathy, sympathy, apathy, defensiveness, identification …? How are you behaving?
5. Use Broad opening statements: summarize at end of interview.
6. Use SILENCE – both you and the client need time to “process” and respond to each other’s messages.
7. GIVE FEEDBACK AND VALIDATE the client’s messages – DO NOT ASSUME!!!
8. Respond to feelings, reality and content.
9. Have a goal for every interaction.
10. Use “I” messages – i.e. “I don’t understand …”; “this is what I understand you to be saying..”; “I do not like to be screamed at …”.
11. Deal with Here and Now issues.

DON’TS

1. GIVE ADVICE – “I think you should ..?” (must, ought)
2. USE CLICHÉS – “Everything will be O.K. soon.”
3. COMPARE – the client with others – “Everybody who is depressed comes out of it sooner or later.”
4. ARGUE – or get involved in POWER struggles – “the facts are …”; “this is why you are wrong…”; “Don’t you realize …”.
5. USE WHY!
6. TRY TO BE A “FRIEND” – avoid superficial chatter.
7. FORCE the RELATIONSHIP; TIME is ESSENTIAL for developing TRUST, INTIMACY, and SELF DISCLOSURE.
LEARNING GUIDE:
SENSORY/PERCEPTION/COGNITION

COMMUNICATION SKILLS – UNHELPFUL RESPONSES TO BE AVOIDED

Patronizing responses: These make the client feel childish, as if the person is not taken seriously, as if you are humoring the person.

Giving advice or quick solutions: These make you seem cold and uncaring, as if you don’t understand.

Clichés, generalities or philosophical statement: These have the effect of wiping out the client’s feelings, trivializing them, and also send the message that you don’t want to be bothered.

Judgmental remarks: These seem to indicate your approval or disapproval. They indicate to the client who you are viewing the person’s feelings from your perspective, not the person’s.

Inadequate responses: These offer nothing and avoid the issue. They indicate that either your mind is elsewhere or you couldn’t care less.

Irrelevant responses: These avoid the client’s feelings and make you seem uncaring.

Condescending responses and put-downs: These include sarcasm, ridicule, inappropriate attempts at humor, scolding and authoritarian reminders. They indicate to the helper that you think the person is silly or selfish or wrong to feel as the person does.

Psychological interpretations: These are unjustified speculations about another’s personality or relationships and can be both insulting and harmful to the client.

Inappropriate self-sharing: These switch the focus to you and your experiences, leaving the client rejected and showing you as more interested in yourself.

Inaccurate empathy: This occurs when you misperceive the client’s feelings by a mile and are way off the beam in your understanding of his reasons for those feelings, or indicate that you are willing to listen or incapable of understanding.
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<tr>
<th>THERAPEUTIC TECHNIQUES</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td>1. Using Silence</td>
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<td>2. Accepting</td>
<td>Yes</td>
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<td></td>
<td>Uh hum</td>
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<td></td>
<td>I follow what you said</td>
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<td></td>
<td>Nodding</td>
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<tr>
<td>3. Giving Recognition</td>
<td>Good morning, Mrs. S.</td>
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<td>You’ve tooled a leather wallet.</td>
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<td>I noticed that you’ve combed your hair.</td>
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<td>4. Offering Self</td>
<td>I’ll sit with you awhile.</td>
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<td>I’ll stay here with you.</td>
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<td></td>
<td>I’m interested in your comfort.</td>
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<td>5. Giving Broad Openings</td>
<td>Is there something you’d like to talk about?</td>
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<td></td>
<td>What are you thinking about?</td>
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<td>Where would you like to begin?</td>
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<tr>
<td>6. Offering General Leads</td>
<td>Is there something you’d like to talk about?</td>
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<td></td>
<td>What are you thinking about?</td>
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<td>Where would you like to begin?</td>
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<tr>
<td>7. Placing the Event in Time or in</td>
<td>What seemed to lead up to …?</td>
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<td>Sequence</td>
<td>Was this before or after …?</td>
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<td>When did this happen?</td>
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<td>Are you uncomfortable when you …?</td>
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<td>I notice that you’re biting your lips.</td>
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<td>It makes me uncomfortable when you …</td>
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<td>9. Encouraging Description of</td>
<td>Tell me when you feel anxious.</td>
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<tr>
<td>Perceptions</td>
<td>What is happening?</td>
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<td>What does the voice seem to be saying?</td>
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<tr>
<td>10. Encouraging Comparison</td>
<td>Was this someone like …?</td>
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<td>Have you had similar experiences?</td>
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<td>11. Reflecting</td>
<td>Client: Do you think I should tell the doctor?</td>
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<td>Nurse: Do you think you should?</td>
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<td>Client: My brother spends all my money and then has the nerve to ask for</td>
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<td></td>
<td>more.</td>
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<td></td>
<td>Nurse: This causes you to feel angry.</td>
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<td>12. Exploring</td>
<td>Tell me more about that?</td>
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<td>Would you describe it more fully?</td>
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<td>What kind of work?</td>
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<tr>
<td>13. Giving Information</td>
<td>My name is …</td>
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<td></td>
<td>Visiting hours are …</td>
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<td></td>
<td>My purpose in being here is …</td>
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<td>I’m taking you to the …</td>
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<td>THERAPEUTIC TECHNIQUES</td>
<td>EXAMPLES</td>
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<tr>
<td>14. Seeking Clarification</td>
<td>I’m not sure that I follow. What would you say is the main point of what you said?</td>
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<td>15. Presenting Reality</td>
<td>I see no one else in the room. That sound was a car backfiring. Your mother is not here. I’m a nurse.</td>
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<td>17. Seeking Consensual Validation</td>
<td>Tell me whether my understanding of it agrees with yours. Are you using this word to convey the idea?</td>
</tr>
<tr>
<td>18. Verbalizing the Implied</td>
<td><strong>Client:</strong> I can’t talk to you or to anyone. It’s a waste of time. <strong>Nurse:</strong> It’s as if you’re feeling that no one understands. <strong>Client:</strong> My wife pushes me around just like my mother and sister did. <strong>Nurse:</strong> Is it your impression that women are domineering?</td>
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<td>19. Encouraging Evaluation</td>
<td>What are your feelings in regard to …? Does this contribute to your discomfort?</td>
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<tr>
<td>20. Attempting to Translate Feelings</td>
<td><strong>Client:</strong> I’m dead <strong>Nurse:</strong> Are you suggesting that you feel lifeless? Or: Is it that life seems without meaning? <strong>Client:</strong> I’m way out in the ocean. <strong>Nurse:</strong> It must be lonely. Or: You seem to feel deserted.</td>
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<tr>
<td>21. Suggesting Collaboration</td>
<td>Perhaps you and I can discuss and discover what produces your anxiety.</td>
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<tr>
<td>22. Summarizing</td>
<td>Have I got this straight? You’ve said that … During the past hour you and I have discussed …</td>
</tr>
<tr>
<td>23. Encouraging Formulation of a Plan of Action</td>
<td>What could you do to let your anger out harmlessly? Next time this comes up, what might you do to handle it?</td>
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</tbody>
</table>
SUMMARY OF VISIT WITH COMMUNITY RESIDENT: COMMUNICATION

WEEK ONE

Your name: __________________________________________ No. of Visits: __________________

Place of meeting: ______________________________________________________________________

Time: ________________________________________________________________________________

Elder’s age: __________________________________________ Sex: ____________________________

1. Describe impressions, general reactions, and feelings related to first visit.

2. Identify at least one communication barrier.

3. Identify at least one therapeutic communication skill utilized.

4. Describe your perspective of client’s response to interview.

5. Identify the practical pointers you utilized when communicating with your client.
STUDENT GUIDE FOR CLINICAL EXPERIENCE WITH A WELL ELDER

WEEK ONE

Topic: Growth and Development

Objectives: Completing this clinical experience will enable the learner to:

1. Identify development tasks of the aged adult.
2. Determine an elder’s developmental status after obtaining a life history.
3. Examine own attitudes about aging.
4. Share experience with clinical group in post conference.

Preparation Activities:

1. Review developmental tasks of the aged adult.
2. Determine from your elders’ life histories which developmental tasks of earlier stages were met or not met?

Student Learning Experience:

1. Continue life history interview utilizing therapeutic communication skills.
2. Discuss with your elder their perception of the life changes of an old age.
3. Note comments made by your elder that made you aware of their developmental issues.

Discussion Guidelines:

1. Discuss impressions, general reactions, and feelings about the second interview.
2. State which developmental tasks your client has met or not met.
3. Discuss possible reasons specific developmental tasks have not been met.
STUDENT GUIDE FOR ASSESSING THE AGED FAMILY DEVELOPMENTAL TASKS

WEEK ONE

The following developmental tasks are to be achieved by the aging couple as a family as well as by the aging person alone:

1. Decide where and how to live out the remaining years.

2. Continue a supportive, close, warm relationship with the spouse or significant other, including a satisfying sexual relationship.

3. Find a satisfactory home or living arrangement and establish a safe, comfortable household routine to fit health and economic status.

4. Adjust living standards to retirement income; supplemental retirement income if possible with remunerative activity.

5. Maintain maximum level of health; care of self physically and emotionally by getting regular health examinations and needed medical or dental care, eating an adequate diet, and maintaining personal hygiene.

6. Maintain contact with children, grandchildren, and other living relatives, finding emotional satisfaction with them.

7. Maintain interest in people outside the family, and in social, civic, and political responsibility.

8. Pursue new interests and maintain former activities in order to gain status, recognition, and a feeling of being needed.

9. Find meaning in life after retirement and in facing inevitable illness and death of oneself and spouse as well as other loved ones.

10. Work out a significant philosophy of life, finding comfort in a philosophy or religion.

11. Adjust to the death of spouse and other loved ones.
# INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

<table>
<thead>
<tr>
<th>IADL</th>
<th>INDEPENDENT</th>
<th>NEED HELP</th>
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<tbody>
<tr>
<td>1. <strong>TELEPHONE USE</strong></td>
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<tr>
<td>Two weeks prior to admission, did you need help using the telephone (e.g., looking up numbers or dialing)?</td>
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<td>2. <strong>SHOPPING FOR GROCERIES</strong></td>
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<td>Two weeks prior to admission, did you need help with shopping for groceries?</td>
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<td>3. <strong>TRANSPORTATION</strong></td>
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<td>Two weeks prior to admission, did you need help getting to places that required a car or public transportation (e.g., going to the grocery store, church)?</td>
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<td>4. <strong>MEAL PREPARATION</strong></td>
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<tr>
<td>Two weeks prior to admission, did you need help preparing your own meals?</td>
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<td></td>
</tr>
<tr>
<td>5. <strong>HOUSEWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two weeks prior to admission, did you need help doing your housework?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <strong>TAKING MEDICATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two weeks prior to admission, did you need help taking your medication (e.g., to take them at the correct time or to sort the pills)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <strong>HANDLING FINANCES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two weeks prior to admission, did you need help with your finances (e.g., handling money, paying bills, or balancing the checkbook)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FUNCTIONAL STATUS QUESTIONNAIRE

Overview
The Functional Status Questionnaire can be used as a self-administered functional assessment. It provides information on the patient’s physical, psychological, social and role functions. It can be used to screen initially for problems and to monitor the patient over time.

**Physical Function (Activities of Daily Living, or ADL)**

Basic ADL: During the past month have you had difficulty with
(1) Taking care of yourself, that is, eating, dressing or bathing?
(2) Moving in or out of a bed or chair?
(3) Walking indoors, such as around your home?

<table>
<thead>
<tr>
<th>Response</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually did with no difficulty</td>
<td>4</td>
</tr>
<tr>
<td>Some difficulty</td>
<td>3</td>
</tr>
<tr>
<td>Much difficulty</td>
<td>2</td>
</tr>
<tr>
<td>Usually did not do because of health</td>
<td>1</td>
</tr>
<tr>
<td>Usually did not do for other reason</td>
<td>0</td>
</tr>
</tbody>
</table>

Where:
- I will assume that “usually did not do for other reasons” is not a “valid” response, so that the \((\text{maximum response score}) – (\text{minimum response score})\) =3;

Intermediate ADL: During the past month have you had difficulty with
(1) Walking several blocks?
(2) Walking one block or climbing one flight of stairs?
(3) Doing work around the house, such as cleaning, light yard work, or home maintenance?
(4) Doing errands such as grocery shopping?
(5) Driving a car or using public transportation?
(6) Doing vigorous activities such as running, lifting heavy objects or participating in strenuous sports?

<table>
<thead>
<tr>
<th>Response</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually did with no difficulty</td>
<td>4</td>
</tr>
<tr>
<td>Some difficulty</td>
<td>3</td>
</tr>
<tr>
<td>Much difficulty</td>
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<tr>
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<td>1</td>
</tr>
<tr>
<td>Usually did not do for other reason</td>
<td>0</td>
</tr>
</tbody>
</table>

Where:
- I will assume that “usually did not do for other reasons” is not a “valid” response, so that the \((\text{maximum response score}) – (\text{minimum response score})\) =3;

**Psychological Function (Mental Health)**
During the past month,
(1) Have you been a very nervous person?
(2) Have you felt calm and peaceful?
(3) Have you felt downhearted and blue?
(4) Were you a happy person?
(5) Do you feel so down in the dumps that nothing could cheer you up?

<table>
<thead>
<tr>
<th>Response to 1, 3 and 5</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response to 2 and 4</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>6</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>4</td>
</tr>
<tr>
<td>Some of the time</td>
<td>3</td>
</tr>
<tr>
<td>A little of the time</td>
<td>2</td>
</tr>
<tr>
<td>None of the time</td>
<td>1</td>
</tr>
</tbody>
</table>

Where:
- \((\text{maximum response score}) - (\text{minimum response score})) = 5\)
  - The subgroups of questions are scored in reverse. Since Table 2 indicates that 0% is poor and 100% is good, I have scored as in the tables above.

**Social/Role Function**

If you were employed during the past month, how was your work performance?
(1) Done as much work as others in similar jobs?
(2) Worked for short periods of time or taken frequent rests because of your health?
(3) Worked your regular number of hours?
(4) Done your job as carefully and accurately as others with similar jobs?
(5) Worked at your usual job, but with some changes because of our health?
(6) Feared losing your job because of your health?

<table>
<thead>
<tr>
<th>Response to 2, 5 and 6</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>Some of the time</td>
<td>3</td>
</tr>
<tr>
<td>None of the time</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response to 1, 3 and 4</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>4</td>
</tr>
<tr>
<td>Most of the time</td>
<td>3</td>
</tr>
</tbody>
</table>
Social Activity: During the past month have you:
   (1) Had difficulty visiting with relatives or friends?
   (2) Had difficulty participating in community activities, such as religious services, social activities, or volunteer work?
   (3) Had difficulty taking care of other people such as family members?

<table>
<thead>
<tr>
<th>Response</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually did with no difficulty</td>
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<tr>
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</tr>
<tr>
<td>Usually did not do for other reasons</td>
<td>0</td>
</tr>
</tbody>
</table>

Where:
- I will assume that “usually did not do for other reasons” is not a “valid” response, so that the \((\text{maximum response score}) - (\text{minimum response score})\) = 3;

Quality of social interaction: During the past month, have you:
   (1) Isolated yourself from people around you?
   (2) Acted affectionate toward others?
   (3) Acted irritable toward those around you?
   (4) Made unreasonable demands on your family and friends?
   (5) Gotten along well with other people?

<table>
<thead>
<tr>
<th>Response to 1, 3 and 4</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
<td>1</td>
</tr>
<tr>
<td>Most of the time</td>
<td>2</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>3</td>
</tr>
<tr>
<td>Some of the time</td>
<td>4</td>
</tr>
<tr>
<td>A little of the time</td>
<td>5</td>
</tr>
<tr>
<td>None of the time</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response to 2 and 5</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the time</td>
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</tr>
<tr>
<td>Most of the time</td>
<td>5</td>
</tr>
<tr>
<td>A good bit of the time</td>
<td>4</td>
</tr>
<tr>
<td>Some of the time</td>
<td>3</td>
</tr>
<tr>
<td>------------------</td>
<td>---</td>
</tr>
<tr>
<td>A little of the time</td>
<td>2</td>
</tr>
<tr>
<td>None of the time</td>
<td>1</td>
</tr>
</tbody>
</table>

Where:
- \( (\text{maximum response score}) - (\text{minimum response score}) = 5 \)
- The subgroups of questions are scored in reverse. Since Table 2 indicates that 0% is poor and 100% is good, I have scored as in the tables above

**Single Item Questions**

(1) Which of the following statements describes your work situation during the past month?
- Working full-time
- Working part-time
- Unemployed looking for work
- Unemployed because of my health
- Retired because of my health
- Retired for some other reason

(2) During the past month, how many days did illness or injury keep you in bed all or most of the time:
- Responses: from 0 to 31 days

(3) During the past month, how many days did you cut down on the things you usually do for one-half day or more because of your illness or injury?
- Responses: from 0 to 31 days

(4) During the past month, how satisfied were you with your sexual relationships?
- Very satisfied
- Satisfied
- Not sure
- Dissatisfied
- Very dissatisfied
- Did not have any sexual relationships

(5) How do you feel about your health?
- Very satisfied
- Satisfied
- Not sure
- Dissatisfied
- Very dissatisfied

(6) During the past month, about how often did you get together with friends or relatives, such as going out together, visiting in each other’s home, or talking on the telephone?
- Every day
Several times a week
• About once a week
• 2 or 3 times a month
• About once a month
• Not at all

Scoring
Transformed scale score =
= (((SUM of response scores for each grouping)/(number of questions with valid information)) – 1) * (100/((maximum valid response score) – (minimum valid response score)))

Where:
• The equation used for the transformed scale score in the original article was corrected in an erratum.
• In the implementation I have made it so that there are no unanswered questions, while the original article allows for unanswered questions.

Interpretation
Based on the diagram in Table 2, the following are approximations were made from the length of the lines for the indicated warning zones.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Warning Zone</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic activities of daily living</td>
<td>0 – 87</td>
<td>88 – 100</td>
</tr>
<tr>
<td>Intermediate activities of daily living</td>
<td>0 – 77</td>
<td>78 – 100</td>
</tr>
<tr>
<td>Mental health</td>
<td>0 – 70</td>
<td>71 – 100</td>
</tr>
<tr>
<td>Work performance</td>
<td>0 – 78</td>
<td>79 – 100</td>
</tr>
<tr>
<td>Social activities</td>
<td>0 – 78</td>
<td>79 – 100</td>
</tr>
<tr>
<td>Quality of interactions</td>
<td>0 – 69</td>
<td>70 – 100</td>
</tr>
</tbody>
</table>

Note: work performance not shown in table, so made same was social activities.

If the person scores within the warning zone, then the patient has a problem that needs to be investigated more.

References:
SUMMARY OF VISIT WITH COMMUNITY RESIDENT: GROWTH AND DEVELOPMENT
Your name: ______________________________________________ No. of Visits: ______________

Place of meeting: _______________________________________________________________________________________

Time: __________________________________________________________________________________________________

Elder’s age: ___________________________________________ Sex: _________________________

1. Describe impressions, general reactions, and feelings related to second visit.

2. Explain which developmental tasks your client has met or not met (refer to “The Aged Family: Developmental Tasks”).

3. Describe possible reasons specific developmental tasks have not been met.

STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
WEEK ONE: COMMUNITY

CHILDHOOD – GROWING UP:
1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
6. What did you used to do in the evening, before the days of radio and television?
7. What kinds of chores did you have to do as a child?
8. What social events and/or occasions did you look forward to?
9. What do you remember about going to school?
10. How did your family take care of you when you were ill?

**YOUNG ADULTHOOD:**
1. What was life like as a young adult who was dating? What kinds of things did you do on a date?
2. Who was the 1st president you voted for? Do you remember why you voted for him?
3. (If married) What do you remember best about your wedding ceremony or wedding day?
4. How many children?
5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
   A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

**LATER ADULTHOOD:**
1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you’ve ever received?
16. What is the most extravagant thing you’ve ever done?
17. What are you most proud of having done?
18. What is the most important rule you’ve lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven’t done yet?
21. Something amusing in life experiences?
22. Best advice for today’s youth?

---

Student Name ______________________

Geriatriecs Clinical: Week Two Packet

Assignments Due: 8 am on ______________________
### Long-Term Care Resident

<table>
<thead>
<tr>
<th>Nursing Care</th>
<th>Assignments to be Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to work with resident and establish rapport; prepare for termination</td>
<td></td>
</tr>
<tr>
<td>Provide personal care</td>
<td></td>
</tr>
<tr>
<td>Complete “Daily Holistic Assessment Tool” (DHAT)</td>
<td>DHAT</td>
</tr>
<tr>
<td>Complete Nursing Care Plan in SimChart based on one physical or psychosocial need of the resident</td>
<td>Nursing Care Plan in SimChart</td>
</tr>
<tr>
<td>Administer medications as assigned</td>
<td>Medication summaries in SimChart for all meds actually given during shift</td>
</tr>
<tr>
<td>Complete treatments as assigned</td>
<td></td>
</tr>
<tr>
<td>Complete “Short Portable Mental Status Questionnaire” (SPMSQ)</td>
<td>SPMSQ</td>
</tr>
<tr>
<td>Continue “Life History” questions</td>
<td>Discuss in post-conference</td>
</tr>
</tbody>
</table>

### Community Resident

<table>
<thead>
<tr>
<th>Nursing Care</th>
<th>Assignments to be Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read entire Week Two Packet: Focus is on Safety and Nutrition</td>
<td></td>
</tr>
<tr>
<td>Continue to work with community resident and develop rapport; prepare for termination</td>
<td></td>
</tr>
<tr>
<td>Complete “Home Safety Assessment” with Gadgets List</td>
<td>Home Safety Assessment</td>
</tr>
<tr>
<td>Continue “Life History” questions</td>
<td>Take notes; to be discussed in post-conference week 3</td>
</tr>
<tr>
<td>Complete “Nutrition Screening Tool”</td>
<td>Nutrition Screening Tool</td>
</tr>
<tr>
<td>Complete “Determine Your Nutritional Health” Tool</td>
<td>Determine Your Nutritional Health Tool</td>
</tr>
<tr>
<td>Complete Summary of Visit Forms</td>
<td>Summary of Visit Forms</td>
</tr>
</tbody>
</table>

### DAILY HOLISTIC ASSESSMENT TOOL (DHAT)

Client Initials ________  Age ________  DOB __________  Gender ________  Date _______________

WT ________  HT ________  Admission Date: ________  Allergies: ____________________________

Admission Diagnosis/Current Diagnosis: ___________________________________________________
Secondary Diagnosis: ____________________________________________________________

Pathophysiology (textbook reference): ____________________________________________

<table>
<thead>
<tr>
<th>Initial Assessment</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital Signs</strong></td>
<td></td>
</tr>
<tr>
<td>T _________  P _________  RR _______  B/P _________</td>
<td></td>
</tr>
<tr>
<td><strong>Sensory/Perception/Cognition:</strong></td>
<td></td>
</tr>
<tr>
<td>LOC/visual or auditory deficits</td>
<td></td>
</tr>
<tr>
<td>IASample: awake □ alert □ oriented □ asleep □ confused □ obtunded □</td>
<td></td>
</tr>
<tr>
<td>□ none specify: __________________</td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td></td>
</tr>
<tr>
<td>□ appropriate □ depressed □ anxious □ angry □ euphoric □ labile □</td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td></td>
</tr>
<tr>
<td>□ cooperative □ uncooperative □ apprehensive □ agitated □ lethargic □</td>
<td></td>
</tr>
<tr>
<td>Speech/Primary language</td>
<td></td>
</tr>
<tr>
<td>□ clear □ appropriate □ inappropriate □ aphasia □ impaired hearing □</td>
<td></td>
</tr>
<tr>
<td>Primary language: ________________</td>
<td></td>
</tr>
<tr>
<td>Pupils</td>
<td></td>
</tr>
<tr>
<td>□ (L) _______mm □ brisk □ sluggish □ nonreactive □</td>
<td></td>
</tr>
<tr>
<td>□ (R) _______mm □ brisk □ sluggish □ nonreactive □</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>□ Score:_________ □ location:_________ □ description:___________________</td>
<td></td>
</tr>
<tr>
<td>□ Medicated Y* N □</td>
<td></td>
</tr>
<tr>
<td><strong>Growth &amp; Development</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(Erikson) Stage</strong></td>
<td></td>
</tr>
<tr>
<td>(Actual Stage) ____________________</td>
<td></td>
</tr>
<tr>
<td>AEB</td>
<td></td>
</tr>
<tr>
<td>□ None present □ R/T__________________________ □</td>
<td></td>
</tr>
<tr>
<td>□ *Alteration in S/P/C □</td>
<td></td>
</tr>
<tr>
<td><strong>Cellular Integrity:</strong></td>
<td></td>
</tr>
<tr>
<td>Skin temperature/moisture</td>
<td></td>
</tr>
<tr>
<td>□ warm □ cool □ cold □ dry □ moist □ diaphoretic □</td>
<td></td>
</tr>
<tr>
<td>Color/turgor</td>
<td></td>
</tr>
<tr>
<td>□ pink □ pale □ cyanotic □ mottled □ jaundiced □ elastic □ tenting □</td>
<td></td>
</tr>
<tr>
<td>Edema</td>
<td></td>
</tr>
<tr>
<td>□ none □ present □ location__________ □ pitting □ +1 □ +2 □ +3 □ +4 □</td>
<td></td>
</tr>
<tr>
<td>Edema</td>
<td></td>
</tr>
<tr>
<td>□ none □ present □ location__________ □ pitting □ +1 □ +2 □ +3 □ +4 □</td>
<td></td>
</tr>
<tr>
<td>Mucous membranes</td>
<td></td>
</tr>
<tr>
<td>□ pink □ pale □ moist □ dry □ lesions □</td>
<td></td>
</tr>
<tr>
<td>Rash/lesion/wound</td>
<td></td>
</tr>
<tr>
<td>□ none □ present □ site describe _________________ □ location____________</td>
<td></td>
</tr>
<tr>
<td>□ *Alteration in Skin Integrity □ none present □ R/T_____________________</td>
<td></td>
</tr>
<tr>
<td><strong>Oxygenation:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory: Effort</strong></td>
<td></td>
</tr>
<tr>
<td>□ unlabored □ dyspneic □ nasal flaring □ abdominal □ stridor □ grunting □ retraits □</td>
<td></td>
</tr>
<tr>
<td>□ Regular □ irregular □</td>
<td></td>
</tr>
</tbody>
</table>

| Lung sounds                        |       |
| □ RUL_____ □ RML_____ □ RLL_____ □ LUL_____ □ LLL_____ □ Clear □ Decreased □ Absent □ Rales □ Rhonchi □ Wheezes |
| O2 therapy/O2 saturation           |       |
| □ none □ O2 therapy _____ lpm □ % □ NC □ Mask □ Oxyhood □ saturation level_______ □ |
| Cough/Respiratory Treatments       |       |
| □ nonproductive □ productive___________ □ tx's □ ____________________________ |
**MCSPN Clinical Syllabus**

**2017**

<table>
<thead>
<tr>
<th><strong>Impaired Gas Exchange</strong></th>
<th>None present R/T ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular: Apical</strong></td>
<td>† regular † irregular † S1 † S2 † PMI † Murmur</td>
</tr>
<tr>
<td><strong>Extremities: Capillary refill/ Peripheral pulses</strong></td>
<td>&lt; &gt; ______ seconds</td>
</tr>
<tr>
<td></td>
<td>{0 – 3} R/L brachial ______ R/L radial ______ R/L dorsal pedalis ______</td>
</tr>
<tr>
<td></td>
<td>R/L posterior tibial ______ other ____________________________</td>
</tr>
<tr>
<td><strong>Monitors</strong></td>
<td>None specify: ___________________________ † O₂ saturation † cardiorespiratory</td>
</tr>
<tr>
<td></td>
<td>† other________________ † alarm parameters verified and on</td>
</tr>
<tr>
<td><strong>Alterations in tissue perfusion</strong></td>
<td>None present R/T ____________________</td>
</tr>
</tbody>
</table>

**Regulation:**

| **Abdomen/LBM** | † soft † firm † rigid † distended † round † flat † tenderness/LBM ____________________ |
| **Diet** | † continent † incontinent |
| **Bowel sounds** | RLQ__ RUQ__ LUQ__ LLQ__ + present absent ++hyperactive +/−hypactive |
| **NG/GT** | none specify ____________________________ |
| **Alteration in nutrition** | none present R/T ____________________ size __ † gravity † suction |
| **GU** | † no problems † foley † dysuria † hematuria † frequency † continent † incontinent LMP |
| **Intravenous Fluids** | † none specify/solution & rate ____________________________ |
| **Alteration in elimination** | † none For shift: total in ______ total out ______ † present R/T ______ |

**Mobility:**

| **Muscle tone/strength/ Range Of Motion** | † strength equal bilaterally UE and LE † weakness (specify) ____________________ |
| **Gait/fall risk** | † steady † unsteady † pre-ambulatory † paralysis/describe ____________________ |
| **Functional ability** | † independent † total assistance † requires assistance (explain) ____________________ |
| **Casts/Assistance devices** | none specify ____________________________ |
| **Alteration in Mobility** | none present R/T ____________________ |

| **for abnormal findings,** see additional notes |

**SN signature:**

---

**STATE AND PRIORITIZE 3 NURSING DIAGNOSES**

---

**NURSES NOTES:**
SPN Signature
THE SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE (SPMSQ)

1. What are the date, month, and year?

2. What is the day of the week?

3. What is the name of this place?

4. What is your phone number?

5. How old are you?

6. When were you born?

7. Who is the current president?

8. Who was the president before him?

9. What was your mother’s maiden name?

10. Can you count backward from 20 by 3’s?

SCORING:*

0-2 errors: normal mental functioning

3-4 errors: mild cognitive impairment

5-7 errors: moderate cognitive impairment

8 or more errors: severe cognitive impairment

*One more error is allowed in the scoring if a patient has had a grade school education or less.
*One less error is allowed if the patient has had education beyond the high school level.


Compiled by the Great Plains Area Chapter of the Alzheimer’s Association, 1999.
Short Portable Mental Status Questionnaire

Instructions: Ask questions 1-10 in this list and record all answers. Ask question 4A only if patient does not have a telephone. Record total number of errors based on ten questions.

1. What is the date today? ______________________________

2. What day of the week is it? ______________________________

3. What is the name of this place? ______________________________

4. What is your telephone number? ______________________________

4A. What is your street address? ______________________________

5. How old are you? ______________________________

6. When were you born? ______________________________

7. Who is the President of the U.S. now? ______________________________

8. Who was President just before him? ______________________________

9. What was your mother’s maiden name? ______________________________

10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down.

Total Number of Errors (0-2 is WNL)

To Be Completed by Interviewer

Patient’s Name: ______________________________  Date: _______________


STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
WEEK TWO

CHILDHOOD – GROWING UP:
1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
6. What did you used to do in the evening, before the days of radio and television?
7. What kinds of chores did you have to do as a child?
8. What social events and/or occasions did you look forward to?
9. What do you remember about going to school?
10. How did your family take care of you when you were ill?

YOUNG ADULTHOOD:
1. What was life like as a young adult who was dating? What kinds of things did you do on a date?
2. Who was the 1st president you voted for? Do you remember why you voted for him?
3. (If married) What do you remember best about your wedding ceremony or wedding day?
4. How many children?
5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
   A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

LATER ADULTHOOD:
1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you’ve ever received?
16. What is the most extravagant thing you’ve ever done?
17. What are you most proud of having done?
18. What is the most important rule you’ve lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven’t done yet?
21. Something amusing in life experiences?
22. Best advice for today’s youth?
STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER

WEEK TWO
Topic: Safety

Objectives: Completing this clinical experience will enable the learner to:
1. Identify potential environmental safety hazards;
2. Identify physical changes that increase the aged adult’s susceptibility to falls and trauma;
3. Conduct a home safety assessment; and
4. Intervene to reduce safety hazards in the aged adult’s environment.
5. List three (3) resources in the community, which provide equipment for the elderly.
7. Share resources with clinical group in a post conference.

Preparation Activities:
2. Discuss experiences in your own life that could have been prevented with adequate information and preventative actions.
3. Identify precipitants to accidents/trauma.

Student Learning Experiences:
1. Discuss any accidents the elder has experienced.
2. Assist elder in making a home safety evaluation by using the home safety assessment tool.
3. Assist the elder in identifying safety measure related to any danger.
4. Recommend home modifications and/or refer to community resources as appropriate.

Student Guides:
Home Safety Assessment Tool
Helpful Household Gadgets
Community Resources List (self-developed)

Discussion Guidelines:
1. Discuss impressions and general reactions.
2. Identify a safety hazard discovered in your elder’s home.
3. Discuss interventions (including modifications and community resources).
HOME SAFETY ASSESSMENT

WEEK TWO
Throughout the interior of the home there are several common features, which should be carefully checked for safety. For example:

- Are scatter rugs firmly anchored with rubber backing? __________ Yes  __________ No
- Are electrical cords in good repair, especially a heating pad? __________ Yes  __________ No

Light, heat and ventilation:
- Is there adequate night lighting? __________ Yes  __________ No
- Are stairways continually lighted? __________ Yes  __________ No
- Is temperature within a comfortable range? __________ Yes  __________ No
- Is the heater adequately ventilated? __________ Yes  __________ No
- Is there cross ventilation? __________ Yes  __________ No
- Is furniture sturdy enough to give support? __________ Yes  __________ No
- Is there a minimum of clutter allowing room for easy mobility as well as a fire hazard? __________ Yes  __________ No
- Are smoke detectors present (at least one on each level of home)? __________ Yes  __________ No
- Are emergency telephone numbers posted in a handy place to read? (ambulance, doctor, fire department, nearest relative, 911) __________ Yes  __________ No
- If you are alone for a period of time do you have someone who checks on you? __________ Yes  __________ No
- If you have limited vision, does phone have enlarged dial? __________ Yes  __________ No
- If you have impaired hearing, does phone have amplified receiver? __________ Yes  __________ No
- If you have small pets do they ever get in your way, causing you to trip or fall? __________ Yes  __________ No

The kitchen can be evaluated for the following:

- Is the stove free of grease and clear of flammable objects? __________ Yes  __________ No
- Is baking soda available in case of grease fire? __________ Yes  __________ No
- Are matches safely stored if there is not a pilot light on stove? __________ Yes  __________ No
- Is the refrigerator working properly? __________ Yes  __________ No
- Is the sink draining well? __________ Yes  __________ No
- Is food being stored properly? __________ Yes  __________ No
- Is trash taken out daily? __________ Yes  __________ No
- Is there a sturdy step stool available? __________ Yes  __________ No
- Are there skid proof mats on the floor? __________ Yes  __________ No

In the bathroom are the following safety features observed:

- If needed, are handrails beside the tub and toilet? __________ Yes  __________ No
- Are skid-proof mats in the bathtub and/or shower? __________ Yes  __________ No
- Are electrical outlets and appliances a safe distance from the bathtub? __________ Yes  __________ No
Outside the home the following points should be considered:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**Walks and stairs:**
- Are there raised or uneven places on the sidewalks?  
- Are stairs in good repair?  
- Are the bottom and top stairs painted white or a bright color to improve visibility?  
- Are handrails securely fastened?  
- Are screens on doors and windows in good repair?  
- Is there an alternate exit from the house?  
- Is there an alarm system or burglar proofing?
# HELPFUL HOUSEHOLD GADGETS

## WEEK TWO

<table>
<thead>
<tr>
<th>ITEM</th>
<th>WHERE TO BUY (Code #)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Bathroom</strong></td>
<td></td>
</tr>
<tr>
<td>Bath sponge</td>
<td>1, 5</td>
</tr>
<tr>
<td>Grab bar to fit outside wall of tub (temporary)</td>
<td>5</td>
</tr>
<tr>
<td>Grab bar straight (permanent)</td>
<td>2</td>
</tr>
<tr>
<td>Hose clamps</td>
<td>3</td>
</tr>
<tr>
<td>Long handled bath sponge</td>
<td>1, 2, 3, 8</td>
</tr>
<tr>
<td>Non-slip plastic tub decals</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Plastic tub mat with suction cups</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Raised toilet seat</td>
<td>5</td>
</tr>
<tr>
<td>Rubber soap holder with suction cups</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Shower hose extension</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Toilet guard rails</td>
<td>5</td>
</tr>
<tr>
<td>Tub stools</td>
<td>5</td>
</tr>
<tr>
<td>Tub transfer seats</td>
<td>5</td>
</tr>
<tr>
<td><strong>B. Kitchen</strong></td>
<td></td>
</tr>
<tr>
<td>Jar opener</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Kitchen stool</td>
<td>1, 3, 5</td>
</tr>
<tr>
<td>Metal tongs</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Rubber jar grip</td>
<td>1, 2, 3, 5, 8</td>
</tr>
<tr>
<td>Rubbermaid pullout shelves, lazy susans, canisters, etc.</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Wheeled cart</td>
<td>5</td>
</tr>
<tr>
<td>Wheeled glider chair</td>
<td>5</td>
</tr>
<tr>
<td><strong>C. Furniture</strong></td>
<td></td>
</tr>
<tr>
<td>*Chair and bed risers</td>
<td></td>
</tr>
<tr>
<td>*Easy life chairs</td>
<td></td>
</tr>
<tr>
<td>Pronged, plastic furniture coasters</td>
<td>1, 3, 5</td>
</tr>
<tr>
<td>*Stair glider</td>
<td></td>
</tr>
<tr>
<td>Two-sided stick carpet tape</td>
<td>1, 3</td>
</tr>
<tr>
<td><strong>D. Dressing Aids</strong></td>
<td></td>
</tr>
<tr>
<td>Buttoner</td>
<td>1, 5</td>
</tr>
<tr>
<td>Elastic shoe laces</td>
<td>4</td>
</tr>
<tr>
<td>Velcro</td>
<td>4</td>
</tr>
<tr>
<td><strong>E. Communication Aids</strong></td>
<td></td>
</tr>
<tr>
<td>Enlarged telephone dial</td>
<td>6</td>
</tr>
<tr>
<td>Raised line checkbook</td>
<td>10</td>
</tr>
<tr>
<td>Telephone amplifier</td>
<td>9</td>
</tr>
</tbody>
</table>
F. Pastime and Hobby Aids

<table>
<thead>
<tr>
<th>Item</th>
<th>Location(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bar magnifying glass</td>
<td>6</td>
</tr>
<tr>
<td>Easy thread needles</td>
<td>1, 4</td>
</tr>
<tr>
<td>Large print books</td>
<td>11, 12</td>
</tr>
<tr>
<td>Needle threader</td>
<td>1, 4</td>
</tr>
<tr>
<td>Pocket magnifying glass</td>
<td>1, 5</td>
</tr>
<tr>
<td>Talking books</td>
<td>11, 12</td>
</tr>
</tbody>
</table>

G. Miscellaneous

<table>
<thead>
<tr>
<th>Item</th>
<th>Location(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colored cloth tape (for marking)</td>
<td>1, 2, 3, 5</td>
</tr>
<tr>
<td>Fluorescent safety tape</td>
<td>1, 3, 5</td>
</tr>
<tr>
<td>Long handled dust pan</td>
<td>1, 3</td>
</tr>
<tr>
<td>Magnet on a pole (for reaching)</td>
<td>1, 3</td>
</tr>
<tr>
<td>Self-sticking dots and numbers (for marking)</td>
<td>1, 6</td>
</tr>
<tr>
<td>Velcro colors</td>
<td>1, 2</td>
</tr>
<tr>
<td>Wide angle car mirrors</td>
<td></td>
</tr>
</tbody>
</table>

WHERE TO BUY

Local

1. Discount department stores
   (i.e., K-Mart, Wal-Mart, Target, Sears, J.C.Penney’s)
2. Drug stores
3. Hardware stores
4. Fabric stores
5. Large department stores
6. Office supply
7. Bookstores
8. Grocery stores
9. Local phone company
10. Banks
11. County library services for the blind
12. Libraries
SUMMARY OF VISIT WITH COMMUNITY RESIDENT: SAFETY

WEEK TWO

Your Name: __________________________________________ No. of Visits: _________________

Place of meeting: ______________________________________________________________________

Time: ________________________________________________________________________________

Elder’s age: __________________________________________ Sex: __________________________

1. List any accidents the elder has experienced.

2. Describe the potential environmental safety hazards you identified during the safety assessment.

3. Explain how the elder’s safety needs are being met (or unmet) in relationship to Maslow’s hierarchy.

4. Describe any physical changes the elder has that increase his susceptibility to falls.

5. Explain any safety measures you taught or recommended to the elder.
STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
WEEK TWO: COMMUNITY

CHILDHOOD – GROWING UP:
1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
6. What did you used to do in the evening, before the days of radio and television?
7. What kinds of chores did you have to do as a child?
8. What social events and/or occasions did you look forward to?
9. What do you remember about going to school?
10. How did your family take care of you when you were ill?

YOUNG ADULTHOOD:
1. What was life like as a young adult who was dating? What kinds of things did you do on a date?
2. Who was the 1st president you voted for? Do you remember why you voted for him?
3. (If married) What do you remember best about your wedding ceremony or wedding day?
4. How many children?
5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
   A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

LATER ADULTHOOD:
1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you’ve ever received?
16. What is the most extravagant thing you’ve ever done?
17. What are you most proud of having done?
18. What is the most important rule you’ve lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven’t done yet?
21. Something amusing in life experiences?
22. Best advice for today’s youth?
STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER

WEEK TWO

Topic: Nutrition

Objective: Completing this clinical experience will enable the learner to:
1. Discuss physical changes related to nutritional status in the elderly.
2. Identify factors that may place aged individuals at risk for malnutrition.
3. Conduct a baseline nutrition screening.
4. Discuss intervention for achieving and/or maintaining an adequate nutritional status in the elderly.
5. List 3 resources in Mineral County that provide nutritional services to the elderly.

Preparation Activities:
1. Review physical changes affecting nutrition in the elderly. (Text & Learning Guide)
2. Discuss sociological factors affecting nutrition in the elderly.
3. Review intervention strategies and community resources.
4. Review Nutrition Screening Tool.
5. Record the past 24-hour diet intake of the elder.
6. Discuss preparation for termination visit.

Student Learning Experience:
1. Assess nutritional status of the elder using the nutrition-screening tool.
2. Identify potential or actual nutrition problems.
3. Discuss basic food groups with elder.
4. Provide information about community resources if appropriate.
5. Prepare for termination by reminding the elder this is final visit.
6. Tell the elder how you benefited from the experience.

Student Guides:
- Nutritional Screening Tool
- Community Resources

Discussion Guidelines:
1. Discuss impressions and general reactions.
2. Identify one actual or potential nutrition problem of the elder.
3. Name one intervention you utilized.
4. What specific factors (physical and/or sociological) affect the elder’s nutrition?
5. Share insights and what you have learned as a result of the “Well Elder” experience.
NUTRITION SCREENING TOOL

WEEK TWO

Height: ______  Weight:______  Ideal Body Weight:_________  Weight 6 mo. Ago: ____________

How many teeth: _______________  Status: _________________________

Date last dental exam: __________  Dentures: ________  Partial: _________  Complete:___________

Chewing problems: What makes it better?  What makes it worse?

Swallowing problems:

Appetite:

Use of Vitamins/Mineral Supp.:

Use of Laxatives:

Use of Alcohol:

Does individual have any health problems that affect his/her ability to eat or drink?

Does individual have any problems that affect his/her ability to prepare food?

How does individual get to the store to buy groceries?

(Identify problems with transportation, mobility, ability to carry grocery bags, etc.)

Does individual have access to:

running water  yes ____  no ____
refrigeration  yes ____  no ____
cooking facilities  yes ____  no ____

24-Hour Diet Recall

“I would like you to tell me everything you ate and drank from the time you got up in the morning until you went to bed at night and what you ate during the night. Include snacks and drinks of all kinds.”

(Record amount and type of food or drink and time taken.)

Was the 24-hour nutritional intake nutritionally sound?

Yes ______  No ______

What changes would you recommend?
COMMUNITY RESOURCES FOR NUTRITIONAL SUPPORT

WEEK TWO

Resource List:
The warning signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Circle the number in the yes column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

<table>
<thead>
<tr>
<th>Statement</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have an illness or condition that made me change the kind and/or amount of food I eat.</td>
<td>2</td>
</tr>
<tr>
<td>I eat fewer than 2 meals per day.</td>
<td>3</td>
</tr>
<tr>
<td>I eat few fruits or vegetables, or milk products.</td>
<td>2</td>
</tr>
<tr>
<td>I have 3 or more drinks of beer, liquor or wine almost every day.</td>
<td>2</td>
</tr>
<tr>
<td>I have tooth or mouth problems that make it hard for me to eat.</td>
<td>2</td>
</tr>
<tr>
<td>I don’t always have enough money to buy the food I need.</td>
<td>4</td>
</tr>
<tr>
<td>I eat alone most of the time.</td>
<td>1</td>
</tr>
<tr>
<td>I take 3 or more different prescribed or over-the-counter drugs a day.</td>
<td>1</td>
</tr>
<tr>
<td>Without wanting to, I have lost or gained 10 pounds in the last 6 months.</td>
<td>1</td>
</tr>
<tr>
<td>I am not always physically able to shop, cook and/or feed myself.</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

Total Your Nutritional Score. If it’s –

**0-2** Good! Recheck your nutritional score in 6 months.

**3-5** You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

**6 or more** You are at high nutritional risk. Brink This checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problem you may have. Ask for help to improve your nutritional health.

These materials developed and distributed by the Nutritional Screening Initiative, a project of:

- AMERICAN ACADEMY OF FAMILY PHYSICIANS
- THE AMERICAN DIETETIC ASSOCIATION
- NATIONAL COUNCIL ON THE AGING, INC.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition. Turn the page to learn more about the Warning Signs of poor nutritional health.

The Nutritional Checklist is based on Warning Signs described below.

Use the word DETERMINE to remind you of the Warning Signs.
DISEASE
Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you’ve eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY
Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/MOUTH PAIN
A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don’t fit well or cause mouth sores make it hard to eat.

ECONOMIC HARDSHIP
As many as 40% of older Americans have incomes of less than $6,000 per year. Having less—or choosing to spend less—than $2530 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT
One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES
Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

INVolUNTARY WEIGHT LOSS/GAIN
Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE
Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80
Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

Nutritional Interventions: CLINICAL CONSIDERATIONS
<table>
<thead>
<tr>
<th>ROUTE</th>
<th>PATIENT CHARACTERISTICS</th>
<th>NUTRITIONAL CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Alert, normal swallowing mechanics, or normally nourished or mildly malnourished.</td>
<td>Monitor hydration and calories: optimal levels determined by nutritional assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Calorie-dense foods.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider nutritional supplements between meals.</td>
</tr>
<tr>
<td>Intravenous fluids</td>
<td>Acutely ill, impaired swallowing, decreased oral fluid intake, dehydration. Ability to eat anticipated in &lt;48 hours.</td>
<td>Glucose solutions with electrolytes. Sole source of nutrition limited to &lt;48 hours.</td>
</tr>
<tr>
<td>Enteral</td>
<td>Oropharyngeal dysphagia, unsafe to eat (e.g., delirium), severely malnourished; capacity for oral feeding expected to return within days to two weeks; cyclic use needed to augment oral nutrition</td>
<td>Nasoenteric tube feeding (continuous or intermittent) with lactose-free solutions; either balanced-protein or high protein solutions. Cyclic or continuous infusions. Nasogastric tube not recommended.</td>
</tr>
<tr>
<td>Peripheral Parenteral Nutrition</td>
<td>Oral and nasoenteric routes are temporarily (e.g., ≤2 weeks) contraindicated (e.g., small bowel obstruction, acute pancreatitis).</td>
<td>Peripheral intravenous (large bore catheter) infusion with isotonic glucose-electrolyte-lipid solution. Limited capacity to deliver high-calorie nutrition. Observe for hypertriglyceridemia.</td>
</tr>
<tr>
<td>Total Parenteral Nutrition</td>
<td>Severely malnourished; enteral route contraindicated (e.g., bowel obstruction, short bowel); hypermetabolic state (e.g., sepsis while enteral route delivery is not sufficient.</td>
<td>Central intravenous (e.g., subclavian vein) catheter (large bore). Infusion of high-calorie, hypertonic and balanced infusions (protein, amino acid, carbohydrate) is achievable.</td>
</tr>
<tr>
<td>Percutaneous Endoscopic Gastrostomy</td>
<td>Severely malnourished; oropharyngeal dysphagia unlikely to resolve soon; oral feeding contraindicated (e.g., stroke); enteral nutrition required for two or more weeks or indefinitely.</td>
<td>Superior to nasoenteric tubes for administering medications (e.g., tablets). No evidence of benefit for severely demented patients.</td>
</tr>
</tbody>
</table>


**SUMMARY OF VISIT WITH COMMUNITY RESIDENT: NUTRITION**

**WEEK TWO**

Your Name: ___________________________ No. of Visits: __________________

Place of meeting: ____________________________________________

Time: ____________________________________________
Elder’s age: __________________________________________ Sex: __________________________

1. Describe specific factors (physical and/or sociological) that affect the elder’s nutrition.

2. Describe at least one actual or potential nutritional problem of the elder.

3. Explain one way you prepared the elder for closure of the experience.

4. What has been most valuable for you in this overall experience?

Student Name __________________________

Geriatrics Clinical: Week Three Packet
Assignments Due: 8 am on
### Long-Term Care Resident

<table>
<thead>
<tr>
<th>Nursing Care</th>
<th>Assignments to be Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to work with resident and establish rapport; prepare for termination and actually terminate</td>
<td></td>
</tr>
<tr>
<td>Provide personal care</td>
<td></td>
</tr>
<tr>
<td>Administer medications as assigned</td>
<td>Medication summaries in SimChart for all meds actually given during shift</td>
</tr>
<tr>
<td>Complete treatments as assigned</td>
<td></td>
</tr>
<tr>
<td>Complete “Braden Scale for Predicting Pressure Sore Risk”</td>
<td>Braden Scale</td>
</tr>
<tr>
<td>Complete “Blaylock Discharge Planning Risk Assessment Screen”</td>
<td>Blaylock and brief written discharge plan based on the total score</td>
</tr>
<tr>
<td>Finish “Life History” questions</td>
<td>Finish discussion in post-conference</td>
</tr>
</tbody>
</table>

### Community Resident

<table>
<thead>
<tr>
<th>Nursing Care</th>
<th>Assignments to be Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read entire Week Three Packet: Focus is on Grief/Loss/Coping and Assessment</td>
<td></td>
</tr>
<tr>
<td>Continue to work with community resident and develop rapport; prepare for termination and actually terminate</td>
<td></td>
</tr>
<tr>
<td>Complete “Grief/Loss/Coping Tool”</td>
<td>Grief/Loss/Coping Tool</td>
</tr>
<tr>
<td>Finish “Life History” questions</td>
<td>Give summary of your community resident’s life in post-conference</td>
</tr>
<tr>
<td>Complete Nursing Assessment in SimChart</td>
<td>Nursing Assessment in SimChart</td>
</tr>
<tr>
<td>Complete Teaching Care Plan Sheet</td>
<td>Teaching Care Plan</td>
</tr>
<tr>
<td>Complete Nursing Care Plan in SimChart based on one physical or psychosocial need of the resident</td>
<td>Nursing Care Plan in SimChart</td>
</tr>
<tr>
<td>Complete Summary of Visit Forms</td>
<td>Summary of Visit Forms</td>
</tr>
</tbody>
</table>
# BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

<table>
<thead>
<tr>
<th>SENSORY PERCEPTION</th>
<th>Ability to respond meaningfully to pressure-related discomfort</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely Limited</td>
<td>Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR Limited ability to feel pain over most of body</td>
</tr>
<tr>
<td>2. Very Limited</td>
<td>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.</td>
</tr>
<tr>
<td>3. Slightly Limited</td>
<td>Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities</td>
</tr>
<tr>
<td>4. No Impairment</td>
<td>Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOISTURE</th>
<th>Degree to which skin is exposed to moisture</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Constantly Moist</td>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.</td>
</tr>
<tr>
<td>2. Very Moist</td>
<td>Skin is often, but not always moist. Linen must be changed at least once a shift.</td>
</tr>
<tr>
<td>3. Occasionally Moist</td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once a day.</td>
</tr>
<tr>
<td>4. Rarely Moist</td>
<td>Skin is usually dry, linen only requires changing at routine intervals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>Degree of physical activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bedfast</td>
<td>Confined to bed.</td>
</tr>
<tr>
<td>2. Chairfast</td>
<td>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</td>
</tr>
<tr>
<td>3. Walks Occasionally</td>
<td>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair</td>
</tr>
<tr>
<td>4. Walks Frequently</td>
<td>Walks outside room at least twice a day and inside room at least once every two hours during waking hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOBILITY</th>
<th>Ability to change and control body position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Completely Immobile</td>
<td>Does not make even slight changes in body or extremity position without assistance</td>
</tr>
<tr>
<td>2. Very Limited</td>
<td>Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.</td>
</tr>
<tr>
<td>3. Slightly Limited</td>
<td>Makes frequent though slight changes in body or extremity position independently.</td>
</tr>
<tr>
<td>4. No Limitation</td>
<td>Makes major and frequent changes in position without assistance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUTRITION</th>
<th>Usual food intake pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Very Poor</td>
<td>Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IV’s for more than 5 days.</td>
</tr>
<tr>
<td>2. Probably Inadequate</td>
<td>Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR Receives less than optimum amount of liquid diet or tube feeding</td>
</tr>
<tr>
<td>3. Adequate</td>
<td>Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy) products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FRICTION &amp; SHEAR</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problem</td>
<td>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction</td>
</tr>
<tr>
<td>2. Potential Problem</td>
<td>Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.</td>
</tr>
<tr>
<td>3. No Apparent Problem</td>
<td>Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.</td>
</tr>
</tbody>
</table>

| Total Score | |
Analysis of Braden Scale Assessments

Based upon the Braden Scale assessments you have performed on the assigned client:

1. Evaluate your client’s risk for skin breakdown.

2. Make recommendations to maintain the client’s skin integrity or, if necessary, list recommendations to restore the integrity of the client’s skin.
Blaylock Discharge Planning Risk Assessment Screen

A. Points

Indicate the numbers of points that apply to the resident in each category

____Age

0 = 55 Years or less
1 = 56 to 64 years
2 = 65 to 79 years
3 = 80 + years

____Behavior Pattern

0 = Appropriate
1 = Wandering
1 = Agitated
1 = Confused
1 = Other

____Living Situation/Social Support

0 = Lives only with Spouse
1 = Lives with Family
2 = Lives alone with family support
3 = Lives alone with friends’ support
4 = Lives alone with no support
5 = Nursing home/residential care

____Mobility

0 = Ambulatory
1 = Ambulatory w/mechanical assistance
2 = Ambulatory w/human assistance
3 = Nonambulatory

____Functional Status

0 = Independent in activities of daily living and instrumental activities of daily living
Dependent in:
1 = Eating/Feeding
1 = Bathing/grooming
1 = Toiletting
1 = Transferring
1 = Incontinent of bowel function
1 = Incontinent of bladder function
1 = Meal Preparation
1 = Responsible for own medication administration
1 = Handling own finances
1 = Grocery shopping
1 = Transportation

____Sensory Deficits

0 = None
1 = Visual or hearing deficits
2 = Visual and hearing deficits

____Number of Previous Admissions/

Emergency Room Visits

0 = None in the last 3 months
1 = One in the last 3 months
2 = Two in the last 3 months
3 = More than two in the last 3 months

____Number of Active Medical Problems

0 = Three medical problems
1 = Three to five medical problems
2 = More than five medical problems

____Number of Drugs

0 = Fewer than three drugs
1 = Three to five drugs
2 = More than five drugs

Total Score: ____________________________

*Risk Factor Index: Score of 10 = at risk for home care resources; score of 11 to 19 = at risk for extended discharge planning/score greater than 20 = at risk for placement other than home for patient’s score is 10 or greater, refer the patient to the discharge planning coordinator or discharge planning team.

Spheres = person
B. Explain the discharge planning this resident would require based on total score.
STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
WEEK THREE

CHILDHOOD – GROWING UP:
1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
6. What did you used to do in the evening, before the days of radio and television?
7. What kinds of chores did you have to do as a child?
8. What social events and/or occasions did you look forward to?
9. What do you remember about going to school?
10. How did your family take care of you when you were ill?

YOUNG ADULTHOOD:
1. What was life like as a young adult who was dating? What kinds of things did you do on a date?
2. Who was the 1st president you voted for? Do you remember why you voted for him?
3. (If married) What do you remember best about your wedding ceremony or wedding day?
4. How many children?
5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
   A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

LATER ADULTHOOD:
1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you’ve ever received?
16. What is the most extravagant thing you’ve ever done?
17. What are you most proud of having done?
18. What is the most important rule you’ve lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven’t done yet?
21. Something amusing in life experiences?
22. Best advice for today’s youth?
STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER

WEEK THREE

Topic: Grief/Loss/Coping

Objectives: Completing this clinical experience will enable the learner to:

1. Discuss losses experienced by the elderly related to: productivity, relocation, relationships with others, and death.
2. Identify factors, which influence adaptation to loss.
3. Verbalize understanding of the grief process; and
4. Identify coping mechanisms utilized by the aged person.
5. Share experience with clinical group at post conference.

Preparation Activities:

1. Share a significant loss you have experienced, your reaction, and coping measures. Who was most helpful and why? What things were said to you that were not helpful?
2. Discuss losses experienced by older adults.
3. Review coping mechanisms utilized by older adults.
4. Review the grief process.
5. Review Grief/Loss/Coping Tool.

Student Learning Experience:

1. Ask the elder about their grief and losses and how they cope. They can teach you how to cope with loss. Focus on their ability and methods of coping.

Student Guides:

Grief/Loss/Coping Tool
GRIEF/LOSS/COPING TOOL

WEEK THREE

1. What changes have you experienced as you’ve grown older?

If elder doesn’t respond, some of the questions below may be asked to direct conversation. Remember, ask open-ended questions. Listen to your elder. Do not feel compelled to ask the sample questions. Allow the individual to tell you what it is like to grow old.

Sample questions:

What changes have you experienced with retirement? Change in status or position? Change in the way you feel about yourself?

How has your health changed? Loss of sight, vision, taste? Loss of balance? Loss of endurance?

Have you lost a loved one?

Do you have anyone close to you who can provide support and comfort you?

What financial changes have you experienced?

Have you had to adjust your standard of living due to a change in income?

Have you had to give up any personal possessions?

Has your level of independence changed any?

Have you experienced changes in your social life?

Have you experienced changes in the types of activities you engage in?
2. For each change or loss mentioned by your elder ask, “How did it make you feel?”

(Common feelings include hurt, anger, hostility, frustration, abandonment, helplessness, loneliness, weakness, guilt, bitterness, resentment, dread, shame, sadness, relief, comfort, content, acceptance.)

3. For each change or loss mentioned by your elder ask, “How have you adjusted?”

Discussion Guidelines:

1. Discuss your impressions and general reactions.

2. Identify at least three losses your elder has experienced.

3. Name one way your elder coped with a loss.

4. Identify where your elder is in the grief process.
SUMMARY OF VISIT WITH COMMUNITY RESIDENT: GRIEF/LOSS/COPING

WEEK THREE

Your Name: ______________________________________________ No. of Visits: __________________

Place of meeting: ______________________________________________________________________

Time: ________________________________________________________________________________

Elder’s age: ___________________________________________ Sex: ___________________________

1. Describe losses the elder has experienced related to:
   
   A. Productivity

   B. Relocation

   C. Relationships with others

   D. Death

2. Explain factors, which influenced the elder’s adaptation to loss.

3. Describe coping behaviors the elder uses.
STUDENT GUIDELINES FOR OBTAINING A LIFE HISTORY
WEEK THREE: COMMUNITY

CHILDHOOD – GROWING UP:
1. What is your first memory from your childhood?
2. What childhood trip is most vivid for you?
3. What is your most vivid historical memory?
4. Did you have any fears while growing up? (i.e., fear of nuclear war of today)
5. What did your parents make you do that you hated doing?
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5. What was it like to be a young parent? Was parenting different than it is today?
6. What is your occupation?
   A. If you had it to do over again, would you pick that profession?
7. What do you remember most about being a young adult (age 20-40)?

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1. Have you ever lived outside the U.S.? If yes, where?
2. Do you have parents or grandparents that were immigrants? If so, from where?
3. Have you decided where and how you want to live out the rest of your life?
4. Is there someone in your life with whom you can have a close, warm relationship?
5. Do you feel your living arrangements are satisfactory?
6. Have you had to adjust your standard of living since retiring?
7. What do you do to keep your health?
8. How many grandchildren? Great grandchildren?
9. How often do you have contact with your children and grandchildren? Other relatives?
10. What do you let your grandchildren do that your children could not do?
11. What kinds of interests do you have outside the family?
12. Do you have any hobbies or ever collected anything?
13. Have you ever played a musical instrument?
14. What is your strongest asset?
15. What is the best gift you’ve ever received?
16. What is the most extravagant thing you’ve ever done?
17. What are you most proud of having done?
18. What is the most important rule you’ve lived by?
19. Who has had the most influence in your life? And how?
20. What would you still like to do that you haven’t done yet?
21. Something amusing in life experiences?
22. Best advice for today’s youth?
STUDENT CLINICAL EXPERIENCE WITH A WELL ELDER

WEEK THREE

Topic: Use of SimChart for Assessment

Objectives: Completing this clinical experience will enable the learner to:

1. Conduct and record a nursing health history.
2. Identify factors that promote wellness.
3. Identify barriers to health promotion.
4. Demonstrate the use of appropriate communication and interpersonal skills when interviewing the elderly person.
5. Develop a teaching plan based on the client’s nursing health history.

Preparation Activities:

1. Review SimChart to determine items in a nursing health history.

Student Learning Experience:

1. Conduct and record a nursing health history using SimChart.
2. Prepare a teaching plan based on the elder’s learning needs.
3. Prepare the elder for termination of the therapeutic relationship by reminding him/her that this is your last week.

Student Guidelines:

   SimChart
   Teaching Care Plan

Discussion Guidelines:

1. How does this elder perceive his/her health?
2. How do you perceive the elder’s health?
3. Where do you think the elder is on the wellness-illness continuum?
4. Identify factors that promote wellness in the elder.
5. Identify anything that interferes with the elder’s health and well-being.
## TEACHING CARE PLAN

<table>
<thead>
<tr>
<th>KNOWLEDGE DEFICIT/ LEARNING NEED</th>
<th>GOAL AND PLAN FOR TEACHING</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SUMMARY OF VISIT WITH COMMUNITY RESIDENT: ASSESSMENT

WEEK THREE

Your Name: ____________________________________ No. of Visits: _______________

Place of meeting: ________________________________________________________________

Time: ________________________________________________________________________

Elder’s age: ___________________________  Sex: ________________________________

1. How does the elder describe his/her health?

2. How do you perceive the elder’s health?

3. Identify factors that promote wellness in the elder.

4. Identify anything that interferes with the elder’s health and well-being.
MEDICAL–SURGICAL NURSING CLINICAL

Course Description
The continuing nursing student will integrate content from classroom learning activities when caring for clients with commonly occurring human responses progressing to less commonly occurring responses to health challenges. Practice involves adult and geriatric clients in a variety of in-patient and out-patient clinical settings.

Instructor’s Expectations
Each clinical group has a faculty member responsible for planning and supervising the activities of the clinical group. The faculty has a strong clinical background and desire to share their expertise and professionalism. In addition to clinical responsibilities, clinical instructors are responsible for evaluating each student’s clinical performance and written assignments and are available for consultations to meet individual student’s needs.

One goal of the instructor is to promote student learning from each clinical experience through planned individual and group activities. The instructor expects students to be prepared for each clinical experience and to demonstrate personal and professional effort in meeting the demands of the course clinical objectives.

Method of Instruction
Methods suitable for adaptation and implementation to the clinical area include:

- Hands-on clinical application of theory with facilitation by clinical instructor;
- Pre-Conference: An organized focused time prior to beginning clinical facilitated by the clinical instructor, which “grounds” the student’s clinical activities;
- Directed observation of procedures by staff;
- DVD and electronic learning as/if available at clinical site; and
- Post-Conference: An organized, focused time after the day’s clinical experience to support the integration of experiences and to debrief from the day.

Evaluation Methods
- Attendance and participation
- Verbal evaluation of clinical performance
- Evaluation of written assignments
- Written evaluation of clinical performance at end of clinical rotation

Confidentiality
Confidentiality is a strict must! Any breach of confidentiality is grounds for immediate dismissal from the program.
PRE-/POST-CONFERENCE GUIDELINES

Pre-Conference
Prior to student providing direct client care, a clinical pre-conference will be held. The time and location of the pre-conference is at the discretion of the clinical instructor. The focus will be reviewed, goals for the day established, and learning needs identified.

Pre-Conference is intended to be a brief, but important, review of the day’s activities. The clinical instructor will assist the clinical group in identifying care priorities, learning opportunities, and organizational needs. Nursing care plans and other written assignments for each client may also be randomly chosen for discussion.

Post-Conference
Post-conference is intended to discuss nursing care challenges of interest for the benefit of all the students in the group, to share ideas for meeting these challenges, and to debrief. The location and time for clinical post-conferences will be scheduled by the clinical instructor.

The clinical instructor will facilitate the post-conference discussion. Each student is expected to participate in evaluating the day’s goals and learning experiences. Activities relevant to the clinical focus will be discussed with emphasis on expected and actual outcomes of care, alternative interventions, and staff nurse responsibilities in the overall management of care for the client.

Student Objectives
The student will:
- Identify the client;
- State client needs;
- Describe pertinent observations in a review of systems manner;
- Report situation and potential or actual problems experienced;
- Discuss nursing approach/solution to these problems;
- List the drugs administered, and state the action, dose, desired effect, side/adverse effects, and methods of administration for each;
- List treatments, and state the purpose of and the client’s response to each;
- Labs pertinent to patient; and
- Client teaching

Student Guide for Discussion
- Who is my client? (For example, age, marital status, psychosocial history, medical conditions and mental status).
- Significant events of this admission (admitting diagnoses, surgery, emotion crises, fracture).
- Client’s needs TODAY? (Describe the situation, your observations, potential or actual problems and your approach).
  - Basic daily needs
  - Needs requiring special attention
- What medications were administered, or is your client receiving?
MCSPN Clinical Syllabus 2017

- Why?
- What were the positive and negative effects?
- What safety measures were used?
- What treatments were done?
  - Why were these done?
  - What special principles or safety measures were involved?
- Did I meet my client’s needs? Explain.
- What could I do to improve my nursing care of this client?
- What were my feelings about taking care of this client?
- Presentation of special topics

Student Learning Outcomes
The student will continue to address learning objectives from the previous rotations, and the student will:
1. Demonstrate professional behavior, dress, and therapeutic communication skills, while interacting with assigned clients, families, and other members of the interdisciplinary team.
2. Demonstrate comprehensive nursing assessment skills while providing therapeutic care to patients experiencing acute health problems.
3. Address client’s culture, values, and beliefs; and incorporate findings into the plan of care.
4. Demonstrate proficiency in documentation (written or electronic client information systems) on clients in the acute care setting in accordance with the facility standards and current professional practice; including documentation of assessments findings, nursing care planning, medication administration, procedures performed, and communication/teaching conducted.
5. Explain the mechanisms of action and rationales of medications, and safely calculate doses and administer medications, including IVPB medications.
6. Submit a written plan of care on assigned client weekly and/or completion of alternative clinical experience assignment, medication summaries, and other documentation as directed.
Care of the Client with a Fluid and/or Electrolyte Imbalance
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with a fluid and/or electrolyte imbalance.
2. Demonstrate an assessment of a client with a fluid and/or electrolyte imbalance.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing a fluid and/or electrolyte imbalance.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment and medications.

Palliative Care of the Terminally Ill Client
Continue to address objectives from previous weeks and
1. Refer to Medical Surgical Book for care of the client who is terminally ill.
2. Help client to express his/her fears by careful and thoughtful questioning.
3. Assess the nature of the client’s fears and methods he/she uses to cope with that fear.
4. Document verbal and nonverbal expressions of fear.
5. Confirm your awareness and validate the feelings the client is having and communicate an acceptance of those feelings.
6. Offer self to client.
7. Provide continuity of care and comfort measures.
8. Identify the client’s grieving process and identify available support for client and family.
9. Assess client’s need for power and control.
10. Allow the client autonomy with care and decisions.
11. Determine if client has a living will and durable power of attorney.
12. Assess religious affiliations and spiritual beliefs.

Care of the Client in Pain
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of the client in pain.
2. Obtain a thorough pain history and the previously used methods of pain control, what was/was not effective, client’s attitude toward pain medication, and the effect of pain on ADLs.
3. Teach client that pain management is part of their treatment.
4. Assess for pain at frequent intervals, using a formal patient-specific method of assessing self-reported pain when possible, including description, location, intensity, and aggravating/alleviating factors. Use selected scale consistently. Educate client about pain assessment tools as appropriate.
5. Assess for behavioral and physiological responses to pain.
6. Administer analgesic according to the World Health Organization (WHO) three step analgesic ladder.
7. Recognized that the preferred route is the one that is least invasive while achieving adequate relief.
8. As prescribed administer non-opioid agents. Recognize that NSAIDs are very effective when combined or used with centrally acting opioid analgesics.
10. Administer analgesics before pain becomes severe.
11. Reassess pain level frequently and assess for side effects.
12. Address addiction concerns of client and family.

Care of the Client with an Infection
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of the client with an infection.
2. Demonstrate an assessment of a client with an infectious disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing an infectious disorder.
4. Address psychosocial issues experienced by the isolated client and their families in the acute care setting using the nursing process.
5. Practice transmission-based precautions as outlined by the Centers for Disease Control and Prevention.
6. Provide client teaching regarding disorder, treatment, and medications.

**Care of the Post-Operative Surgical Client**
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of the post-operative client.
2. Demonstrate a head-to-toe assessment of a post-operative client.
3. Provide preventive measures to prevent post-operative complications.
4. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for post-operative clients.
5. Address psychosocial issues experienced by the post-operative client and their family using the nursing process.
6. Provide client teaching regarding care of wound, nutrition, activity, medications, and follow-up appointment.

**Care of a Client with Respiratory Disorder**
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a respiratory disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing respiratory disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.
6. If available, assist with management of chest tubes.

**Care of the Client with Musculoskeletal Disorder**
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a musculoskeletal disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing musculoskeletal disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.

**Care of the Client with Cardiovascular Disorder**
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a cardiovascular disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing cardiovascular disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.
6. Submit the completed alternate clinical experience assignment sheet.

**Care of the Client with Renal Disorder**
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a renal disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing renal disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Review a dialysis client’s chart and observe the procedure of dialysis in the unit.
6. Provide client teaching regarding disorder, treatment, and medications.
7. Complete and submit dialysis worksheet to your clinical instructor.
8. Submit the completed alternate clinical experience assignment sheet.

**Care of the Client with Endocrine Disorder**

Continue to address the objectives from previous weeks and

1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with an endocrine disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing endocrine disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.

**Care of the Client with a Neurological Disorder**

Continue to address the objectives from previous weeks and

1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a neurological disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing a neurological disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.

**Care of the Client with a Skin Disorder**

Continue to address the objectives from previous weeks and

1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a skin disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing a skin disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.
6. Submit the completed alternate clinical experience assignment sheet.

**Care of the Client with a Gastrointestinal Disorder**

Continue to address the objectives from previous weeks and

1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a gastrointestinal disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing a gastrointestinal disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.
6. Submit the completed alternate clinical experience assignment sheet.
Care of the Client with an EENT Disorder
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with an EENT disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing an EENT disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.

Care of the Client with a Reproductive Disorder
Continue to address the objectives from previous weeks and
1. Refer to Medical Surgical Book for care of client with specific disorder.
2. Demonstrate an assessment of a client with a reproductive disorder.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for patients experiencing a reproductive disorder.
4. Address psychosocial issues experienced by the client and families in the acute care setting using the nursing process.
5. Provide client teaching regarding disorder, treatment, and medications.

Team Meds Experience
During this clinical rotation, the student will:
- Work with a faculty member to administer medications to a team of patients.
- Discuss details about the medications administered, including the indications, side/adverse effects, nursing assessments, and patient teaching responsibilities.
- Complete and submit medication summaries in SimChart as directed.
Observational Clinical Experiences (As Available; See Rotation Schedule)

Cancer Center
During this clinical rotation, the student will:
- Follow a nurse to observe the care of the patient with cancer, including chemotherapy, adjunct, and supportive therapies.
- Participate in noninvasive nursing care for stable patients, including assessments and vital signs.
- Complete and submit an Alternative Clinical Experience Assignment Sheet.

Cardiovascular Unit
During this clinical rotation, the student will:
- Follow a nurse to observe the care of the patient with a cardiovascular problem.
- Observe cardiac procedures (as available), including cardiac testing, cardiac catheterizations, and surgeries.
- Participate in noninvasive nursing care for stable patients, including assessments and vital signs.
- Complete and submit an Alternative Clinical Experience Assignment Sheet.

Dialysis
During this clinical rotation, the student will:
- Observe the dialysis process.
- Assess a patient receiving dialysis, using the Dialysis Worksheet as a guide.
- Complete the ATI Real Life Clinical Reasoning Scenario, entitled Kidney Disease.
- Complete and submit the Dialysis Worksheet.
- Complete and submit an Alternative Clinical Experience Assignment Sheet.

Emergency Department
During this clinical rotation, the student will:
- Follow a nurse to observe the care of the patient with an emergent problem and the triage process.
- Observe procedures performed by physicians/physician’s assistants/nurse practitioners, as available.
- Participate in noninvasive nursing care for stable patients, including assessments and vital signs.
- Complete and submit an Alternative Clinical Experience Assignment Sheet.

GI Department
During this clinical rotation, the student will:
1. Follow a nurse to observe the care of the patient having a GI procedure.
2. Observe GI procedures (as available), especially endoscopic exams.
3. Participate in noninvasive nursing care for stable patients, including assessments and vital signs.
4. Complete and submit an Alternative Clinical Experience Assignment Sheet.

Surgery and Same Day Surgery
During this clinical rotation, the student will:
1. Dress in proper attire, per hospital policy.
2. Observe a head-to-toe assessment of a pre-operative client, completion of pre-surgical diagnosis tests, and preoperative teaching.
3. Explain the rationale for diagnostic procedures and therapeutic interventions utilized for pre-operative clients.
4. Observe how the nurse addresses psychosocial issues experienced by the pre-operative client and his/her family.
5. Observe and distinguish between medical and surgical asepsis carried out in the OR suite.
6. Observe the skin preparation, insertion of Foley catheters, IVs, chest tubes, or other special techniques performed.
7. Observe the roles and responsibilities of the scrub and circulating nurses and OR technicians.
8. Observe procedures, assessments, and monitoring performed by the anesthetist.
9. Observe various surgical procedures while maintaining strict surgical asepsis.
10. Assist with transporting the client to PACU and listen to the report given to the PACU nurse.
11. Observe the nursing care in PACU.
12. Ascertain the rationale for IV fluids, blood transfusion, I&O, and other treatments given and note the client’s response and tolerance of each treatment.
13. Describe equipment used in the care of the client and its purpose, including stents and drains.
14. Complete and submit an Alternative Clinical Experience Assignment Sheet for each rotation (one for Surgery and one for Same Day Surgery).

Wound Clinic

During this clinical rotation, the student will:
1. Observe the treatment modalities of various wounds.
2. For stable patients, assist the therapist with treatments, as needed.
3. Understand the rationale of wound treatments and dressings.
4. Understand the correlation of adequate circulation and wound healing, including the effects of uncontrolled diabetes and heart disease on the circulatory system and tissues of the lower extremities.
5. Complete and submit an Alternative Clinical Experience Assignment Sheet.

Cardiac Rehabilitation

During this clinical rotation, the student will:
- Understand the basic medical history of individuals eligible for cardiac rehabilitation services.
- Identify the phases of cardiac rehabilitation.
- Summarize the goals of cardiac rehabilitation.
- Observe assessments made by the nurse and other healthcare providers during the cardiac rehabilitation process, and the rationale for each.
- State the physical effects and benefits of cardiac rehabilitation.
- Describe patients’ overall impression of cardiac rehabilitation and its benefits.
- Observe cardiac testing procedures, as available.
- Describe the role of the nurse in cardiac testing and rehabilitation.
- Complete and submit an Alternative Clinical Experience Assignment Sheet.

Respiratory Therapy

During this clinical rotation, the student will:
- Understand the basic medical history of patients needing specialized respiratory care.
- Observe various respiratory therapy procedures, as available, including respiratory assessments, chest therapies, drawing of arterial blood gases (ABGs), and medication administration.
- Discuss the components of and importance of a focused respiratory system assessment.
Summarize the rationale for various chest therapies.

Describe medications administered by the respiratory therapist, including their classifications; rationales for use; associated side/adverse effects (local and systemic); and specific assessments/labs/monitoring that must be conducted before, during, and after administration.

Auscultate normal and adventitious breath sounds, with guidance from the respiratory therapist.

Review the results of an ABG to determine the basic acid-base imbalance.

Describe the role of the respiratory therapist in an acute care setting.

Complete and submit an Alternative Clinical Experience Assignment Sheet.

### Jail/Corrections

During this clinical rotation, the student will:

1. Receive an in-depth orientation to all sections of the facility
   a. pharmacy, infirmary, daily sick call room;
   b. key personnel; and
   c. philosophy and disaster planning.
2. Observe all facility policies, all safety protocols, and recommended personal safety measures.
3. Observe the nursing staff dispense medication, assess clients, and provide physical care.
4. Develop an understanding of the role of the practical nurse within a correctional institution.
5. Complete and submit an Alternative Clinical Experience Assignment Sheet.

### Hospice

During this clinical rotation, the student will:

- Apply death and dying principles learned in the classroom to the care of hospice clients.
- Observe aspects of hospice nursing care, such as medication administration, oxygen monitoring, suctioning, enteral feedings, and comfort measures including pain management.
- Participate in noninvasive/nonsterile aspects of hospice care, such as taking vital signs, assisting with patient assessment, and documentation.
- Observe the education and support provided to families, noting families’ involvement in patient care.
- Practice effective communication skills, including active listening, reflecting, and focusing.
- Describe adaptations made to provide effective nursing care in the home.
- Understand the job responsibilities of a nurse working in hospice, including the commitment to travel in inclement weather and being on 24/7 call.
- Participate in the intake/admission process and assist with termination/death procedures, as available, noting the nursing responsibilities involved in each.
- Complete and submit an Alternative Clinical Experience Assignment Sheet.

### ResCare

During this clinical rotation, the student will:

1. Follow a nurse to observe the adaptation of nursing care for the patient with intellectual and developmental disabilities.
2. Participate in noninvasive nursing care for stable patients, including assessments and vital signs.
3. Complete and submit an Alternative Clinical Experience Assignment Sheet.
# Dialysis Worksheet

<table>
<thead>
<tr>
<th>Patient History Information</th>
<th>Current Medications</th>
<th>Labs/Diagnostic Tests</th>
<th>Type of Dialysis Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Diabetes, HTN, Renal, &amp; Other Significant Health Issues)</td>
<td>(Drug, Dose, Route, Frequency)</td>
<td>(Most Recent BUN/Cr, Lytes, FBS, &amp; Other Renal Tests)</td>
<td>(Fistula, Shunt, Port)</td>
</tr>
</tbody>
</table>

## Vital Signs
- **T**
- **P**
- **R**
- **BP**
  - Pre-treatment
  - During treatment
  - Post-treatment
- **O₂ sat**
- **Pain (Rating, Location)**
- **Weight Pre & Post Treatment**

## Patient Assessment
- **(Perform Basic Assessment)**
  - LOC/Orientation
  - Skin Status
  - Lung Sounds
  - Apical Pulse
  - CMS ALL Extremities
    - Arms
    - Legs
  - Circulation
  - Motion
  - Sensation
  - Edema

## Dialyzer Machine Assessments/Checks Performed by Nurse/Tech Before, During, & After Treatment
- **Before**
- **During**
- **After**

## Coping Skills
- **(Talk with Patient: How Coping with Living with Dialysis?)**
**NURSING SPECIALTIES CLINICAL: MATERNAL-NEWBORN NURSING, PEDIATRICS, AND BEHAVIORAL HEALTH**

**Course Description**
The student will integrate content from classroom learning activities into delivery of care in various clinical settings to vulnerable populations. The student will assess the needs and provided care to selected clients. The focus is on assessment of growth and development of individuals from newborns to elderly adults; maintaining a safe environment while meeting the individual’s physical and psychosocial needs; teaching; and promoting wellness.

**Course Learning Outcomes**
1. Provide care to all assigned clients in a professional manner, demonstrating awareness of legal/ethical principles.
2. Utilize critical thinking skills, Maslow’s Hierarchy of Human Needs, and holistic assessment of the client to implement the nursing process.
3. Maintain a safe environment during all aspects of client care.
4. Use therapeutic communication with all assigned clients and colleagues.
5. State the rationale for all aspects of care administered to assigned clients including laboratory, nutritional, and medication orders.
6. Assist all assigned clients with activities of daily living, based on the assessment of the client’s developmental level.
7. Demonstrate the use of the “six rights” of medication administration.
8. Administer medications to assigned clients, after dosages are verified by clinical instructor with 100% accuracy.
9. Perform basic nursing skills in the clinical setting upon availability. These skills may include providing personal hygiene, physical assessment, documentation, catheterization, changing dressings, sitz bath, facilitating breastfeeding, and assisting clients with nutritional needs.
10. Document the client care and teaching provided.
11. Discuss client care priorities and goal attainment issues in relation to the nursing process during clinical post conference.
12. Integrate Maslow’s and developmental theories with all nursing process related assignments.
13. Document implementation of all aspects of the nursing process.

**Instructor’s Expectations**
Each clinical group has a faculty member responsible for planning and supervising the activities of the clinical group. The faculty has a strong clinical background and desire to share their expertise and professionalism. In addition to clinical responsibilities, clinical instructors are responsible for evaluating each student’s clinical performance and written assignments and are available for consultations to meet individual student’s needs.

One goal of the instructor is to promote student learning from each clinical experience through planned individual and group activities. The instructor expects students to be prepared for each clinical experience and to demonstrate personal and professional effort in meeting the demands of the course clinical objectives.
Method of Instruction
Methods suitable for adaptation and implementation to the clinical area include:
- Hands-on clinical application of theory with facilitation by clinical instructor;
- Pre-Conference: An organized focused time prior to beginning clinical facilitated by the clinical instructor, which “grounds” the student’s clinical activities;
- Directed observation of procedures by staff;
- DVD and electronic learning as/if available at clinical site; and
- Post-Conference: An organized, focused time after the day’s clinical experience to support the integration of experiences and to debrief from the day.

Evaluation Methods
- Attendance and participation
- Verbal evaluation of clinical performance
- Evaluation of written assignments
- Written evaluation of clinical performance at end of clinical rotation

Confidentiality
Confidentiality is a strict must! Any breach of confidentiality is grounds for immediate dismissal from the program.
PRE-/POST-CONFERENCE GUIDELINES

Pre-Conference
Prior to student providing direct client care, a clinical pre-conference will be held. The time and location of the pre-conference is at the discretion of the clinical instructor. The focus will be reviewed, goals for the day established, and learning needs identified.

Pre-Conference is intended to be a brief, but important, review of the day’s activities. The clinical instructor will assist the clinical group in identifying care priorities, learning opportunities, and organizational needs. Nursing care plans and other written assignments for each client may also be randomly chosen for discussion.

Post-Conference
Post-conference is intended to discuss nursing care challenges of interest for the benefit of all the students in the group, to share ideas for meeting these challenges, and to debrief. The location and time for clinical post-conferences will be scheduled by the clinical instructor.

The clinical instructor will facilitate the post-conference discussion. Each student is expected to participate in evaluating the day’s goals and learning experiences. Activities relevant to the clinical focus will be discussed with emphasis on expected and actual outcomes of care, alternative interventions, and staff nurse responsibilities in the overall management of care for the client.

Student Objectives
The student will:
- Identify the client;
- State client needs;
- Describe pertinent observations in a review of systems manner;
- Report situation and potential or actual problems experienced;
- Discuss nursing approach/solution to these problems;
- List the drugs administered, and state the action, dose, desired effect, side/adverse effects, and methods of administration for each;
- List treatments, and state the purpose of and the client’s response to each;
- Labs pertinent to patient; and
- Client teaching
Student Guide for Discussion

1. Who is my client? (For example, age, marital status, psychosocial history, medical conditions and mental status).
2. Significant events of this admission (admitting diagnoses, surgery, emotion crises, fracture).
3. Client’s needs TODAY? (Describe the situation, your observations, potential or actual problems and your approach).
   a. Basic daily needs
   b. Needs requiring special attention
4. What medications were administered, or is your client receiving?
   a. Why?
   b. What were the positive and negative effects?
   c. What safety measures were used?
5. What treatments were done?
   a. Why were these done?
   b. What special principles or safety measures were involved?
6. Did I meet my client’s needs? Explain.
7. What could I do to improve my nursing care of this client?
8. What were my feelings about taking care of this client?
9. Presentation of special topics
MATERNAL-NEWBORN CLINICAL

Labor and Delivery: The student will continue to address the objectives from previous weeks and follow a Labor & Delivery Nurse to observe the following:

- Health history/admission process
- Nursing care & assessment of antepartum & laboring patients
- Attaching the monitor
- Non-stress test
- Epidural insertion & other pain management strategies
- Insertion of internal contraction/fetal monitoring devices
- Cervical examination for dilation & effacement
- Cesarean section and vaginal birth (as available)

Post Partum Unit: The student will continue to address the objectives from previous weeks and

1. Observe the admission and admission assessment of a post partum patient
2. Perform (with a nurse/nursing instructor) a post partum shift assessment (BUBBLE/REEDA)
3. Perform/Assist the patient with showering, AM care & ADLs as well as change the bed linens
4. Administer medication (with nursing instructor); can administer all medications except for blood/blood products (including RhoGam), first doses of IV antibiotics & Flagyl (hospital policy) & all IV push medications
5. Observe post partum teaching & discharge teaching

Newborn Care/Nursery: The student will continue to address the objectives from previous weeks and

1. Observe & have explained to them the admission process of a newborn
2. Observe & have explained to them the newborn assessment
3. Observe initial newborn vaccinations & prophylactic eye ointment administration
4. Observe the administration of a hearing test
5. Observe and have explained to them a circumcision & the post circumcision care
6. Observe & have explained to them phototherapy
7. Observe care of a newborn that is going through drug withdrawal & how that newborn is scored for their withdrawal symptoms
8. Be assigned a newborn to assess vital signs & monitor intake & output on
9. Feed & burp a newborn
10. Bathe & change a newborn
11. Observe parent education about newborn care, feeding & bathing
MINERAL COUNTY SCHOOL OF PRACTICAL NURSING
NEWBORN ASSESSMENT FORM

Birth Data

Gestational Age ____________ Male Female
Weight ____________ Vital Signs: T _____
Length ____________ P _____
Head Circumference ____________ R _____
Chest Circumference ____________
Apgars: 1 minute________ 5 minutes________

Supportive Data

Complications of Pregnancy ____________________________________________
Preexisting Maternal Condition _________________________________________
Prenatal Care: Yes No
Maternal Age________________________________________________________
Maternal Smoking/Alcohol/Drugs (Circle and Explain) ____________________________
Anesthesia Used During Labor and Delivery_______________________________
Length of Labor _______________________________________________________
Length of Membrane Rupture ____________________________________________
Amniotic Fluid Clear Meconium Stained
Complications of Labor _________________________________________________
Presentation __________________________________________________________

Type of Delivery: Vaginal C-section VBAC
Resuscitation Measures ________________________________________________
**Physical Assessment**

Skin (Color, Appearance, Turgor, Birthmarks): ____________________________

____________________________________________________________________

Head/Scalp (Fontanels, Molding, Cephalohematoma, Caput Succedaneum): __

____________________________________________________________________

Eyes (Reactivity/Discharge): ___________________________________________

____________________________________________________________________

Mouth and Throat: ____________________________________________________

____________________________________________________________________

Chest (Quality of Respirations, Lung Sounds, Effort, Retractions, Grunting): __________________________

____________________________________________________________________

Heart (Apical Rate & Rhythm, Heart Sounds, Pulses): ______________________

____________________________________________________________________

Abdomen (Shape, Umbilicus, Hernia, Bowel Sounds): ______________________

____________________________________________________________________

Anogenital (Anal Patency, Stool Type, Genital Swelling): ____________________

____________________________________________________________________

Reflexes (Moro, Tonic Neck, Palmar Grasp, Step, Babinski, Rooting, Sucking): __________________________

____________________________________________________________________

Extremities (Symmetry, Polydactyly, or Syndactyly): ______________________

____________________________________________________________________
# Maternal-Newborn Clinical Evaluation

Upon completion of the clinical rotation, the student will:

<table>
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<tr>
<th>Date</th>
<th>Comments</th>
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<tr>
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<td><strong>Labor and Delivery</strong></td>
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<tr>
<td></td>
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<td>2. Observe nursing care &amp; assessment of antepartum &amp; laboring patients</td>
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<td>3. Observe/assist in attaching the monitor</td>
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<td>4. View &amp; have explained to them a non-stress test</td>
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<td>7. Observe cervical examination for dilation &amp; effacement</td>
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<td>8. Observe a cesarean section and vaginal birth (as available)</td>
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<td>4. Administer medication (with nursing instructor); can administer all medications except for blood/ blood products (including RhoGam), <strong>first</strong> doses of IV antibiotics &amp; Flagyl (hospital policy) &amp; all IV push medications.</td>
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<td>5. Observe post partum teaching &amp; discharge teaching</td>
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<td>11. Observe parent education about newborn care, feeding &amp; bathing</td>
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Instructor Signature  
Written: 08/12  
Revised: 08/13; 11/13; 10/15  
Student Signature  
Date
During or upon completion of the clinical rotation, the student will:

**Primary/Middle School/College Level: School Nurse**
- Observe the nurse’s role in the school setting
- Describe preventive student assessments the school nurse performs
- Discuss the school nurse’s role in health education within the classroom
- Describe acute and common chronic illnesses affecting children in this population & the care/teaching provided to them
- Note first aid provided to children & the rationale for each nursing action
- Participate in obtaining & documenting student vital signs/weight/height, & other assessments/measurements as available
- **Document these observations in a written summary**

**Kindergarten Class & Special Needs Class**
- Assess the development level of various students, especially based on Erikson’s (psychosocial) & Piaget’s (cognitive) theories
- Observe the growth differences in children of various ages
- Note developmental tasks/milestones for this age group & any deviations from this “norm”
- Discuss the nutritional needs of age group & your observations of students’ eating habits throughout the day
- Describe physical/play activities in which students are involved, noting their interaction/communication with each other
- Discuss mental/cognitive activities in which students are involved
- Discuss health issues prevalent in students of this age group in this setting
- Describe types of discipline problems encountered by the faculty & how they are handled
- Note reward/motivational systems used by the faculty & how students respond to them
- Discuss safety precautions & interventions in place within the facility, & the rationale for each
- Describe the level of parental involvement within the educational process
- **Document these observations on the “Pediatrics Observation Sheet”**

**Mineral County Technical Center: Kids in the Lab Day**
- Obtain vitals, height, & weight on a child
- Complete an admission history & physical examination on a child
- Observe infant assessment variations, including reflexes, fontanels, & head/ chest circumferences
- Observe adolescent assessment variations, including Tanner’s stages
- Complete a Denver II assessment on a toddler (age 9 – 24 months)
- Administer an oral & intramuscular “medication” to a child
- Provide discharge teaching to the parent/family and child
- **Document assessments and care in the SimChart program and complete case study**

**WV Schools for the Deaf & the Blind: Multisensory Unit**
- Describe various sensory losses & effects within each individual child
- Summarize the effects of sensory loss on growth & development
• Discuss adaptations the teacher makes in education & communication related to varying degrees of sensory losses
• Describe the technological advances in communication/education related to multi-sensory losses
• Describe psychosocial adjustments the teacher makes to relate to each individual child
• Observe interactions between children
• Assist the teacher as directed & as appropriate in education/care of child
• Review the individualized education plan (IEP) process
• **Document these observations on worksheet provided**

**Mineral County Technical Center: Virtual Patient Care**

• Complete virtual clinical excursion & case study
• **Document virtual care on worksheet, document safe dosage calculations on paper, & complete care plan & medication summaries in the SimChart program**
**Pediatrics: Common Pain Assessment Tools**

### FLACC Scale

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant quivering chin, clenched jaw</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking, or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, rigid or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimper; occasional complaint</td>
<td>Crying steadily, screams or sob, frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging or being talked to, distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

### FACES Scale

**Wong-Baker FACES Pain Rating Scale**

![Wong-Baker FACES Pain Rating Scale](image)

0 No Hurt  
2 Hurts Little Bit  
4 Hurts Little More  
6 Hurts Even More  
8 Hurts Whole Lot  
10 Hurts Worst

Name _________________________________________________________________

Date ________________________

_Pediatrics Observation Sheet_
<table>
<thead>
<tr>
<th>Developmental Level (Erikson)</th>
<th>Growth Differences</th>
<th>Developmental Tasks/Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional Needs/Eating Habits</td>
<td>Physical/Play Activities</td>
<td>Mental/Cognitive Activities</td>
</tr>
<tr>
<td>Health Issues</td>
<td>Discipline Problems &amp; Management</td>
<td>Reward/Motivational Systems</td>
</tr>
<tr>
<td>Safety Precautions &amp; Interventions</td>
<td></td>
<td>Parental Involvement</td>
</tr>
</tbody>
</table>

Name _________________________________________________________________  Date __________________________

Pediatrics Observation Sheet
<table>
<thead>
<tr>
<th>Developmental Level (Erikson)</th>
<th>Growth Differences</th>
<th>Developmental Tasks/Milestones</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Physical/Play Activities</td>
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</tr>
<tr>
<td>Safety Precautions &amp; Interventions</td>
<td></td>
<td>Parental Involvement</td>
</tr>
</tbody>
</table>

LPN Student Name ____________________________ Date ____________________

Pediatrics Clinical Rotation
WV Schools for the Deaf & the Blind: Multi-Sensory Classroom

REMINDER: FOR CONFIDENTIALITY PROTECTION, DO NOT USE STUDENT NAMES!

✓ Describe two sensory losses you observed and the effects on that individual child.
  a. 
  b. 

✓ Summarize two effects of sensory loss on growth & development.
  a. 
  b. 

✓ Discuss two adaptations the teacher made to communicate to students.
  a. 
  b. 

✓ Describe two technological advances in communication/education related to multi-sensory losses.
  a. 
  b. 

✓ Describe two psychosocial adjustments the teacher made to relate to the child.
  a. 
  b. 

✓ What interactions did you observe between children? Give an example.

✓ How did you assist the teacher in the education/care? Give two examples.
  a. 
  b. 

✓ What did you learn about the individualized education plan (IEP) process? How does it compare & contrast to the individualized nursing care plan?
  a. 
  b.
Upon completion of the clinical rotation, the student will:

<table>
<thead>
<tr>
<th>Date</th>
<th>Grade</th>
<th>Rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Primary School, Middle School, and College: School Nurse</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Observe the nurse’s role in the school setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Describe preventive student assessments the school nurse performs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Discuss the school nurse’s role in health education within the classroom</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Describe common chronic illnesses affecting children in this population &amp; the care/teaching provided to them</td>
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<tr>
<td></td>
<td></td>
<td>5. Note first aid provided to children &amp; the rationale for each nursing action</td>
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<tr>
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<td></td>
<td>6. Participate in obtaining &amp; documenting student vital signs/weight/height, &amp; other assessments/measurements</td>
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<tr>
<td></td>
<td></td>
<td>7. Document these observations in a written summary</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Primary School: Kindergarten Class and Special Needs Class</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Assess the development level of various students, especially based on Erikson’s (psychosocial) &amp; Piaget’s (cognitive) theories</td>
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<tr>
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<td></td>
<td>2. Observe the growth differences in children of various ages</td>
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<td></td>
<td>11. Describe the level of parental involvement within the educational process</td>
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<td>12. Document these observations on the “Pediatrics Observation Sheet”</td>
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<td>9. Document these observations on worksheet provided</td>
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</tbody>
</table>

**General Performance Standards**

1. Notify agency/school & instructor appropriately if late/sick/off/leaving early
2. Prepare for assignment: Supplies, uniform policy/dress code, paperwork
3. Demonstrate professionalism in appearance, behavior, & conversation
4. Work cooperatively with others, demonstrating assertiveness, positive work ethic, & team approach
5. Protect patient/student privacy/confidentiality (HIPAA)
6. Comply with policies of school, county, & facility
7. Practice safety & report errors/unsafe conditions appropriately & timely

Instructor Signature ___________________________ Date ___________________________

Student Signature ____________________________ Date ____________________________

Written: 08/12 Revised: 08/13, 11/13, 10/15, 10/16

**BEHAVIORAL HEALTH CLINICAL**

During this clinical experience, the student will:

1. Have an orientation to each facility
1. Policies and procedures
   a. Work with assigned patient, guided by the Daily Focus Sheet
   b. Apply the nursing process in patient care situations, based on patient diagnosis
   c. Differentiate and recognize mental health diagnoses and their s/s, treatment, medications, and nursing implications (including safety precautions)
   d. Attend available groups/meetings, including ITP, rounds, and therapeutic recreation activities, and document attendance on Daily Focus Sheet
   e. Protect patient confidentiality at all times
   f. Interact with all patients on unit to be accepted into milieu
   g. Ask appropriate questions to instructor/staff/patient to enhance learning
   h. Follow staff direction for safety in event of escalations/emergencies to protect self and others
   i. Report unsafe behaviors/hazards/possession of sharps/dangerous items to staff immediately
   j. Participate in pre- and post-conference discussions, guided by the Daily Focus Sheet
   k. Maintain professional boundaries in all interactions
   l. Therapeutically communicate with patients and record examples on the Daily Focus Sheet
   m. Complete daily, written journal on the Daily Focus Sheet
   n. Rotate to Willowbrook Assisted Living, WMHS, and WMRS for observation of other behavioral health settings, and document observations on the Daily Focus Sheet for that rotation
   o. Document and submit observations on Daily Focus Sheets
   p. Meet all objectives outlined on the Behavioral Health Performance Evaluation

2. Rules and regulations
   a. Financial
      1. Dress Code
Wear conservative, neutral clothing. No tight pants, shorts, skirts, low-cut tops, midriffs, tight tops, or high heels. Nothing suggestive or revealing, including writing on shirts. No hoodies or jackets with strings. No "loud" prints/colors/stripes/polka dots. No perfumes/colognes/scented products. If you are dressed inappropriately, you will receive a violation, be sent home, and counted absent for the day.

2. **Identification**
   You must wear your name tag at all times; it is state law that all employees, instructors, and students wear ID.

3. **Signing In/Out**
   You must sign in and out each day. These regulations are for safety and security.

4. **Calling in Sick**
   You must call the main number by 7:30 a.m. to report off. (301) 777 – 2405

5. **Lunch**
   We will take our lunch break together as a group from 12 to 12:45 p.m. Meet at the front desk/lobby area. Everyone must eat at the facility; students may not leave the facility for lunch.

6. **Leaving the Facility**
   Do not leave the facility without notifying your clinical instructor.

7. **Phone Calls**
   Cell phone use is not permitted in the building. A telephone is available at the front entrance area; you must have permission from your instructor and staff before using the phone. You are not to use any other phones unless permitted by your instructor and staff.

8. **Smoking**
   Even though you are not in uniform, you are not permitted to smoke at any time on agency property. Do not carry a lighter, matches, or cigarettes into the agency; this includes electronic and vapor cigarettes.

9. **Parking**
   Park in the lowest parking lot. No exceptions.

10. **Cottage Assignments**
    You will be assigned to a designated cottage (1, 2, or C) and a designated patient. You are to remain in that cottage unless you are with your patient (see “Leaving the Cottage”) or rotated out to another unit. You are not to enter any pod area/patient’s bedroom unless accompanied by a staff person or instructor. No visiting other cottages! Do not wander in the halls. Your time with patients is limited and valuable, so make the most of it – **don’t waste time**.

11. **Leaving the Cottage**
    Patients are only permitted to leave cottages with staff approval. Check your patient’s “level” for their privileges. You may attend activities with your patient if the therapist and the patients
permit you to do so; ask for therapist permission before discussing it with or in front of any patients. A student and their assigned patient should be accompanied by staff when leaving the cottage for groups if the patient is on escorted restrictions. If you are working with a patient with unescorted privileges, ask for staff approval before accompanying the patient to his/her group activity. Students are not to accompany unescorted-level patients or groups of patients to/from their activities.

12. **Gym Activity/Walking on Loop Road**
   If attending any activity in the gym or walking on Loop Road around Finan with your patient, you must have a staff person, instructor, or classmate with you.

13. **Community Meetings**
   Community meetings are usually on Mondays, Tuesdays, and/or Fridays, depending on the cottage schedule. It is important that you take part in these meetings – you are expected to sit in the circle with the patients and observe; at times, you may be asked to participate. Get involved to be accepted in the milieu.

14. **ITP Meetings**
   Individualized Treatment Plan (ITP) meetings are usually held two days each week. The ITP team, including the patient, must give you permission to attend these meetings. Take advantage of these meetings – they are a great learning opportunity and a chance to see the multidisciplinary treatment approach. Check with the charge nurse for permission to attend.

15. **Group Therapy**
   Refer to your group list. You are allowed to attend group therapy sessions if the group leader and patients give permission. Remember to ask the group leader privately first. Pay attention to the activities, the number of people attending, and interactions. Some of the group therapies available include stress management, directed activities, crafts, leisure awareness/skills, and health and wellness.

16. **Cottage Activities**
   Puzzles, games, and other activities are available in the cottages. Get the patients involved and use this time to communicate – be a positive role model. Encourage patient independence and active involvement in their care for successful transition back into the community.

17. **Chart Review**
   Remember confidentiality/HIPAA. You are only permitted to look at your assigned patient’s chart because you are actively involved in their care and, therefore, have a “need to know” – do not look at others’ charts. Each day, you will be asked to focus on a certain aspect of the patient’s record/treatments; see the “Daily Focus Sheet” for info.

18. **Body Language**
   Remember the power of nonverbals – watch your body language. Observe professionalism at all times.
19. **Proxemics/Personal Relationships**
There will not be any personal relationships between students and patients – this is in violation of state law and is grounds for immediate dismissal from the LPN program. Do not exchange names, telephone numbers, addresses, or any information of a personal nature. Upon leaving the Finan Center at the end of the clinical rotation, there is to be no communication of any kind between students and patients. See “Proxemics” info and the brochure, “Professional Boundaries.”

20. **Gifts**
You are not permitted to give to patients/accept from patients any gifts, regardless of value.

21. **Other Rules**
We are expected to follow all agency rules as a guest in their facility. If you have any questions/concerns about these rules, please notify your instructor or a staff person. Remember that the clinical site is an extension of the classroom, so Mineral County Schools and Mineral County School of Practical Nursing policies apply. Violation of any policy may result in dismissal from the LPN program.

22. **Interactions Process Recordings/Group Attendance Log/Journal**
You must have at least one therapeutic interaction with (preferably) your assigned patient each day. Each interaction should last at least 30 minutes. Jot down notes privately after you have interacted with the patient – not while you are talking with the patient. Never write your name, the patient’s name, or the agency on the notes. Your instructor will be asking to see your notes and talking with you about the assignment. See each day’s Daily Focus Sheet to document the daily objectives, your goal(s), therapeutic communication, and activities/groups you attended. You are also expected to write a journal entry each day on the focus sheet. All records must be legibly handwritten in black ink. Your instructor will check your work periodically to monitor your progress. See Daily Focus Sheet for further instructions.

23. **Questions?** Never hesitate to ask! Your instructor will be rotating cottage to cottage throughout the day; staff members are always available for information. Be assertive in your learning – introduce yourself and talk to people. Remember that questions are an essential part of the learning process and demonstrate critical thinking. Take advantage of every learning opportunity!

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Psych emergency; threat to self or others</td>
</tr>
<tr>
<td>Blue</td>
<td>CV/Respiratory code</td>
</tr>
<tr>
<td>Red</td>
<td>Fire</td>
</tr>
<tr>
<td>Black</td>
<td>Bomb threat</td>
</tr>
<tr>
<td>Yellow</td>
<td>Internal disaster</td>
</tr>
<tr>
<td>White</td>
<td>External disaster</td>
</tr>
</tbody>
</table>

**Proxemics: Hall’s Interactive Distance Zones**
**Professional Boundaries**
Intimate (1½ feet or closer)
- Usually reserved for close relatives, lovers, and friends; hugging is an example
- Nurses work in this zone only when assisting patients with personal needs, such as bathing or dressing
- Not appropriate distance for therapeutic communication

Personal (1½ – 4 feet)
- Space at which many communications take place, such as one-on-one interactions
- Messages received at 1½ feet are more “forceful” than those at 4 feet
- Each individual has their own “personal space” and boundaries
- Appropriate distance for therapeutic communication

Social (4 – 12 feet)
- Commonly used for working in groups
- Communication at this distance is less threatening than at closer levels
- No physical and very little direct eye contact takes place
- Some individuals may be intimidated by groups of people and may, therefore, limit their communications

Public (Further than 12 feet)
- Large groups or large places, such as malls or airports
- If group, speaker would require a microphone
- Not as interactive; little one-on-one or group interaction occurs

In therapeutically communicating with patients, we are best to work in the personal to social zones - never in the intimate zone. See the booklet, “Professional Boundaries,” for more information.

Maintain appropriate boundaries at all times!
# Behavioral Health Clinical Rotation

<table>
<thead>
<tr>
<th>Day 1: ___________</th>
<th>Daily Focus</th>
<th>Daily Goal/Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, Thoughts/Feelings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation/Review of paperwork (See Finan Rules &amp; Regulations)</td>
<td></td>
<td></td>
<td>Active listening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic relationship phases: Orientation, working, &amp; termination</td>
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<td></td>
<td>Broad opening</td>
<td></td>
<td></td>
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<tr>
<td>Observations &amp; cottage guidelines (See handout)</td>
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<td></td>
<td>General leads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning &amp; preparing for termination/discharge</td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

# Behavioral Health Clinical Rotation

<table>
<thead>
<tr>
<th>Day 2: ___________</th>
<th>Daily Focus</th>
<th>Daily Goal/Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, Thoughts/Feelings)</th>
</tr>
</thead>
</table>
**Behavioral Health Clinical Rotation**

<table>
<thead>
<tr>
<th>Day 3: ____________</th>
<th>Daily Focus</th>
<th>Daily Goal/Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, &amp; Thoughts/Feelings)</th>
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</thead>
<tbody>
<tr>
<td>Chart review:</td>
<td>Admission status &amp; paperwork</td>
<td>Presenting reality</td>
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<td></td>
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</tr>
</tbody>
</table>
### Behavioral Health Clinical Rotation

<table>
<thead>
<tr>
<th>Day 4: ____________</th>
<th>Daily Focus</th>
<th>Daily Goal/Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, &amp; Thoughts/Feelings)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use of words: Therapeutic communication basic principles (See techniques handout)</td>
<td></td>
<td>Sharing perceptions/making observations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Blocks/Barriers to Communication:

- Personality: Defense mechanisms (See handout)
- Personality disorders:
  - Antisocial
  - Borderline
- Patient's perception of ability to communicate assertively & awareness of defense mechanisms?

#### Identifying Themes

### Behavioral Health Clinical Rotation

<table>
<thead>
<tr>
<th>Day 5: ____________</th>
<th>Daily Goal/Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, &amp; Thoughts/Feelings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications:</td>
<td></td>
<td></td>
<td></td>
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| MAR (regular & prn meds)  
Ask staff to print patient’s med list |                     |                                      |                           |                                                  |
| Major classifications (action, s/e & a/e, nursing implications):  
Antipsychotics – AIMS scale & labs (WBC, FBS, lipids, lytes) |                     |                                      |                           |                                                  |
|                      |                     | Informing                           |                           |                                                  |
|                      |                     | Suggesting                          |                           |                                                  |
**Behavioral Health Clinical Rotation**

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<th>Daily Focus</th>
<th>Daily Goal/ Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
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#### Daily Focus

- **Therapies (Review progress notes to read therapists' assessments of patient's progress in therapies)**
- Community meeting
- Groups
- Activities
- Individual therapy
- Group therapy
- Family therapy
- Support groups (e.g. AA/NA)
- Patient's perception of overall treatment process, groups/activities, & therapies?

#### Daily Goal/Outcome

- **Validating**
- **Sequencing**
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</table>
### Behavioral Health Clinical Rotation

**Day 9:**

<table>
<thead>
<tr>
<th>Daily Focus</th>
<th>Daily Goal/Outcome</th>
<th>Therapeutic Communication Techniques</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, &amp; Thoughts/Feelings)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Termination/venting</strong>&lt;br&gt;<strong>Clinical evals: Instruction &amp; agency</strong>&lt;br&gt;<strong>Self eval: Communication skills</strong>&lt;br&gt;<strong>Strengths</strong>&lt;br&gt;1.</td>
<td></td>
<td>Active listening</td>
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<td>2.</td>
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<td>3.</td>
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<td>Summarizing</td>
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<td><strong>Areas needing improvement</strong>&lt;br&gt;1.</td>
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<tr>
<td><strong>Patient's perception of termination?</strong></td>
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</table>
## Recovery Services

<table>
<thead>
<tr>
<th>Learning Questions</th>
<th>Outcome</th>
<th>(Answer questions in column 1)</th>
<th>Attended</th>
<th>Disliked, &amp; Thoughts/Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is methadone? What is it used for in this setting? List three potential side/adverse effects of this drug.</td>
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<td>• What is the difference between methadone induction &amp; methadone maintenance?</td>
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<tr>
<td>• What medical history &amp; assessment info does the physician/nurse gather before initiating methadone treatment? Discuss three of these.</td>
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<tr>
<td>• What does “COWS” stand for? How is this tool used in the recovery process?</td>
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<tr>
<td>• What precautions are taken for safe handling &amp; administration of each client’s methadone dosing? Discuss three each for handling &amp; administration.</td>
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<td>• List three roles of a nurse working within this setting.</td>
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## Behavioral Health Clinical Rotation

### Willowbrook Assisted Living Program (ALP)

<table>
<thead>
<tr>
<th>Learning Questions</th>
<th>Daily Goal/ Outcome</th>
<th>Learning Outcomes (Answer questions in column 1)</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/ Disliked, &amp; Thoughts/Feelings)</th>
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</thead>
</table>
1. What services are offered through this program?

2. How many hours of treatment per week are clients required to complete? What types of treatments are offered?

3. What is the average length of stay before community placement is made?

4. What is “Rounds?” What is a “Service Plan?”

5. Describe the nurse’s role on this unit. Discuss three areas of responsibility.

6. How do mental illness and substance dependence impact patients’ daily lives? Discuss three areas you learned about in your discussion with patients (remember, no names or identifying info).

---

### Behavioral Health Clinical Rotation

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<tr>
<th>WMHS: Behavioral Health Unit Learning Questions</th>
<th>Daily Goal/Outcome</th>
<th>Learning Outcomes (Answer questions in column 1)</th>
<th>Groups/Activities Attended</th>
<th>Journal (Learned, Liked/Disliked, &amp; Thoughts/Feelings)</th>
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<tbody>
<tr>
<td>1. What assessments/</td>
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<td>Question</td>
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<td>What teaching are necessary in the admission process?</td>
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<tr>
<td>Discharge process?</td>
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<td>2. What meds are commonly given on the unit? Discuss three meds, with their associated nursing implications.</td>
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<td>3. What safety assessments are done on the unit by the nursing assistant? The nurse? How often are these conducted?</td>
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<td>4. What type of groups/therapies are patients involved in? Describe three benefits of these treatments.</td>
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<td>5. How do mental illness and substance dependence impact patients' daily lives? Discuss three areas you learned about in your discussion with patients on the unit (remember, no names or identifying info).</td>
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Behavioral Health Observational Experiences

**Western Maryland Regional Medical Center**
During this clinical experience, the student will:
1. Have an orientation that briefly covers
   a. Policies and procedures
   b. Rules and regulations
   c. Safety
   d. Tour
2. Protect patient confidentiality at all times
3. Receive a brief report of all patients on the unit
4. Differentiate & recognize mental health diagnoses & their s/s, treatment, medications, & nursing implications (including safety precautions), including dual diagnosis
5. Apply the nursing process in patient care situations, based on patient diagnosis
6. Discuss detox protocols for particular substances & associated nursing implications
7. Interact with patients on unit to be accepted into milieu
8. Maintain professional boundaries in all interactions with patients/staff
9. Therapeutically communicate with patients & record examples on Daily Focus Sheet for rotation
10. Ask appropriate questions to staff/patients to enhance learning
11. Accompany a nurse on a med pass, discussing commonly administered medications and associated nursing implications
12. Participate in safety checks performed on the unit
13. Follow staff direction for safety in event of escalations/emergencies to protect self/others
14. Report unsafe behaviors/hazards/possession of sharps/dangerous items to staff STAT
15. Observe documentation procedures in Medi-Tech and in/on other systems/records
16. Attend available groups/meetings & document on Daily Focus Sheet for rotation
17. Observe electroconvulsive therapy treatments, if available
18. Complete daily, written journal on Daily Focus Sheet for rotation
19. Debrief with staff to discuss learning & report off
20. Document and submit observations on the Daily Focus Sheet for this rotation

**Western Maryland Recovery Services**
During this clinical experience, the student will:
1. Have an orientation that briefly covers
   a. Policies and procedures
   b. Rules and regulations
   c. Safety
   d. Tour
2. Protect patient confidentiality at all times
3. Describe methadone, its use, and potential side/adverse effects of the drug.
4. Discuss the difference between methadone induction & methadone maintenance.
6. Learn what “COWS” stands for and how the tool is used in the recovery process.
7. Understand precautions taken for safe handling & administration of each client’s methadone dosing.
8. List roles of a nurse working within this setting.
9. Document and submit observations on the Daily Focus Sheet for this rotation.

_Willowbrook Assisted Living Program (ALP)_
1. Have an orientation that briefly covers
   a. Policies and procedures
   b. Rules and regulations
   c. Safety
   d. Tour
2. Protect patient confidentiality at all times
3. Determine the services offered through the ALP program.
4. Describe the required number of treatment hours of treatment per week and the types of treatments offered.
5. Determine the average length of stay before community placement is made.
6. Attend Rounds and a Service Plan Meeting.
7. Describe the nurse’s role on this unit and areas of responsibility.
8. Discuss with patients how mental illness and substance dependence impact their daily lives.
9. Document and submit observations on the Daily Focus Sheet for this rotation.
### Behavioral Health: Therapeutic Communication Techniques

<table>
<thead>
<tr>
<th>Technique</th>
<th>Definition</th>
<th>Example(s)/Considerations</th>
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</thead>
<tbody>
<tr>
<td>Active listening</td>
<td>Receiving info from/paying attention to pt's verbal &amp; nonverbal cues, thinking/feeling patterns, &amp; behaviors using all senses</td>
<td>Eye contact; eye level; proxemics; body language; attentive, open posture; congruent verbal and nonverbal language; patience; empathy; focusing</td>
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<td>Broad opening</td>
<td>Open-ended statements/questions that encourage pt. to elaborate on feelings &amp; to give more than yes/no answers</td>
<td>“Tell me what you are thinking about.” “What would you like to talk about today?”</td>
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<td>General leads</td>
<td>Brief, neutral statements to encourage pt. to continue talking</td>
<td>“Yes…” “I’m listening…” “Go on…”</td>
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<td>Restating</td>
<td>Repeating some or all of the pt.’s words to remind them of what they said/main thought &amp; to let them know they’ve been heard</td>
<td>Pt: “I am so afraid to talk to my mom about this.” N: “You're afraid to talk to your mom about depression.”</td>
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<td>Clarifying</td>
<td>Asking pt. for more information to understand what they are saying; to make vague information clear</td>
<td>“I’m not sure what you mean by feeling 'buttery.’” “You keep saying, “she” – who are you referring to?</td>
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<tr>
<td>Focusing</td>
<td>Taking notice of a single idea/word and concentrating on it in discussions to encourage the pt. to consider/discuss it further</td>
<td>“Let’s talk more about your relationship with your father.” “Tell me more about your stressors at work.”</td>
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<td>Sharing perceptions/</td>
<td>Verbalizing to the pt. what you see/hear during their conversations</td>
<td>I notice you have been pacing more.” “I see you smiling, but I sense that you are angry.”</td>
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<tr>
<td>Making observations</td>
<td>Pointing out recurrent patterns in thoughts, feelings &amp; behaviors</td>
<td>“I notice that every time we talk about your sister, you cry.” “When I come to get you for group, you say you can’t come today.”</td>
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<td>Silence</td>
<td>Planned absence of verbal remarks to allow pt. to think about what's been said/what they want to say, or just to collect thoughts</td>
<td>Therapeutic pause in communication</td>
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<td>Informing</td>
<td>Providing information that will help the pt. in the tx process</td>
<td>“Let’s review the information about your medication.” “The AA meeting you asked about starts tonight at 7 p.m.”</td>
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<tr>
<td>Suggesting</td>
<td>Offering possible alternatives/solutions to encourage the pt. to think “outside the box;” it is not giving advice!</td>
<td>“Have you ever thought about trying...?” “What do you think might happen if you...?”</td>
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<tr>
<td>Humor</td>
<td>Appropriate use of laughter/pun in communication; helps to discharge energy (“break the ice”)</td>
<td>Pt: “I was so embarrassed... I got up to leave and tripped over the chair!” N: “Well, that’s one way to get everyone’s attention, isn’t it!”</td>
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<tr>
<td>Validating</td>
<td>Affirming/confirming the pt.’s thoughts/feelings</td>
<td>“I can understand why John’s statement made you angry.” “I know you were embarrassed during the meeting.”</td>
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<td>Sequencing</td>
<td>Putting thoughts/occurrences in order to make sense of them</td>
<td>“So you started feeling depressed after the loss of your job?”</td>
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<tr>
<td>Presenting reality</td>
<td>Defining what is real and directing pt. back to it</td>
<td>“I believe you hear the voices, but I don’t – let’s get back to our drawings.”</td>
</tr>
<tr>
<td>Summarizing</td>
<td>Reviewing main points and conclusions</td>
<td>“Let’s see, so far we have talked about...”</td>
</tr>
</tbody>
</table>
## Behavioral Health: Common Defense Mechanisms

<table>
<thead>
<tr>
<th>Defense Mechanism</th>
<th>Definition</th>
<th>Patient Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>Unconscious refusal to admit an unacceptable idea or behavior</td>
<td>Mr. Davis, who is alcohol-dependent, believes that he can control his drinking if he so desires.</td>
</tr>
<tr>
<td>Repression</td>
<td>Unconscious and involuntary forgetting of painful ideas, events, and conflicts</td>
<td>Ms. Young, a victim of incest, no longer remembers the reason she always hated the uncle who molested her.</td>
</tr>
<tr>
<td>Suppression</td>
<td>Conscious exclusion from awareness anxiety-producing feelings, ideas, and situations</td>
<td>Ms. Ames states to the nurse that she is not ready to talk about her recent divorce.</td>
</tr>
<tr>
<td>Rationalization</td>
<td>Conscious or unconscious attempts to make or prove that one’s feelings or behaviors are justifiable</td>
<td>Mr. Jones, diagnosed with schizophrenia, states that he cannot go to work because his co-workers are mean, instead of admitting that his illness interferes with working.</td>
</tr>
<tr>
<td>Intellectualization</td>
<td>Consciously or unconsciously using only logical explanations without feelings or an affective component</td>
<td>Ms. Mann talks about her son’s death from cancer as being merciful and shows no signs of her sadness and anger.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>The unconscious separation of painful feelings and emotions from an unacceptable idea, situation, or object</td>
<td>Ms. Adams recalls that when she was sexually molested as a child, she felt as if she were outside of her body watching what was happening without feeling anything.</td>
</tr>
<tr>
<td>Identification</td>
<td>Conscious or unconscious attempt to model oneself after a respected person</td>
<td>Ms. Kelly states to the nurse, “When I get out of the hospital, I want to be a nurse just like you.”</td>
</tr>
<tr>
<td>Introspection</td>
<td>Unconsciously incorporating values and attitudes of others as if they were your own</td>
<td>Without realizing it, Mr. Chad wishes, talks, and acts similarly to his therapist, analyzing other patients.</td>
</tr>
<tr>
<td>Compensation</td>
<td>Consciously covering up for a weakness by overemphasizing or making up a desirable trait</td>
<td>Mr. Hahn, who is depressed and unable to share his feelings with other patients, writes and becomes known for his expressive poetry.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Consciously or unconsciously channeling instinctual drives into acceptable activities</td>
<td>Mr. Smith, a former perpetrator of incest who fees relapse, forms a local chapter of Sex Addicts Anonymous.</td>
</tr>
<tr>
<td>Reaction formation</td>
<td>A conscious behavior that is the exact opposite of an unconscious feeling</td>
<td>Ms. Wren, who unconsciously wishes her mother were dead, continuously tells staff that her mother is wonderful.</td>
</tr>
<tr>
<td>Undoing</td>
<td>Consciously doing something to counteract or make up for a transgression or wrongdoing</td>
<td>After accidentally eating another patient’s cookies, Ms. Donnelly apologizes to the patients, cleans the refrigerator, and labels everyone’s snack with their names.</td>
</tr>
<tr>
<td>Displacement</td>
<td>Unconsciously discharging pent-up feelings to a less threatening object</td>
<td>A husband comes home after a bad day at work and yells at his wife.</td>
</tr>
<tr>
<td>Projection</td>
<td>Unconsciously (or consciously) blaming someone else for one’s difficulties or placing one’s unethical desires on someone else</td>
<td>An adolescent comes home late from a dance and states that her date would not bring her home on time.</td>
</tr>
<tr>
<td>Conversion</td>
<td>The unconscious expression of intrapsychic conflict symbolically through physical symptoms</td>
<td>A student awakens with a migraine headache the morning of a final examination and feels too ill to take the test. She does not realize that 2 hours of cramming left her unprepared.</td>
</tr>
<tr>
<td>Regression</td>
<td>Unconscious return to an earlier and more comfortable developmental level</td>
<td>A 6-year-old child has been wetting the bed at night since the birth of his baby sister.</td>
</tr>
</tbody>
</table>
# Mineral County School of Practical Nursing
## Student Performance Evaluation

<table>
<thead>
<tr>
<th>Student</th>
<th>Instructor</th>
</tr>
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</table>

### Rotation: Behavioral Health

<table>
<thead>
<tr>
<th>Dates</th>
<th></th>
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### Attendance and Punctuality

<table>
<thead>
<tr>
<th>Tardy</th>
<th>Date(s)</th>
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<table>
<thead>
<tr>
<th>Absent</th>
<th>Date(s)</th>
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<table>
<thead>
<tr>
<th>Calls Agency to Report Off or to Report Late by 7:30 a.m.</th>
<th></th>
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### Assignment Preparation

<table>
<thead>
<tr>
<th>Submits Photo ID &amp; Wears Nametag</th>
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<table>
<thead>
<tr>
<th>Brings Clinical Syllabus &amp; Handouts Daily</th>
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<table>
<thead>
<tr>
<th>Carries Note Pad or Paper &amp; Group Schedules</th>
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<table>
<thead>
<tr>
<th>Follows Daily Focus Sheet</th>
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<table>
<thead>
<tr>
<th>Uses Appropriate Black Ink Pens</th>
<th></th>
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<table>
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<tr>
<th>Follows Dress Code</th>
<th></th>
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### Patient Interactions

<table>
<thead>
<tr>
<th>Follows Proxemics/Boundaries Guidelines</th>
<th></th>
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<table>
<thead>
<tr>
<th>Maintains Clinically-Focused Activities</th>
<th></th>
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<table>
<thead>
<tr>
<th>Interacts w/ Pt, as Guided by ITP/Treatment Team</th>
<th></th>
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<table>
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<tr>
<th>Practices Safety</th>
<th></th>
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<table>
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<tr>
<th>Protects Patient's Privacy/Rights</th>
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<tr>
<th>Promotes Therapeutic Milieu, Including Limit Setting</th>
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<thead>
<tr>
<th>Describes Patient's Axis Diagnoses, Meds, and Care</th>
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<tr>
<th>Attends Groups &amp; Therapies as Available</th>
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<table>
<thead>
<tr>
<th>Reviews Pt. Record (Chart, MAR, Kardex, Shift Report, &amp; Others)</th>
<th></th>
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<table>
<thead>
<tr>
<th>Completes Other Daily Assignments as Guided by the Daily Focus Sheet</th>
<th></th>
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</table>

### Communications

<table>
<thead>
<tr>
<th>Exhibits Honesty in Communication</th>
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<table>
<thead>
<tr>
<th>Maintains Confidentiality/HIPAA Standards</th>
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<thead>
<tr>
<th>Facilitates Clinically-Focused Conversations</th>
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<tr>
<th>Reports Observations as Appropriate</th>
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<thead>
<tr>
<th>Participates in Pre-/Post-Conference Discussions</th>
<th></th>
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<table>
<thead>
<tr>
<th>Communicates Therapeutically w/ Patients and Documents Examples on Daily Focus Sheet as Instructed</th>
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<table>
<thead>
<tr>
<th>Maintains Daily Journal/Other Required Paperwork</th>
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<table>
<thead>
<tr>
<th>Records Group Attendances</th>
<th></th>
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### Affective Behaviors

<table>
<thead>
<tr>
<th>Demonstrates Assertive Patient/Staff Interactions</th>
<th></th>
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<table>
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<tr>
<th>Exhibits Professional Behavior/Attitude</th>
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<thead>
<tr>
<th>Cooperates w/ Staff, Patients, Instructor, &amp; Peers</th>
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<tr>
<th>Follows Directions</th>
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<tr>
<th>Complies with Policies of School, Facility, &amp; Specific Cottage/Unit</th>
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<tr>
<th>Makes Self Accessible to Instructor/Patient/Staff</th>
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<tr>
<th>Identifies Personal Strengths &amp; Areas for Improvement</th>
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<tr>
<th>Reports Unsafe Conditions Appropriately &amp; in Timely Manner</th>
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<tr>
<th>Exhibits Positive/Appropriate Facial Expressions</th>
<th></th>
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<table>
<thead>
<tr>
<th>Responds Appropriately &amp; Professionally to Others</th>
<th></th>
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<table>
<thead>
<tr>
<th>Asks Questions to Instructor, Staff, Patients, and Peers as Part of the Learning Process</th>
<th></th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Demonstrates Respect to Instructor, Staff, Patients, &amp; Peers at All Times</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Notifies Instructor Before Leaving Facility For Any Reason</th>
<th></th>
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### Comments:

Satisfactory

Unsatisfactory

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</table>

#### Instructor’s Signature

Date

#### Student’s Signature

Date

Written 12/01
Revised 1/02; 11/03; 11/05; 10/08; 10/09; 10/11; 10/16
Reviewed 11/04; 10/06; 10/07; 1/09; 10/10; 1/12; 12/12; 11/13; 10/15
SOCIAL CONCEPTS OF NURSING PRECEPTORSHIP

For this clinical component, the student works with a practicing nurse in an area of nursing the student has interest in or would like to learn more about. The precepting nurse must be an LPN or RN with at least three years of experience in his/her current nursing position. The student and nursing faculty work together to arrange this 72-hour experience with the participating facility and precepting nurse.

The clinical preceptorship experience focuses on the leadership and management role of the practical nurse.

During this clinical experience, the student will:

1. Observe and describe multi-tasks in the scope of practice of a licensed practical nurse
2. Observe and describe the leadership and management style and critical thinking of a staff nurse while
   a. organizing a multi-patient assignment
   b. continuously monitoring and assessing multiple patients
   c. assisting doctors and other primary care providers
   d. monitoring charts for physician’s orders
   e. transcribing physician’s orders
   f. notifying the physician of abnormal laboratory test results, change in patient’s condition, and other complications
   g. supervising and communicating with nursing assistants and other personnel

See separate Preceptorship packet for further information, including the Do and Do Not List and other guidelines
APPENDIX
Set Yourself Up… For Success!

Guidelines for Student Performance of Skills in Med-Surg and Specialty Clinical Rotations

Students may do Independently:

a. Review charts
b. Client assessments, including vital signs, weights, Accuchecks, intake and output, and interviews
c. Hygiene, including bed bath, back rub, mouth care, hair, nails, and bed-making
d. TED hose, cough and deep breathing, and incentive spirometer
e. Environmental assessment and interventions
f. Transfer clients (if a lift is required, student must practice with staff first; two people are always required for lift use)
g. Apply and assess effectiveness of assistive devices and apply splints
h. Toilet clients
   i. Ambulate, position, and provide range of motion
   j. Feeding (staff must report swallowing ability)

Students must Perform with Instructor:

1. Medication administration
   a. Intravenous assessment, monitoring, and medications (peripheral lines only; no central/PICC/SQ port lines; not first dose of medication; not IV push; see agency policy for other medications practical nursing student may not hang, e.g. Flagyl)
2. Tube feedings
3. Colostomy care
4. Dressing changes and wound care
5. Sterile procedures, such as catheterization and tracheostomy care
6. Suture or staple removal
7. Specimen collection
8. Any invasive or sterile procedure
9. Postmortem care
10. Document care in client chart

Students may NOT:

1. Take physician orders
2. Witness consents or legal documents
3. Draw or administer blood or blood products
4. Change IV pump settings or syringes
5. Participate in show of force or restraint of client
   a. Participate in spinal immobilization, change of position, or cervical collar for unstable spine

Check with Instructor for Questions/Concerns about Other Care/Skills Available
GUIDELINES FOR CHARTING

1. Follow agency policy regarding notes – format, frequency.
2. Must use black ball point pen, only, and print or write legibly.
3. Precede each entry with date and time.
4. Do not erase or completely mark out a mistake. Draw a single line through the error and sign it.
5. Always sign your name, on any entry you have made on flow sheets or nurse’s notes, according to agency policy, e.g. N. Nurse, SPN.
6. Avoid using the word “patient” – some facilities chart the clients’ name.
7. Chart in chronological order, recording on every line so the order cannot be altered.
8. Do not write between the lines. If you inadvertently omit a note – make a late entry.
9. Record information as close as possible to the time you deliver care. Do not document in advance.
10. Write notes only for clients you have cared for.
11. Never change your documentation to cover up for someone else’s mistakes.
13. Indicate in the record that you not only know what complications may occur – but that you are seeking to prevent them.
14. Document problems as they occur, the interventions, and the evaluation of the patient status.
15. Document the safeguards you use to protect your patient.
17. Record any significant symptoms or changes in the clients’ conditions.
18. Record physician visits.
20. If something goes wrong – document the mistake or accident in the nurse’s notes, and on the incident report. Do not document “completion of incident report” in patient record.
21. Avoid vague words like – “normal”, “good”, “bad”, or “adequate.”
22. Use proper spelling – keep a dictionary handy if needed. Do not use abbreviations.
GUIDELINES FOR NARRATIVE NURSING NOTES

1. **PSYCHO-SOCIAL**
   Overall appearance and behavior (anxious, afraid, impatient, angry), emotional response to current treatment/hospitalization, self-concept/body image changes, grieving, limitations in intellectual capacity, cultural factors (beliefs, response to pain), ineffective family coping.

2. **SKIN**
   Change in skin pigmentation (color), texture (turgor), temperature, eruptions, rashes, unusual hair growth or loss.

3. **NEURO**
   Headache, nervousness, sleep disturbance, vertigo, syncope, sensory or motor disturbance, paralysis/paresis, paresthesia/hyperesthesia/hypoesthesia, memory loss, nightmares, twitching, convulsions, tremors, dysphagia, handwriting changes, mental status, level of consciousness (ability to follow command), disorientation, pupil size and reaction.

4. **CARDIOVASCULAR**
   Dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, hypertension, claudication, varicose veins, thrombophlebitis, chest pain, heart rate (palpitations, rhythm changes, heart murmur), edema (pedal, sacral, periorbital), heart sounds, pulses (peripheral, aical, jugular veins), and capillary refill.

5. **RESPIRATORY**
   Breath sounds (clear or adventitious: wheezing, rales, etc.), character of breathing (rate, rhythm, unlabored/labored, dyspnea, shallow, etc.), chest movement, cough, expectoration, hemoptysis, night sweats, sneezing rhinorrhea, oxygen, chest drainage tubes, sputum specimens and characteristics, oral hygiene, post-op coughing and deep breathing exercises, incentive spirometry, position of bed, pulse oximeter/apnea monitor.

6. **GI/METABOLIC**
   Dietary habits, appetite, food intolerance, use of antacids, indigestion, nausea, vomiting, distension, abdominal pains, abdominal masses, jaundice, hematemesis, bowel habits, diarrhea, constipation (laxative use), melena, stool formation and description, hemorrhoids, incontinence, abdominal surgery, bowel sounds, abdominal tubes/drainage, ostomies, diaphoresis, TPN, diabetes/thyroid, goiter, polyphagia, inspection, auscultation, percussion, palpation.

7. **GU/GYN**
   Dysuria, polyuria, oliguria, hematuria, pyuria, calculi, force of stream, output (color, amount, etc.), strain urine, retention, bladder distention, frequency, hesitancy, nocturia, incontinence, discharge (type, color, odors), care of tubes (foley, suprapubic), LMP (vaginal discharge/bleeding), rashes.

8. **MUSCULOSKELETAL**
   Muscle weakness, pain, aches, cramps, atrophy, back or joint stiffness, deformities, dislocation, fractures, radicular pain, casts, ambulation, therapy, use of devices, elevation/immobilization of extremities or body parts, traction.
CLINICAL EXPECTATIONS REGARDING MEDICATION ADMINISTRATION

1. Check medication sheets/computer at beginning of shift to verify administration schedules.

2. Look up all meds to be given and know the following:
   a. Drug Name
   b. Classification
   c. Uses
   d. Action in Body
   e. Normal Dosage
   f. Side Effects
   g. Nursing Interventions
   h. Pertinent lab or assessment data in relation to medication effects.
   i. Contraindications
   J. Pertinent teaching points to educate the client

   (You may use the required Drug Guide – but you must be prepared before giving the med.)

3. All drugs must be given on time. There is a 30-minute leeway before or after administration time. Be ready.

4. PRN meds MAY NOT be given until the ordered time limit.

5. All meds must be checked by instructor to verify dosage.

6. All injectable meds must be prepared and administered with instructor present.

7. All meds must be charted as given immediately after being administered.

8. PRN meds are a priority. If patient needs a PRN, the procedure is to:
   a. Check MAR for appropriate order and when last dose was given.
   b. Obtain med with instructor
   c. Prepare med.
   d. Administer med.
   e. Chart med.
   f. Reassess patient within 30-60 min.

9. ALWAYS maintain close communication with your Clinical Instructor regarding your patient’s status.
ALTERNATIVE CLINICAL EXPERIENCE

Objectives:

1. The student will identify the primary population served.

2. The student will describe the similarities and differences of this population as compared to the primary population of his/her assigned clinical unit.

3. The student will describe the healthcare professional he/she shadowed, in terms of educational requirements (credentialing, certifications, etc.) and essential job responsibilities.

4. The student will discuss how these responsibilities differ from the essential responsibilities of the nurses on his/her assigned clinical unit.

5. The student will discuss the likelihood of pursuing a job in this area.
ALTERNATIVE CLINICAL EXPERIENCE ASSIGNMENT SHEET

Name: ________________________________ Date: ________________________________

Alternative experience: __________________________________________________________

Name and title of nurse shadowed: ________________________________________________

1. Credentials of nurse (advanced degree, certification, years of experience, or training) necessary to perform role.

2. What are the essential job responsibilities of the nurse?

3. How do these responsibilities differ from the essential responsibilities of the nurses on your assigned clinical unit?

4. Describe the primary population served.

5. Describe the similarities and differences of this population as compared to the population on your assigned clinical unit.

6. What did you observe?

7. What was the best/most interesting part of the experience?

8. What did you like least about the experience?

9. Is this an area where you would consider working? Why or Why not?

10. Had you considered working in this area before today?

11. Would you recommend this experience to a fellow student? Why or Why not?

12. Other comments?
ASSESSMENT, NURSING CARE PLAN, AND MEDICATION SUMMARIES POLICY

Assessment, care planning, and medication administration are critical roles of the practicing nurse. These skills involve much knowledge, accountability, responsibility, and attention to detail. Learning about these roles extends beyond the classroom and clinical settings; it involves spending quiet, quality time critically thinking about the patients’ medical information, analyzing the findings, and documenting the conclusions.

To accomplish these essential educational outcomes, we expect you to:

- Learn about your assigned patient, including his/her medical history, assessment info, current orders, and medications;
- Document vital signs and a complete head-to-toe assessment, following the *Completing a Systems Assessment in SimChart* and *SimChart Systems Assessment* requirements;
- Document a nursing care plan, following the *Completing Nursing Care Plans in SimChart* requirements;
- For clinical, document medication summaries for each med you actually gave, following the *Completing Med Summaries in SimChart for Clinical* requirements;
- For the classroom, document medication summaries for each system as assigned by the instructor, following the *Completing Med Summaries in SimChart for the Classroom* requirements; and
- Save all the above info in the SimChart program in the correct file, and submit it to the appropriate instructor by the specified deadline.

Violations will be given if the above criteria are not followed and/or if the work is not submitted on time to the appropriate instructor. Part of your clinical performance grade (S/U) is determined by this work.

See the following pages for the specific requirements for each type of assignment:

- Completing Medication Summaries in SimChart: For Clinical
- Completing Medication Summaries in SimChart: For the Classroom
- Completing Nursing Care Plans in SimChart
- Completing a Systems Assessment in SimChart
- SimChart Systems Assessments

Written 12/03
Revised 04/06; 01/08; 03/10; 04/10; 03/11; 03/12; 03/14; 05/14; 07/14; 10/14; 10/15
Reviewed 04/13; 10/16
Completing Medication Summaries in SimChart:

FOR CLINICAL

You Will Need

- Patient med list
- Davis’s Drug Guide resource on internet
- SimChart program on internet

Davis’s Drug Guide Online

- Go to www.drugguide.com
- In the upper right corner, click log in, and sign in with the appropriate user name and password
- Search for the drug by generic name; a list will come up
- Click on the generic name listing for the drug; the monograph will then display on the screen
- If you don’t see the entire monograph on the screen, click on “Display all Sections” on the right side of the screen
- Read the information about the drug

SimChart

- Open a new tab in your internet browser
- Go to evolve.elsevier.com and click on student site
- Sign in using your personal username and password
- Click on SimChart in your list of resources
- On the left menu bar, click on “My Clinicals”, the clinical week’s date(s), and “Click to access simulation.” Pay close attention to the instructor and date… make sure you have the correct one for your assignment!
- Complete the “Clinical Setup” screen – you must enter something in all sections and choose an avatar. Do NOT type patient information here; just type your own personal data
- On the left side of the screen, click on “Patient Charting,” then “Special Charts”
- At the top of this list, select “Miscellaneous Nursing Notes” – this is where you will always document your medication summaries

Type this information into SimChart

- Generic name (must be spelled exactly and not capitalized)
- Brand name (specific one listed on MAR/med list; if none, discuss w/ instructor; must be spelled exactly and capitalized)
- Indication (specific one for your patient)
- Ordered dose, route, and frequency (for your patient; from the MAR/med list)
- Whether dose is WNL, high (↑), or low (↓)

Read, then copy and paste these sections into SimChart

- Contraindication/Precautions (ONLY the “Contraindicated in” part of this section; NO OTHER PARTS)
- Adverse Reactions/Side Effects (ALL)
- Assessment, including Lab Test Considerations, and Toxicity Overdose (ALL)
- Implementation (ALL sections except the lists of compatibility and incompatibility drugs/solutions; don’t forget to check below the lists of these drugs/solutions for other routes, such as transdermal or intranasal)
- Patient/Family Teaching (ALL)

DON’T FORGET TO SAVE YOUR WORK!!!
Completing Med Summaries in SimChart:

FOR THE CLASSROOM

You Will Need

- Patient med list
- Davis’s Drug Guide resource on internet
- SimChart program on internet

Davis’s Drug Guide Online

- Go to www.drugguide.com
- In the upper right corner, click log in, and sign in with the appropriate user name and password
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- Sign in using your personal username and password
- Click on SimChart in your list of resources
- On the left menu bar, click on “My Clinicals”, the classroom assignment, and “Click to access simulation.” Pay close attention to the system/assignment name… make sure you have the correct one for your assignment!
- Complete the “Clinical Setup” screen – you must enter something in all sections and choose an avatar. Do NOT type patient information here; just type your own personal data
- On the left side of the screen, click on “Patient Charting,” then “Special Charts”
- At the top of this list, select “Miscellaneous Nursing Notes” – this is where you will always document your medication summaries

Type this information into SimChart

- Generic name (must be spelled exactly and not capitalized)
- Brand name(s) (those listed on assignment sheet given to you by instructor; must be spelled exactly and capitalized)

Read, then copy and paste these sections into SimChart

- Indications (ALL FDA-approved uses; you are learning about the medication and its many uses so list all FDA-approved uses, but not the unlabeled uses)
- Contraindication/Precautions (ONLY the “Contraindicated in” part of this section; NO OTHER PARTS)
- Adverse Reactions/Side Effects (ALL)
- Assessment, including Lab Test Considerations, and Toxicity Overdose (ALL)
- Implementation (ALL sections except the lists of compatibility and incompatibility drugs/solutions; don’t forget to check below the lists of these drugs/solutions for other routes, such as transdermal or intranasal)
- Patient/Family Teaching (ALL)

DON’T FORGET TO SAVE YOUR WORK!!!
Completing Nursing Care Plans in SimChart

You Will Need
- Patient assessment data
- Nurse’s Pocket Guide (care planning guide)
- SimChart program on internet

Opening SimChart
- Open your internet browser
- Go to evolve.elsevier.com and click on student site
- Sign in using your personal username and password
- Click on SimChart in your list of resources
- On the left menu bar, click on “My Clinicals”, the clinical week’s date(s), and “Click to access simulation.” Pay close attention to the instructor and date… make sure you have the correct one for your assignment!
- Complete the “Clinical Setup” screen – you must enter something in all sections and choose an avatar. Do NOT type patient information here; just type your own personal data

Completing Your Care Plan: An Example – “Pain Related to Recent Surgery”
- On the left side of the screen, click on “Care Plan,” then “Care Plan” below it
- Select one Medical Diagnosis: Click on your patient’s medical diagnosis
  - e.g. Appendicitis, acute
- Select one Nursing Diagnosis: Click on the appropriate nursing diagnosis based on your assessment findings
  - e.g. Acute pain
- Select Type: Actual – you must base your care plan on an actual problem the patient is experiencing
  - e.g. Physical agents (specify) Add: Recent surgery
- Related To: This is the one, primary etiology/cause of the problem; check the box that applies and add details for your particular patient if needed (e.g. if any item says “specify,” add the specific info for the patient)
  - e.g. Physical agents (specify)
- Evidenced By: Select/add three assessment findings (may be a mix of subjective and objective); if adding subjective data, check the “Subjective data” box and add your three assessment findings, one at a time
  - e.g. Subjective data Add: Grimacing, especially with movement; rates pain 7 on 0-10 scale; and c/o abdominal tenderness @ incision site
- Expected Outcome: Check the box for one appropriate outcome for your patient – make sure it is SMART (specific, measurable, achievable, relevant, and time bound); add in the time frame and how you will measure the outcome
  - e.g. Patient will decrease in pain-related behaviors Add: Patient will rate pain 3 or less on 0-10 scale within one hour of pain med
- Interventions: Select three appropriate interventions or type in your own from your nursing pocket guide; make sure you type in the rationale for each
  - e.g. Administering medications for pain relief as ordered R: to alleviate/control pain
  - Assessing the patient’s pain level, using an age-appropriate scale R: to monitor pain med effectiveness
  - Demonstrating the use of nonpharmacologic approaches R: to encourage pt. involvement in own pain management

DON’T FORGET TO SAVE YOUR WORK!!!
Completing a Systems Assessment in SimChart

You Will Need
- Patient assessment data
- SimChart program on internet

Opening SimChart
- Open your internet browser
- Go to evolve.elsevier.com and click on student site
- Sign in using your personal username and password
- Click on SimChart in your list of resources
- On the left menu bar, click on “My Clinicals”, the assignment or the clinical week’s date(s), and “Click to access simulation.” Pay close attention to the instructor and date… make sure you have the correct one for your assignment!
- Complete the “Clinical Setup” screen – you must enter something in all sections and choose an avatar. Do NOT type patient information here; just type your own personal data

Completing the Assessment Data
- On the left side of the screen, choose “Vital Signs” and enter your vitals
- On the left side of the screen, choose “Patient Charting” and then “System Assessments”
- Use your “SimChart System Assessment” sheet as a guide to document the required patient assessment information

DON’T FORGET TO SAVE YOUR WORK!!!
**SimChart Systems Assessment**

### Cardiovascular
- **Pulses:** Apical ______ Regular / Irregular  Murmurs: Y / N
- **Radial_________ Pedal_________**
- **Edema:_________ Skin Temp:_________**
- **Cap Refill:_________ Telemetry:_________ Rhythm:_________**
- **Mucous Membranes: Color_________ Moisture_________**
- **Cardiac Problems:________________**

### Respiratory
- **Lung Sounds:________________**
- **Pattern:_________ Effort:_________**
- **Oxygen:_________ lpm via_________ SPO2:_________ cont / intermit**
- **IS:_________ Nebs:_________ Suctioning:_________**
- **Artificial Airway:_________ Chest Tube:_________**
- **Cough:_________ Prod / Nonprod Color:_________ Consist:_________**
- **Respiratory Problems:________________**

### Neurological
- **Level of Consciousness:_________ Person, Place, Time and Situation**
- **Emotional State:_________ Grips:_________**
- **CNS Problems:________________**

### Integumentary
- **Color:_________ Temp:_________ Moisture:_________**
- **Turgor:_________ Integrity:_________**
- **Hair: Distribution:_________ Health:_________**
- **Characteristics:________________**
- **Nails: Configuration:_________ Condition:_________**
- **Color:_________ Base:_________**

### Sensory
- **Vision Problems:________________**
- **Hearing Problems:________________**
- **Pupils: Equality:_________ Size:_________**
- **Reaction:_________ Accommodation:_________**

### Musculoskeletal
- **ROM:_________ Gait:_________**
- **Balance:_________ Amputations:_________**
- **Post-Op Area:_________ Homan’s:_________**
- **Post-Op Assessment:_________**

### Gastrointestinal
- **Mouth/Gums/Teeth:________________**
- **Swallowing problems:________________**
- **GI Problems:________________**
- **Abd:_________ Bowel Sounds:_________**
- **Continent / Incontinent:_________ Last BM:_________**
- **Stool Characteristics:________________**
- **Ostomies:________________**

### Genitourinary
- **Voiding:_________ Catheter Y / N  Dialysis Y / N**
- **Urine Color:_________ Characteristics:________________**
- **Odor:_________ Continent / Incontinent:_________**
- **Ostomies:________________**
- **Genitalia Abnormalities/Problems:________________**

### Pain
- **Pain Y / N Location:_________ Intensity:_________**
- **Constant / Intermittent / Unable to Report:________________**
- **Quality:_________ Nonverbal Cues:_________**
- **Interventions:________________**
- **Aggravating factors:________________**
- **Relieving factors:________________**

### Psychosocial
- **Perception:________________**
- **Support:________________**
- **Coping:________________**
- **Anxiety:_________**

### Safety
- **Orientation:_________**
- **Bracelet Check:_________ Hospital Band:_________**
- **__Allergy Band:_________ __Fall Risk Band:_________**
- **Fall Risk:_________ Restraints:_________**
- **Isolation:_________**

### Vital Signs
- **Time:_________ Temp:_________ Pulse:_________**
- **Resp:_________ B/P:_________ SPO2:_________**
- **Pain Level:_________ Interventions:________________**
- **Time:_________ Temp:_________ Pulse:_________**
- **Resp:_________ B/P:_________ SPO2:_________**
- **Pain Level:_________ Interventions:________________**

### Accu Checks
- **0700:_________ Coverage:_________**
- **1100:_________ Coverage:_________**

### Other:

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**Page 159**
Mineral County School of Practical Nursing  
Student’s Evaluation of CLINICAL Instruction

Course __________________________  Instructor __________________________  Date ________________

Directions: After reflecting on the teacher’s instruction, read the criteria statements and rate the teacher’s performance by checking the box that represents your perception.

The teacher did this activity:  C-Consistently;  F-Frequently;  O-Occasionally;  S- Seldom;  or R-Rarely.

<table>
<thead>
<tr>
<th>Criteria Statement</th>
<th>Frequency</th>
<th>C</th>
<th>F</th>
<th>O</th>
<th>S</th>
<th>R</th>
<th>Not Applicable OR Comments</th>
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</thead>
<tbody>
<tr>
<td>The instructor informs students of their progress.</td>
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<td>The instructor offers constructive suggestions to improve technique.</td>
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<td>A variety of assignments, as available, are assigned for learning.</td>
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<td>The instructor assigns clinical assignments that correlate to classroom learning.</td>
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<td>The instructor clarifies the relationship between theory and clinical practice, during pre and/or post-conferences.</td>
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<td>The instructor emphasizes the importance of individual patients and their autonomy.</td>
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<td>The instructor stresses the student nurse’s responsibility and accountability, as well as that of the staff nurse.</td>
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<td>The instructor models and expects students to have professional attitude, language, and behavior.</td>
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<td>The instructor encourages students to take initiative in judgment in prioritizing patient needs, organizing, planning, and directing own activities with the instructor’s assistance.</td>
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<td>The instructor maintains a clinical atmosphere that encourages students to ask questions about any area of uncertainty.</td>
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<td>The instructor conducts pre- and post-conferences in a meaningful manner to analyze clinical situations.</td>
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<td>The instructor practices current standards of nursing.</td>
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<td>The instructor provides a clinical syllabus with a course description, clearly stated learning objectives, and student’s responsibility prior to or on the first day of this clinical experience.</td>
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You may write more comments on the back of this paper, if you desire.
Mineral County School of Practical Nursing
Student’s Evaluation of Clinical Site/Learning Experiences

Facility

Clinical Rotation

Length of Rotation

Directions
Please answer the following questions. Please be frank and honest in your answers; they, in no way, affect your grade. Your comments are used to maintain quality and learning effectiveness in the clinical setting.

1. Do you feel this facility offered learning experiences appropriate to the clinical specialty of classroom subject material? Please circle Yes _____ No______

2. If yes, please state briefly what you perceived as valuable learning experiences:

3. Do you feel this is a valuable learning site for future classes? Please circle Yes No

4. If no, why?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

You may write more comments on the back of this paper, if you desire.

THANK YOU FOR YOUR FEEDBACK!
Mineral County School of Practical Nursing

**Student Clinical Self-Evaluation**

<table>
<thead>
<tr>
<th>Student</th>
<th>__________________________________________________________________________________</th>
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<tbody>
<tr>
<td>Rotation</td>
<td>__________________________________________________________________________________</td>
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<tr>
<td>Date</td>
<td>__________________________________________________________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Challenges/Areas for Improvement/“Problems to be Solved”</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<tr>
<td>3.</td>
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</tbody>
</table>

**Instructor Comments:**

Written 03/12
Reviewed 03/15; 03/14; 10/16