

**GRAYSON COLLEGE
ASSOCIATE DEGREE
NURSING PROGRAM**



**NURSING 4
RNSG 2463
Spring 2017**

GRAYSON COLLEGE

Course Syllabus

Course Information

RNSG 2463, Clinical Nursing 4, Spring 2017

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Course Pre-requisites, Co-requisites, and/or Other Restrictions

RNSG 1523, 1119, 1460, 2504, 1144, 1461, 2514, 2562; or RNSG 1227, 2404; BIOL 2320, 2120, 2301, 2101, 2302, 2102; PSY 2301, 2314, 2562, 2514.

Course Placement: Fourth semester of the nursing program.

Course Description

A health-related work-based learning experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional. This course must be taken concurrently with RNSG 2435.

Student Learning Outcomes: Student learning outcomes for concurrent completion of RNSG 2435 and RNSG 2463:

Member of the Profession:

1. Demonstrate professional attitudes and behaviors.
2. Demonstrate personal accountability and growth.
3. Advocate on behalf of patients, families, self, and the profession.

Provider of Patient-Centered Care:

4. Use clinical decision making skills to provide safe, effective care for patients and families.
5. Develop, implement and evaluate teaching plans to meet the needs of patients and families.
6. Integrate a caring approach in the provision of care for diverse patients and families.
7. Perform skills safely and correctly in the provision of patient care.
8. Manage resources in the provision of safe, effective care for patients and families.

Patient Safety Advocate:

9. Implement measures to promote a safe environment for patients, self, and others.
10. Formulate goals and outcomes to reduce risk using evidence-based guidelines.

Member of the Health Care Team:

11. Initiate and facilitate communication to meet the needs of patients and families.
12. Collaborate with patients, families, and health care team members to promote quality care.
13. Function as a member of the interdisciplinary health care team.

Scans Skills:

When taken concurrently with RNSG 2435, the following skills will be achieved:

Workplace Competencies

1. Resources: Identifies, Organizes, Plans and Allocates Resources:
Students in RNSG 2463 have to be able to allocate their time and material/facility resources in an efficient manner in the clinical setting. They must be able to manage the care of a group of clients in the clinical setting. Students must organize and plan patient care activities so that the work is completed in the allocated time. Concepts of making client assignments for a team, that helps students learn how to distribute the patient care among members of the team, is introduced.
2. Interpersonal Skills: Works with Others
Students in RNSG 2463 must demonstrate skills of negotiation, delegation, and participation as a member of a team. Students learn to use concepts of management and evaluation skills as they work with other healthcare team disciplines. Students are also expected to meet self-directed learning goals that enable them to identify needs of growth.
3. Information: Acquires and Uses Information

Students in RNSG 2463 must continue with development of information skills so that all resources of patient information are used to collect data. Sources of information include the individual hospital information systems, the college's extensive collection of resources including internet, CAI, (available in the Health Science computer lab), patient record, physician record, nursing journals and other available references.

4. Systems: Understands Complex Inter-Relations

Students in RNSG 2463 must be able to practice within the legal scope of nursing practice. This legal scope includes the state of nursing regulations, federal legislation, state statutes and common law. The practice of nursing is governed by the Nurse Practice Act, which was enacted by the state legislature. A variety of laws are enacted at the state level that has a direct impact on the nurse providing clinical care.

5. Technology: Works with a Variety of Technology

Students in RNSG 2463 must be able to manage information and knowledge with use of advanced and emerging technology. Emerging technologies can be used to provide linkages, specifically information technologies used for information handling. The current focus is on using information collected by emerging technologies to gain a competitive advantage in healthcare.

Foundation Skills

1. Basic Skills: Reading, Writing, Math, Listening and Speaking

Students in RNSG 2463 are required to do several written assignments reflective of their clinical experiences such as nursing care plans and/or teaching plans. Participation in case study presentations is also required. Dosage calculations on math mastery exams requiring 90% competency is required.

2. Thinking Skills: Creative Thinking, Problem Solving, Visualizing Relationships, Reasoning and Learning

Students in RNSG 2463 are encouraged to be active participants in the learning process as well as self-directed learners. They must be able to identify their learning needs. They are required to complete case studies for the purpose of problem solving and critical thinking. Formulation of a philosophy of Nursing and personal values are exposed. By recognizing and identifying problems in the client populations, students develop and implement a plan of care.

3. Personal Qualities: Responsibility, Self-esteem, Sociability, Self-Management, Integrity and Honesty

Students in RNSG 2463 critique themselves after each clinical day with regard to professional development. They are expected to demonstrate the professional nursing role by expressing insight into their own learning needs. They must demonstrate respect for others, assume accountability for decisions and/or actions and involve self in finding solutions to problems.

Required Textbooks and Materials: See RNSG 2435 Syllabus

Methods of Evaluation:

The course grade is based upon clinical performance, assigned projects/presentations, and written assignments. Clinical performance is measured on a pass/fail clinical evaluation tool. To achieve a clinical performance grade of "Pass" the student must receive satisfactory (75%) on all items identified with an asterisk at the time of the final evaluation. All assignments (including daily/weekly evaluations and paperwork) must be satisfactorily completed and submitted in a timely manner to the clinical instructor in order to receive a grade of "Pass" on the clinical evaluation tool.

Skills Review Check-off

All students must pass a skills review check-off at the beginning of the semester in the lab sections of the second, third and fourth semesters of the program. All students will be allowed two attempts to successfully

complete a random selection of any two previously learned skills. Check-offs will be conducted using a skills check-off form. Both skills selected must be completed within a 30 minute time period. Students will be given the option of a five minute warning. Failure to pass the check-off will result in the need to withdraw from the course and any concurrent nursing courses.

Clinical Requirements

1. Written assignments must be completed as designated by the Nursing 4 faculty.
2. Students will bring current drug information to clinical.
3. Students will come prepared to assume designated assignments whether in the acute care setting or a community setting. Each student will assume the role of student Team Leader when assigned.
4. Critical skills must be passed in the designated time frame and performed according to critical criteria.
5. Assignments for the community resource and simulation rotations must be completed by the designated time. Performance will be reflected on the final clinical evaluation.

Methods of Instruction

1. Discussion
2. Group Process - Role Play
3. Simulation of client situations
4. Study Guides
5. Audio-visual /Computer materials
6. Clinical practicum
7. Written assignments
8. Required textbooks
9. Instructor - student conferences
10. Supervised care of selected clients
11. Daily evaluations

Course & Instructor Policies

Attendance Policy

(Revised 11/15)

Regular attendance is mandatory for accomplishment of the ADN program's goals and objectives. The ADN program adheres to the *Grayson College Student Handbook* attendance policy. Should absences occur which do not allow for full evaluation of student performance (quality and consistency) faculty will be unable to assign a passing grade.

The following policies are specific to the clinical course.

1. Attendance on the assigned clinical day is mandatory. Any missed clinical time must be made up on the assigned clinical make-up day. More than one clinical absence during the entire program may be grounds for dismissal based on the recommendation of the Admission, Retention and Graduation Committee.
2. Students must attend all pre and post-conferences either in the clinical setting or on campus (i.e., guest speakers, lab practices, etc.).
3. Students are expected to remain on the clinical campus during the entire clinical day. If a student must leave the clinical campus during a designated meal or break time, the student must have permission of the clinical instructor and is responsible to ensure that there is adequate coverage to meet the needs of assigned clients.

4. Students must notify the professor or a designated alternate at least one hour prior to time scheduled for clinical if they are going to be absent. Failure to notify the professor will be reflected on the final clinical evaluation and may result in a clinical failure.

Clinical Course Policies: This is not a complete list of clinical course policies. All policies related to clinical courses are published in the ADN Program Student Handbook

Required Assignments: Specific assignments, requirements, objectives, and clinical forms related to RNSG 2463 are included at the end of the course syllabus for ease of printing.

Academic Calendar: See RNSG 2435 Calendar

Grayson College is not responsible for illness/injury that occurs during the normal course of classroom/lab/clinical experiences.

These descriptions and timelines are subject to change at the discretion of the Professor.

Grayson College campus-wide student policies may be found in each Canvas course shell.

Specialty Area Objectives

A clinical experience in a specialty area involves personal & professional responsibility in the following areas:

1. Preparation prior to the clinical experience as assigned
2. Communication & collaboration with the specialty area staff & your assigned preceptor
3. Completion of the specialty area objectives for the assigned experience
4. Completion of two clinical objectives
5. Timely submission of required paperwork related to your experience

Specialty Area Objectives: Emergency Department

1. Report to the ER supervisor or charge nurse following pre-conference. Assist an RN preceptor with client assessment, care and discharge. Invasive procedures may be performed with RN preceptor supervision. Observe the process of triage.
2. Written work: Submit a summary of your day. Compare nursing care you performed with standard triage procedures. Complete the two additional objectives you selected. Submit with daily evaluation.

Specialty Area Objectives: Day Surgery

1. Report to the DS supervisor or charge nurse at the time designated by the instructor. Assist with client assessment, care and discharge in the pre- and post-operative phases. Observe and assist with IV fluid preparation and IV insertion as available. Invasive procedures may be performed with RN preceptor supervision.
2. Written work: Submit a summary of your day. Identify nursing priorities observed in the pre and post-operative phases. List nursing care and skills performed. Complete the two additional objectives you selected. Submit with daily evaluation.

Critical Care Clinical Objectives

1. Report to the ICU charge nurse following pre-conference. Assist with client assessment and care. Invasive procedures may be performed with RN preceptor supervision. Manually calculate IV flow rates on any continuous IV infusions, such as dopamine, lidocaine or heparin. Compare your results with the computer generated calculations. Perform a complete systems assessment for one client.
2. Written work: Submit a summary of day. Submit your math calculations, systems assessment, and a list of nursing care and skills. Complete two additional objectives that you selected. Submit these with your daily evaluation.

Cardiac Cath Lab Clinical Objectives

1. Report to the cath lab supervisor or charge nurse following pre-conference. Observe nursing priorities of care. Observe the procedure and assess for arrhythmias on the ECG. Identify medications used during the procedure.
2. Written work: Submit a summary of your day. List nursing priorities observed, ECG rhythms observed, and medications administered during the procedure. Complete the two additional objectives you selected. Submit with your daily evaluation.

GI Lab Clinical Objectives

1. Report to the GI Lab following pre-conference. Observe nursing priorities of care prior to, during, and post-procedure. Observe procedures, and identify medications used during the procedure. Invasive procedures may be performed with RN preceptor supervision.
2. Written work: Submit a summary of your nursing priorities observed, medications used, and nursing care and skills you performed. Complete the two additional objectives you selected. Submit with your daily evaluation.

Operating Room Clinical Objectives

1. Report to the OR at designated time. Observe the responsibilities and priorities of the circulating RN.
2. Written work: Submit a summary of your day. Describe the nursing care and priorities demonstrated by the circulating nurse and the operative procedures observed. Complete the two additional objectives you selected. Submit with your daily evaluation.

Hyperbarics/Wound Care Clinical Objectives

1. Report to the Hyperbarics Unit following pre-conference. Observe the nursing care and priorities of the hyperbarics & wound care nurses. Assist with wound care procedures. Invasive procedures may be performed with RN preceptor supervision.
2. Written work: Submit a summary of your day. Describe the nursing care and priorities demonstrated by the hyperbarics & wound care nurses. List procedures you performed. Complete the two additional objectives you selected. Submit with your daily evaluation.

Pediatrics Clinical Objectives

1. Observe the nursing care priorities and nursing care performed by the pediatric nurse. Assess and implement care for a pediatric client. Invasive procedures may be performed with RN preceptor supervision. Complete a full systems assessment on a pediatric client. In addition, include the following information:
 - Age, height, weight.
 - Locomotor skill level (sitting, crawling, walking, etc.)
 - Developmental stage, including evidence of successful accomplishment of previous stage (Erickson)
 - Interaction with family members
2. Written work: Submit a summary of your day. Describe nursing care and priorities of the pediatric nurse and the procedures you performed. Complete assessment data (#2). Complete the two additional objectives you selected. Submit with your daily evaluation.

Rehabilitation Unit Clinical Objectives

1. Observe the nursing care priorities and nursing care performed by the rehab nurse. Implement nursing care for a group of clients. Invasive procedures may be performed with RN preceptor supervision. Attend an interdisciplinary team meeting, if possible.
2. Written work: Submit a summary of your day. Describe the nursing care priorities in the rehab setting and the care and procedures you performed. Describe team collaboration observed. Complete the two additional objectives you selected. Submit with your daily evaluation.

Telemetry Unit Clinical Objectives

1. Observe telemetry recordings for normal electrical activity. Identify electrical and mechanical interference. Identify normal sinus rhythm, and compare with abnormal ECG recordings. Observe collaboration between the telemetry nurse and telemetry technician.
2. Written work: Submit a summary of your day. Describe the cardiac rhythms observed and the significance and treatment of each dysrhythmia. Complete the two additional objectives you selected. Submit with your daily evaluation.

Case Manager Clinical Objectives

1. Observe the role of the case manager. Identify priorities of case management, and communication and collaboration skills used to implement care.
2. Written work: Submit a summary of your day. Describe the role and priorities of the case manager, and the collaboration and communication skills observed. Complete the two additional objectives you selected. Submit with your daily evaluation.

House Supervisor Clinical Objectives

1. Observe the role of the house supervisor. Identify priorities of the house supervisor, and the impact this role has on the provision of client care.
2. Written work: Submit a summary of your day. Describe the role and priorities of the house supervisor, the impact on client care, and your activities during the experience. Complete the two additional objectives you selected. Submit with your daily evaluation.

Obstetrics Specialty Objectives

1. Report to the unit following preconference. Assist with client care. Perform a complete systems assessment for one client.
2. Written Work: Submit a summary of your day. Describe the nursing care and priorities demonstrated by the OB nurses. List procedures you performed. Complete the two additional objectives you selected. Submit with your daily evaluation.

Radiology Nursing Specialty Objectives

1. Report to the radiology nurse following preconference. Assist with nursing procedures and start IV's supervised by the radiology RN.
2. Written work: Submit a summary of your day. Describe the nursing care and priorities demonstrated by the radiology nurse. List procedures you performed. Complete the two additional objectives you selected. Submit with your daily evaluation.

Simulation Lab Specialty Objectives:

1. Completes all applicable components of the daily evaluation form.
2. Actively participates in role playing and simulation scenarios.
3. Contributes to the debriefing process using a positive approach.

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Clinical Objectives

May include any of the objectives for previous clinical courses, as well as those listed for each course.

	RNSG 1360	RNSG 1461	RSNG 2462	RNSG 2463
<i>Member of the Profession</i>				
Professionalism	<p>Describe professional behaviors and attitudes observed on your assigned unit.</p> <p>Describe a clinical situation you observed which involved an ethical issue.</p> <p>Describe a clinical situation you observed which involved a legal issue</p>	<p>Describe how you demonstrated professional behaviors in the provision of care to your assigned patients.</p> <p>Describe how you used an ethical principle to in planning and implementing care for your assigned patients.</p> <p>Describe how you used a legal principle in planning and implementing care for your assigned patients.</p>	<p>Analyze the impact of professionalism on the outcome of care for your assigned patients.</p> <p>Analyze the impact of ethical principles in the outcome of care for your assigned patients.</p> <p>Analyze the impact of legal principles in the outcome of care for your assigned patients.</p>	<p>Analyze the impact of professionalism on patient care outcomes on your assigned unit.</p> <p>Analyze a clinical situation that involved an ethical dilemma.</p> <p>Analyze legal considerations that impact the outcome of care for patients on your assigned unit.</p>
Personal Accountability	Describe a situation where you took personal accountability for your actions within the clinical setting.	Analyze the outcome of a situation in which you assumed personal accountability for your actions in the clinical setting.	Implement a plan to address your personal learning needs in the clinical setting.	Evaluate strategies you implemented to address your personal learning needs in the clinical setting.
Advocacy	Describe a specific clinical situation which involved advocacy.	Describe how you acted as an advocate for your assigned patient.	Analyze how patient advocacy impacted the outcome of patient care in a clinical situation.	Analyze how you independently advocated on behalf of your patients, families, self, or the profession.

<i>Provider of Patient-Centered Care</i>				
Clinical Decision Making	Describe the nursing knowledge needed to plan safe, effective care for your assigned patient.	Describe how your assigned patient's plan of care relates to your assessment findings. Describe a patient care situation in which clinical decision making skills impacted the outcome of patient care.	Analyze a clinical situation in which additional nursing knowledge might have impacted the outcome of patient care. Analyze a clinical situation in which decision making skills impacted the outcome of patient care.	Discuss how the nurse manager on your assigned unit uses nursing knowledge in the management of care for the patients on the unit. Analyze how your use of decision making skills impacted the outcome of patient care for a group of patients.
Patient Teaching	Describe your assigned patient's response to the teaching you provided	Discuss the principles underlying your approach to patient teaching for your assigned patients.	Analyze a clinical situation in which the strategies used to provide patient teaching impacted the outcome of patient care.	Analyze how your approach to patient teaching impacted the outcome of patient care.
Caring Approach	Describe caring interventions you used in the care of your assigned patient.	Describe a patient care situation in which the implementation of a caring approach impacted the outcome of patient care.	Analyze how a caring approach impacted the outcome of patient care in a clinical situation.	Analyze the utilization of a caring approach to meet the needs of a diverse patient population
Resource management	Identify resources available to you in the provision of care for your assigned patient.	Describe how your use of resources impacted the outcome of your patient care.	Discuss the role of the nurse in ensuring adequate resources for patient care.	Analyze how availability of adequate resources impacts outcomes of care on your assigned unit.
Skill Competency	Describe skills used to ensure safe, effective care. Discuss the importance of the rights of medication administration. Identify factors that may impact safe medication administration on your assigned unit.	Analyze the effectiveness of the skills you used in the care of your patients. Analyze the effectiveness of the strategies you used to organize medication administration for your assigned patients.	Analyze a clinical situation in which effective time management skills impacted the outcome of patient care. Evaluate a clinical situation in which the approach to medication administration impacted the outcome of patient care.	Analyze the effectiveness of the strategies you used to care for a group of patients. Discuss alternate approaches to promote safe medication administration.

<i>Patient Safety Advocate</i>				
Safety	Describe measures you used to promote a safe environment for your patient, self, and others.	Discuss measures you used to promote a safe environment for your patients, self, and others.	Analyze measures used to promote a safe environment for patients, self, and others.	Evaluate measures to promote a safe environment for patients, self, and others.
Risk Reduction	Describe how abnormal values (vital signs; diagnostic test findings) reflect increased risk for your assigned patient.	Describe the diagnostic test results, prescribed medications and/or treatments for your assigned patients.	Analyze the relationship between the assessment findings, diagnostic test results, and prescribed treatments for your assigned patients. Analyze how the implementation of risk reduction strategies impacted the outcome of care for your assigned patients.	Analyze the impact of evidence-based practice on the outcomes of care on your assigned unit. Describe a clinical situation where failure to rescue could lead to potential harm.
<i>Member of the Health Care Team</i>				
Communication	Identify communication skills used in the care of your assigned patient.	Describe a patient care situation in which therapeutic communication skills impacted the outcome of patient care.	Analyze a clinical situation in which therapeutic communication skills impacted the outcome of patient care.	Analyze how your use of therapeutic communication skills impacted the outcome of patient care.
Collaboration & Coordination	Describe activities you used to encourage participation of the patient, family, and/or health care team to meet patient needs. Describe the role of a non-nurse member of the interdisciplinary healthcare team.	Describe how varying members of the IDT healthcare team impacted the outcome of care for your assigned patient.	Describe how your collaboration with other IDT members impacted the outcome of care for your assigned patients.	Analyze strategies you used to promote effective collaboration.

WRITTEN CLINICAL REQUIREMENTS

** Team Leaders and / or designated others are responsible for bringing an NCLEX-RN review book and drug reference to clinical for patient care preparation during pre-conference time.

1) **Systems assessment and Client Care Documentation:**

Facility based assessment charting to be utilized as assigned by instructor.

2) **Completed Daily Evaluation:**

Each clinical day documented on one weekly form.

3) **Medication Administration Sheet**

Completed weekly until satisfactory achieved or until released by instructor.

3) **Team Leader or Team Member Evaluations**

One completed weekly for Team Leader or member as applicable.

4) **Plan of care**

Facility based plan of care to be utilized.

5) **Pediatric Clinical Assessment**

Complete the Pediatric Clinical Assessment included in this packet on a child in the acute care or community setting. Students may not complete the assessment on their own children, but may choose another child in the community setting. If the child is not in the hospital, the parental consent form must be signed by one of the child's legal guardians.

6) **Professional Resume**

Due by date given in orientation. Reviewed by clinical instructor and corrected until satisfactory.

7) **Performance Improvement Group Project**

One per semester as assigned by instructor.

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TEAM LEADER / MEMBER CLINICAL RESPONSIBILITIES

Team Leader/ Member activities are starred items in Nursing 4.

Daily student assignments will be organized around either direct client care or objectives for use in specialty areas. In addition to specific clinical objectives for the day, the student will:

- a) Prioritize needs and manage care for a group of clients.
- b) Perform assigned client care.
- c) Perform assigned nursing skills.
- d) Complete all assignments in a reasonable time.
- e) Complete written assignments by designated deadline.
- f) Utilize the nursing process as the basis for clinical performance.
- g) Maintain professional behavior and attitudes in the clinical area.

STUDENT TEAM MEMBERS WILL:

1. Prepare for clinical by:
 - a) Obtaining client assignment from Student Team Leader.
 - b) Completing a standardized care plan for all initially assigned clients.
 - c) Organizing a nursing care flow sheet.
 - d) Having appropriate drug information for all assigned clients.
2. Provide / manage client care by:
 - a) Receiving a report on all assigned clients.
 - b) Completing an assessment and charting on all assigned clients within one hour of obtaining report.
 - c) Independently administering non-invasive nursing care to a group of assigned clients.
 - d) Seeking instructor for supervision of medication, treatments, etc., as appropriate.
 - e) Keeping the student team leader and primary nurse informed of assigned clients' status.
 - f) Documenting pertinent, complete information on client's chart.
 - g) Giving a pertinent report on all assigned clients to the appropriate nurse.
 - h) Follow "Look, Check, Connect – Follow that line" procedure
3. Utilize the nursing process as the basis for all nursing care by:
 - a) Collecting assessment data and identifying problems on all assigned clients.
 - b) Analyzing and formulating nursing diagnoses.
 - c) Planning goal-directed nursing interventions.
 - d) Implementing nursing care according to plan, and seeking instructor verification when appropriate.
 - e) Evaluating care provided, and revising care when appropriate.
4. Function as a member within the Discipline of Nursing by:
 - a) Meeting all objectives for professional behavior and attitude as identified on the clinical evaluation tool.

STUDENT TEAM LEADERS WILL:

1. Organize clinical by:
 - a) Assigning clients for individual Student Team Members on the day of clinical. Assignments should include clients appropriate to the unit of study when possible.
 - b) Posting assignments according to hospital requirements.
 - c) Constructing and utilizing a nursing care flow sheet.
 - d) Assigning breaks and lunch for Student Team Members.
 - e) Planning, organizing and directing the activities of Student Team Members

2. Provide / manage care by:
 - a) Receiving and giving report for assigned clients.
 - b) Making nursing assessment rounds for all team clients.
 - c) Supervising and assisting team members with client's care as appropriate.
 - d) Consulting with appropriate nurse and instructor regarding changes in client status
 - e) Making rounds with physicians, primary nurse/charge nurse and instructor.
 - f) Advising student team members of any changes in orders for assigned clients.
 - g) Reviewing information documented on client chart
 - h) Coordinating team leader activities with those of other health team members
 - i) Facilitating communication between students and other health team members
 - j) Conducting a student conference
 - k) Follow "Look, Check, Connect – Follow that line" procedures
 - l) Maintains accountability for nursing care provided by members

3. Utilize the nursing process by:
 - a) Collecting assessment data and identifying problems.
 - b) Analyzing and formulating nursing diagnoses.
 - c) Planning nursing activities according to team priorities.
 - d) Implementing planned activities, following verification with instructor when appropriate.
 - e) Evaluation team activities and revising team priorities as needed.

4. Function as a member within the Discipline of Nursing by:
 - a) Meeting all objectives for professional behavior and attitude as identified on the clinical evaluation tool.

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Team Leader Rounds/Checklist: Day Shift

The goal is to make rounds with each team member immediately after getting report from the night shift, or as soon as 7:30 meds are given.
Make rounds alone if team member is unavailable. Communicate with team members often!!!!

Team member:

Room #:									
First rounds:									
Basic homeostasis intact/ no acute distress									
IV: Correct solution, rate, additives IV site ok/ type of site identified									
Oxygen as ordered									
Dressings, drains, suction, therapies as ordered & intact									
Dialysis access intact (Tessio, fistula, graft, etc.)									
Safety: siderails, call bell, restraints, Bed in low position, Client ID bands: ID, allergy, DNR									
Special signs needed: NPO, No BP, isolation									
Mid-morning checks:									
0800 VS charted									
0730, 0800, 0900 meds given									
Needed flow sheets in use (Blood sugars, restraints, decub, etc.)									
New orders completed (meds, etc.)									
End of shift rounds w TM &/or Instructor									
Basic homeostasis intact/ no acute distress									
IV: Correct solution, rate, additives IV site ok									
Oxygen as ordered									

Dressings, drains, suction, therapies as ordered & intact									
Dialysis access intact (Tessio, fistula, graft, etc.)									
Safety: siderails, call bell, restraints, Bed in low position, Client ID bands: ID, allergy, DNR									
Special signs needed: NPO, No BP, isolation									
End of shift checks									
1200 VS charted									
Care plans updated/revised									
All meds given									
All new orders completed									
All nsg notes updated as needed									
Report given to staff nurse									

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Team Leader Rounds/Checklist: Evening Shift

The goal is to make rounds with each team member immediately after getting report from the primary RN, or as soon as 3:00 meds are given. Make rounds alone if team member is unavailable. Communicate with team members often!!!!

Team member:

Room #:									
First rounds:									
Basic homeostasis intact/ no acute distress									
IV: Correct solution, rate, additives IV site ok/ type of site identified									
Oxygen as ordered									
Dressings, drains, suction, therapies as ordered & intact									
Dialysis access intact (Tessio, fistula, graft, etc.)									
Safety: siderails, call bell, restraints, Bed in low position, Client ID bands: ID, allergy, DNR									
Special signs needed: NPO, No BP, isolation									
Mid-afternoon checks:									
VS charted									
1500, 1600, 1700 meds given									
Needed flow sheets in use (Blood sugars, restraints, decub, etc.)									
New orders completed (meds, etc.)									
Late afternoon-evening checks:									
VS charted I&O as required									
1800 meds given									
Charting updated									
End of shift rounds w TM &/or Instructor									

Basic homeostasis intact/ no acute distress									
IV: Correct solution, rate, additives IV site ok									
Oxygen as ordered									
Dressings, drains, suction, therapies as ordered & intact									
Dialysis access intact (Tessio, fistula, graft, etc.)									
Safety: siderails, call bell, restraints, Bed in low position, Client ID bands: ID, allergy, DNR									
Special signs needed: NPO, No BP, isolation									
End of shift checks									
All meds given, MARs signed, Nsg notes ck.									
All new orders completed									
All I & O recorded, IV pumps cleared									
Report given to staff nurse & oncoming SN									

(May substitute with your own worksheet)

Team Leader:

Unit:

Date:

Team Member	Rm #	Client initials Age/Gender CPR status, Dr.	Medical Diagnoses & Significant Labs	IV Fluids, Tubes, Treatments	Parenteral Meds (IV, IM, SC)	Parenteral Med Times

SBAR Communication with a Health Care Provider (Always follow appropriate Chain of Command)

S	<p><u>Situation</u></p> <p>This is: <i>identify self and agency / location</i> I am calling about: <i>Patient name and location, Physician's name</i> The problem I am calling about is: <i>briefly state the situation, what it is, when it happened or started, and how severe the problem is.</i></p>
B	<p><u>Background</u></p> <p>Have available any pertinent background information/ past medical history related to the situation. Might include:</p> <ul style="list-style-type: none"> Admitting diagnosis / date of admission Review of most recent progress notes / nurses notes Current medications, allergies, IV fluids, restrictions Special directives (code status, isolation, restraints, etc.) Most recent vital signs Lab results: significant / appropriate and compare to previous results Current / previous treatments used & how pt. responded Brief systems review: (specific to problem) <ul style="list-style-type: none"> Cardiac status Respiratory status Neurological / mental status
A	<p><u>Assessment</u></p> <p>This is what I think the situation is: <i>say what you think the problem is.</i> If unsure of the problem: <i>"I do not know what is going on; but the patient is deteriorating."</i> <i>"The patient is unstable and seems to be worsening."</i> <i>"I thought you would want to know about this situation / lab value / change in condition/etc."</i></p>
R	<p><u>Recommendation</u></p> <p>What is the nurse's recommendation; or what does the nurse need / want from the health care provider? Are any tests needed? Is a change in treatment needed? Does the patient need to be seen immediately?</p>

Documentation should include:

- 1) **Date and time healthcare provider notified, or report given. If multiple attempts were made; document time of each attempt.**
- 2) **Healthcare providers response to communication, orders received, and that "read back" of orders was completed.**

Adapted from JCAHO website

Medication Sheet - Example

Medication (brand/generic) Dose/route	Classification Information	Nursing Interventions (expected outcome of the med, what the nurse will monitor or watch for)	Client's Relevant Supporting Data
Lasix/ Furosemide 20mg IV BID	Loop Diuretic	May give undiluted 20mg over 1 minute. Check electrolyte level Monitor Urine Output, b/p	Given slowly over 1 minute K level 3.9 UO 900ml for the shift b/p 140/88
Insulin/ Humulin R Sliding scale Subcutaneous	Anti-diabetic Agent	Insulin syringe Give 30min before meals Rotate sites Monitor blood glucose Monitor for s/s of hypoglycemia	5 units given subcutaneously in Lt upper arm 30 min before breakfast and 2 units in Rt upper arm 30 min before lunch BSG = 198 0600 BSG = 134 12:00 No s/s hypoglycemia
Lanoxin/ digoxin 0.05 mg PO QD	Antiarrhythmic	Check apical rate for 1 minute Monitor rhythm Hold if HR less than 60 Monitor for s/s of bradycardia Monitor dig and K levels Hold if dig level > 2ng/ml Monitor for s/s dig toxicity	HR 86 Atrial Fibrillation Dig level 1.4 K level 4.0 No visual disturbance, n/v
Tenormin/ Atenolol 25mg PO QD	Beta-adrenergic antagonist Antihypertensive	Monitor B/p Monitor for s/s of hypotension after administration Encourage to change positions slowly	b/p 140/88 0700 b/p 128/78 1 hr after administration at 10:00 no s/s of hypotension
Xanax/ Alprazolam 0.5 mg PO q 8 hrs prn	Antianxiety Agent	Assess CNS effects and risk for Falls	pt alert and oriented x 4, fall precautions in place
Zoloft / Sertraline HCL 60 mg PO daily	Antidepressant	Monitor appetite and nutritional intake Monitor mood changes	Ate 90% of breakfast, appetite adequate, pt calm, cooperative and attentive

8. Peer review standards require all unprofessional and/or substandard nursing behaviors to be evaluated. Please document any irregularities or discrepancies occurring in the following areas.

a) Medication administration (include problems with med. Knowledge, preparation and / or administration by yourself or team members.

b) Basic patient care (include any aspect of basic care not done and why)

c) Patient relations (include circumstances surrounding difficulties, if any)

d) Staff relations (include circumstances surrounding difficulties, if any)

9. Summarize the performance of **each** of your student team members.

Team Member name _____

Team Member name _____

Team member name _____

Team member name _____

GRAYSON COLLEGE
ASSOCIATE DEGREE NURSING
RNSG 2562 & 2463

TEAM MEMBERS EVALUATION OF TEAM LEADER

(Turn in when team member)

TEAM LEADER: _____ DATE: _____

Comment on the following aspects of team leading, based on your experience with the above team leader.

1. Availability / accessibility throughout the shift:

2. Information resource:

3. Quality of report:

4. Feedback—positive or negative:

5. Delegation and / or organizational skills:

6. Strengths or weaknesses as a leader: (include points for improvement)

7. Interactions with staff / peers:

Grayson College
Associate Degree Nursing Program
Clinical Evaluation RNSG 2463

Name _____ Dates _____ and _____

State today's assigned clinical objective(s) and describe how **you** met it:

Clinical Objective 1:

Clinical Objective 2:

Please check all skills performed during clinical day:

Comments

Insertion of IV		
Administration of IV Solutions		
Administration of IVP		
Administration of IVPB		
Other		

Pt # 1 MDx _____

Pt # 2 MDx _____

Pt # 3 MDx _____

Pt # 4 MDx _____

1. Identify **your** independent decisions/interventions for each day.

2. Describe specifically what you did to implement "look-check-connect"

3. Describe patient teaching **you** did. (include patient's response to teaching, and method of documentation).

4. Describe any clarification **you** need about the clinical experience and/or other comments:

Instructor Comments:

Instructor's Signature _____ Student's Signature _____

Acknowledges having read instructor's remarks & evaluation criteria

Grayson College
Associate Degree Nursing Program
Clinical Evaluation RNSG 2463

Name: _____ Dates _____ and _____

State today's assigned clinical objective(s) and describe how *you* met it:

Clinical Objective 1: _____ **Clinical Objective 2:** _____

Please check all skills performed during clinical day:

Comments

Insertion of IV	<input type="checkbox"/>	
Administration of IV Solutions	<input type="checkbox"/>	
Administration of IVP	<input type="checkbox"/>	
Administration of IVPB	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

Pt # 1 MDx _____

Pt # 2 MDx _____

Pt # 3 MDx _____

Pt # 4 MDx _____

5. Identify *your* independent decisions/interventions for each day.
6. Describe specifically what you did to implement "look-check-connect"
7. Describe patient teaching *you* did. (include patient's response to teaching, and method of documentation).
8. Describe any clarification *you* need about the clinical experience and/or other comments:

Instructor Comments

Instructor's Signature _____ Student's Signature _____

Acknowledges having read instructor's remarks & evaluation criteria

Revised 4/12

RNSG 2463 – Criteria for Student Clinical Daily Evaluation:

✓/S = Satisfactory; U = Unsatisfactory; S = Student; I = Instructor

S 1	S 2	I 1	I 2	Evaluative Criteria	S 1	S 2	I 1	I 2	Evaluative Criteria
				<u>Member of the Profession:</u>					7. Effective use of resources
				1. Professionalism	-	-			*a. Uses appropriate resources to ensure safe, effective care: Human: faculty, staff, patient, HCP, families
-	-			*a. Maintains confidentiality.					Information: medical record, report, current data, policies references, worksheet
-	-			*b. Seeks appropriate supervision and direction.					Material: supplies, equipment
-	-			*c. Adheres to agency policies.					
-	-			*d. Demonstrates positive, respectful demeanor and approach to others.					
				2. Personal Accountability	-	-			8. Skill Competency
-	-			*a. Demonstrates accountability through insightful self-evaluation.					*a. Performs skills/ tasks correctly.
-	-			*b. Adheres to ADN program policies.	-	-			*b. Safe Medication Administration:
-	-			*c. Meets requirements for attendance.	-	-			*1. Demonstrates knowledge of medications being given
-	-			*d. Meets requirements for written paperwork.	-	-			*2. Identifies unsafe &/or inaccurate drug orders & practices.
-	-			*e. Implements instructions from instructor and licensed personnel.	-	-			*3. Calculates dosages accurately.
-	-			*f. Assumes responsibility for achievement of learning outcomes.	-	-			*4. Demonstrates use of client's rights.
				3. Advocacy	-	-			*5. Demonstrates correct administration procedures.
-	-			*a. Identifies situations of concern to assigned patients and families.	-	-			*6. Documents medication administration correctly.
-	-			*b. Reports situations of concern in an effective manner.	-	-			*c. Completes skills/tasks in an organized, efficient manner.
-	-			*c. Acts on behalf of patients and families in an effective manner.	-	-			*d. Ensures client comfort and privacy during tasks.
				<u>Provider of Patient-Centered Care:</u>	-	-			*e. Evaluates and reports patient outcomes following skills.
				4. Clinical decision making in the provision of care					<u>Patient Safety Advocate:</u>
-	-			*a. Demonstrates sound clinical reasoning based on accurate, relevant knowledge.					9. Safety
-	-			*b. Obtains report/gathers needed information before assuming care of patient.	-	-			*a. Adheres to recognized safety standards.
-	-			*c. Completes focused assessment within one hour of report.					10. Risk Reduction
-	-			*d. Analyzes assessment data to plan and prioritize care.	-	-			*a. Implements care to reduce patient risk
-	-			*e. Reports abnormal findings to instructor and staff.	-	-			*b. Uses evidence-based guidelines to impact quality of care.
-	-			*f. Completes assigned care according to priorities.					<u>Member of the Health Care Team</u>
-	-			*g. Evaluates nursing care.					11. Communication
-	-			*h. Uses outcomes of care to revise the plan of care.	-	-			*a. Manages information using available technology.
-	-			*i. Documents nursing care Accurate, legible, concise, timely.	-	-			*b. Communicates information accurately and in a timely manner Written and Verbal
-	-			*j. Reports client's condition and summary of care at end of clinical day.	-	-			*c. Clearly identifies self and student nurse role to patient, family and healthcare team
-	-			*k. Organize and manage time effectively.					12. Collaboration & Coordination
				5. Patient Teaching	-	-			*a. Negotiates mutually agreeable solutions with others.
-	-			*a. Provides appropriate explanations prior to implementing care.	-	-			*b. Elicits participation of patient, family, and HC team members
-	-			*b. Implements patient teaching.	-	-			*c. Accepts criticism in a constructive manner.
-	-			*c. Documents effectiveness of patient teaching.					13. Demonstrates skill as a team leader.
				6. Caring approach to diverse patients and families	-	-			*a. Makes team assignments when team leader.
-	-			*a. Provides considerate, non-judgmental, and respectful care.	-	-			*b. Makes critical client needs assessment during nursing rounds.
-	-			*b. Offers self in a therapeutic manner within professional boundaries.	-	-			*c. Identifies, assesses team member's activities when team leader
					-	-			*d. Reviews information documented on client chart & EMR
					-	-			*e. Assist team members when appropriate.
					-	-			*f. Accepts accountability for team member actions.

Independent
Satisfactory

Supervised
Satisfactory

Assisted
Unsatisfactory

Provisional
Unsatisfactory

Dependent
Unsatisfactory

Grayson College
Associate Degree Nursing Program
2463 Clinical Evaluation

Performance Standards which Define Satisfactory Performance of Expected Behaviors

A summative clinical evaluation grade of Satisfactory is achieved by demonstrating expected behaviors 75% of the clinical time on all starred items. Behaviors that are graded are listed in the course clinical evaluation tool for each semester, under each clinical objective. The criteria that define behavioral standards at each level are listed below.

INDEPENDENT

- Performs safely and accurately each time behavior is observed without supportive cues from instructor.
- Demonstrates dexterity.
- Spends minimal time on task.
- Appears relaxed and confident during performance of task.
- Applies theoretical knowledge accurately each time.
- Focuses on client while giving care.

SUPERVISED

- Performs safely and accurately each time behavior observed.
- Requires supportive or directive cue occasionally during performance of task.
- Demonstrates coordination, but uses some unnecessary energy to complete behavior/activity.
- Spends reasonable time on task.
- Appears generally relaxed and confident; occasional anxiety may be noticeable.
- Applies theoretical knowledge accurately with occasional cues.
- Focuses on client initially; as complexity increases, focuses on task.

ASSISTED

- Performs safely and accurately each time observed.
- Requires frequent supportive and occasional directive cues.
- Demonstrates partial lack of skill and/or dexterity in part of activity; awkward.
- Takes longer time to complete task; occasionally late.
- Appears to waste energy due to poor planning.
- Identifies principles, but needs direction to identify application.
- Focuses primarily on task or own behavior, not on client.

PROVISIONAL

- Performs safely under supervision, not always accurate.
- Requires continuous supportive and directive cues.
- Demonstrates lack of skill; uncoordinated in majority of behavior.
- Performs task with considerable delay; activities are disrupted or omitted.
- Wastes energy due to incompetence.
- Identifies fragments of principles; applies principles inappropriately.
- Focuses entirely on task or own behavior.

DEPENDENT

- Performs in an unsafe manner; unable to demonstrate behavior.
- Requires continuous supportive and directive cues.
- Performs in an unskilled manner; lacks organization.
- Appears frozen unable to move, non-productive.
- Unable to identify principles or apply them.
- Attempts activity or behavior, yet is unable to complete.
- Focuses entirely on task or own behavior.

Distinctive feature of the level of competence.: *Developed by Krichbaum, K. from Bondy, K (1983). Criterion-reference definitions for rating scales in clinical evaluation. Journal of Nursing Education 22, 276-382.*

Satisfactory: "Independent" criteria
 "Assisted" or above in new clinical learning experience
 Unsatisfactory: "Supervised" or lower criteria

GRAYSON COLLEGE
 ASSOCIATE DEGREE NURSING
 CLINICAL PERFORMANCE EVALUATION TOOL
 Nursing IV - RNSG 2463

STUDENT _____ Term _____ Instructor _____
 Clinical Facility _____

I have read this evaluation tool and understand that my clinical performance will be evaluated according to these criteria.

Date: _____ Signature: _____

1. The student shares the responsibility for seeking opportunities for evaluation.
2. Definition for criteria for clinical evaluation:
 S - (Satisfactory) Student demonstrates expected behaviors 75%-100% of clinical time.
 U - (Unsatisfactory) Student demonstrates expected behaviors 74% or less of clinical time.
3. In order to pass clinical, the student must achieve Satisfactory on all items identified with an asterisk at the time of final evaluation.

RNSG 2463 EXPECTED STUDENT BEHAVIOR	Mid-term		Final		INSTRUCTOR COMMENTS
	S	U	S	U	
I. MEMBER OF THE PROFESSION					
1. Professionalism					
*a. Maintains confidentiality					
*b. Seeks appropriate supervision and direction.					
*c. Adheres to agency policies					
*d. Demonstrates positive, respectful demeanor and approach to others.					
2. Personal Accountability					
*a. Demonstrates accountability through insightful self-evaluation.					
*b. Adheres to ADN program policies.					
*c. Meets deadlines for attendance and written assignments.					
*d. Implements instructions from instructor and licensed personnel.					

RNSG 2463 EXPECTED STUDENT BEHAVIOR	Mid-term		Final		INSTRUCTOR COMMENTS
	S	U	S	U	
*e. Assumes responsibility for achievement of learning outcomes.					
3. Advocacy					
*a. Identifies situations of concern to assigned patients and families.					
*b. Reports situations of concern in an effective manner.					
*c. Acts on behalf of patients and families in an effective manner.					
II. PROVIDER OF PATIENT CENTERED CARE					
4. Clinical decision making in the provision of Care					
*a. Demonstrates sound clinical reasoning based on accurate, relevant knowledge.					
*b. Obtains report/gathers needed information before assuming care of the patient.					
*c. Completes focused assessment within one hour of report.					
*d. Analyzes assessment data to plan and prioritize care.					
*e. Report abnormal findings to instructor and staff.					
*f. Completes assigned care according to priorities.					
*g. Evaluates nursing care.					
*h. Uses outcomes of care to revise the plan of care.					
*i. Documents nursing care: Accurate, legible, concise, Timely.					
*j. Reports patient's condition and summary of care at the end of clinical day.					
*k. Organize and manage time effectively.					
5. Patient Teaching					
*a. Provides appropriate explanations prior to implementing care.					

RNSG 2463 EXPECTED STUDENT BEHAVIOR	Mid-term		Final		INSTRUCTOR COMMENTS
	S	U	S	U	
*b. Implements teaching plans.					
*c. Documents effectiveness of patient teaching.					
6. Caring approach to diverse patients and Families					
*a. Provides considerate, non-judgmental, and respectful care.					
*b. Offers self in a therapeutic manner within professional boundaries.					
7. Effective use of Resources					
*a. Uses appropriate resources to ensure safe, effective care:					
Human: faculty, staff, patient, HCP, families					
Information: medical record, report, current data, policies, references, worksheets					
8. Skill Competency					
*a. Performs skills/tasks correctly.					
*b. Safe Medication Administration:					
1. Demonstrates knowledge of medications being given.					
2. Identifies unsafe/or inaccurate drug orders and practices.					
3. Calculates dosages accurately.					
4. Demonstrates use of patient's rights.					
5. Demonstrates correct administration procedures.					

RNSG 2463 EXPECTED STUDENT BEHAVIOR	Mid-term		Final		INSTRUCTOR COMMENTS
	S	U	S	U	
6. Documents medication administration correctly.					
*c. Completes skills/tasks in an organized, efficient manner.					
*d. Ensures patient comfort and privacy during tasks.					
*e. Evaluates and reports patient outcomes following skills.					
III. PATIENT SAFETY ADVOCATE					
9. Safety					
*a. Adheres to recognized safety standards.					
10. Risk Reduction					
*a. Implements care to reduce patient risk.					
*b. Uses evidence-based guidelines to impact quality of care.					
IV MEMBER OF THE HEALTH CARE TEAM					
11. Communication					
*a. Manages information using available technology.					
*b. Communicates information accurately and in a timely manner: Written and Verbal					
*c. Clearly identifies self and student nurse role to patient, family, and healthcare team.					
12. Collaboration & Coordination					
*a. Negotiates mutually agreeable solutions with others.					
*b. Elicits participation of patient, family, and HC team members.					
*c. Accepts criticism in a constructive manner.					
13. Demonstrates skill as a team					

RNSG 2463 EXPECTED STUDENT BEHAVIOR	Mid-term		Final		INSTRUCTOR COMMENTS
	S	U	S	U	
leader					
*1. Makes team assignments when team leader.					
*2. Makes critical patient needs assessments during nursing rounds.					
*3. Identifies, assesses team member's activities when team leader.					
*4. Reviews information documented on patient chart and kardex.					
*5. Assist team members when appropriate.					
*6. Accepts accountability for team member actions.					

RNSG 2463

Date _____ Mid-Rotation Grade _____ Absences _____

Instructor Comments:

Instructor Signature: _____ Student Signature: _____

Date _____ Final Grade _____ Absences _____

Specialty Rotations satisfactorily completed: Community Simulation OR

Required paperwork/presentations satisfactorily completed: Yes No

Instructor Comments:

IV Start _____
IVP _____
IVPB _____
Other _____

Instructor Signature: _____ Student Signature: _____

Grayson College
Associate Degree Nursing
RNSG 2563
Performance Improvement Project

Objectives:

1. Demonstrate team work when completing the project.
2. Identify a “need for change” in the assigned clinical facility.
3. Write a project objective.
4. Utilize the Plan component of the Plan, Do, Study, Act Model to complete the project.
5. Incorporate evidenced-based research using the GC online library.
6. Present the project to peers and instructor during post conference.
7. Present the project to clinical facility representatives if assigned by instructor.
8. Complete the project peer evaluation form.
9. If assigned, follow up with the Do, Study, Act portion of the model.

Assignment:

1. Students will choose or be assigned to a team by the clinical instructor.
2. Students will identify a problem or need for change that is applicable to the clinical unit or general facility in which students are assigned.
3. Students will conduct evidenced based research to identify a change and plan how that change can be implemented.
4. Students will put together a presentation encompassing all of the objectives and present it in post conference by the designated date. (20-30 minute presentation).
5. Students will utilize visual aids (poster, handouts, or powerpoint) during the presentation. (Check with instructor before preparing a powerpoint to find out if equipment will be available for the presentation.)

Access to Internet Library Resources

To access peer reviewed journals including evidence-based practice required for assignments:

1. Login to the GC Portal
2. Under the home tab, look for Quick Links on the left of the screen
3. Click on GC Library
4. Click on Find Articles and More
5. Click on Databases by subject
6. Click on Health and Medicine or another appropriate Database
7. Choose an appropriate Database (ie. Medline)
8. Search by subject or keywords
9. If you are off campus and are prompted for a login/password – use your portal login/password.

Performance Improvement Project Evaluation (To be turned in with project)

Student Names:

Clinical Facility:

	Met	Not Met	Instructor Comments
1. Demonstrate team work to complete the project. (peer evaluation form completed by each student.)			
2. Clearly identify “need for change”.			
3. Written objective clear and measurable			
4. Plan— a. Review available data to understand existing practice conditions or problems in order to identify the need for change. b. Include questions and predictions. c. Utilize evidenced based research using GC online library when planning the change. d. Determine plan to carry out the cycle (who, what, when, where).			
5. Present the plan during post conference, (and to clinical facility representative if assigned.)			
6. Utilize at least one visual resource during presentation (posters, powerpoint, handouts etc.)			
7. If assigned, follow up with the Do, Study, Act portion of the model.			

The PDSA Cycle

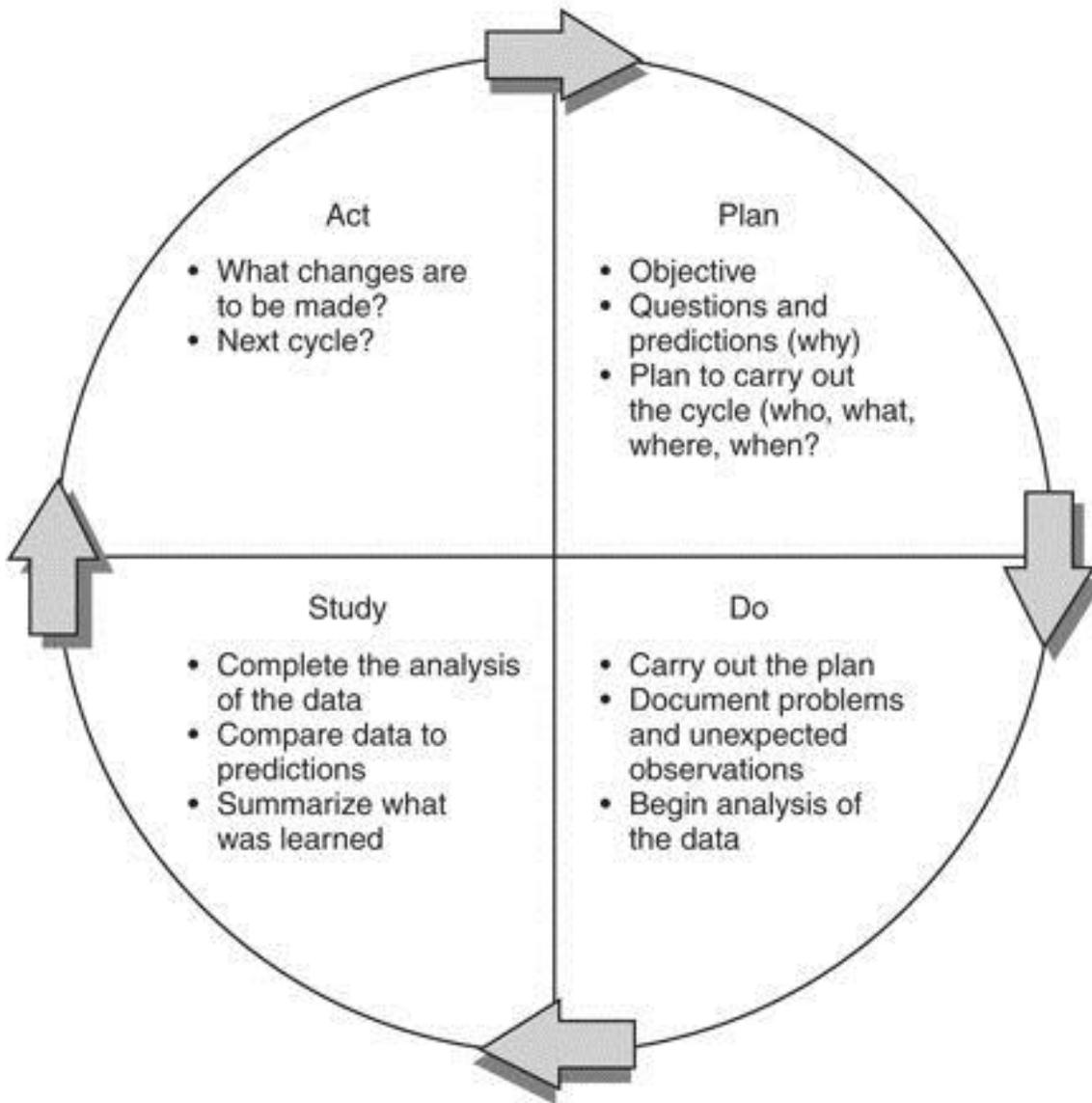


FIGURE 35-1 Model for improvement. From Langley, G. J., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (1996). *The improvement guide: A practical approach to enhancing organizational performance* (p. 10). San Francisco: Jossey-Bass.

Cowen, P. S. *Current Issues in Nursing, 7th Edition*. Mosby, 052006.

<vbk:0-323-03652-X#B032303652X500430_f1>

*Performance Improvement Project
RNSG 2435
Peer Evaluation of Group Work
To Be Completed by Each Team Member and Turned in with Project*

Student completing form: _____ Date: _____

Rate your team members using a five point scale:

5 = superior 4 = above average 3 = average 2 = below average 1 = weak

Team Members Names				
Participated in group discussions or meetings				
Contributed ideas and made useful suggestions				
Completed assigned tasks in a timely manner				
Produced quality work				
Demonstrated professional behavior throughout project				

Describe your interactions with the student team members. Comment on any issues or concerns you had during the project:

**Grayson College
Associate Degree Nursing Program
RNSG 2463**

Clinical Pediatric Assessment Consent Form

I _____ (Parent or legal guardian name) give
_____(student name) consent to perform a noninvasive
nursing assessment on my child.

Signature of Parent or Legal Guardian _____

Signature of Nursing Student _____

Date: _____

PEDIATRIC ASSESSMENT GUIDE

Patient initials _____ Room # _____
Admitting Diagnosis _____
Date: _____ Student Name: _____
Primary Instructor _____

BIO/DATA/GENERAL

Age ___ Sex ___ Ht. ___ Wt. ___ (kg) ___ (Lb.)
Origin/ethnicity _____
Vitals Admitting: T/route ___ P ___ R ___ BP ___
Vitals Current: T/route ___ P ___ R ___ BP ___ pain/rate ___
Legal Guardian _____
Informant and reliability _____
Parents occupation and education _____
Childs educational level _____

HEALTH HISTORY

Chief Complaint: ("") _____
Onset and duration of problem _____
Past medical Hx: Birth Hx: (as available)
Prenatal: Planned pregnancy _____
Complications _____ wt. gain _____
Alcohol/drug/medication use _____
Natal: length of labor _____ vaginal/cesarean _____
Spontaneous/induced _____ Complications _____
Anesthesia _____
Neonatal: Wt. _____ length _____ Apgar _____
Nursery course _____

Immunizations (see CDC recommendations)

Hep A: #1 ___ #2 ___
Hep B: #1 ___ #2 ___ #3 ___
DtaP: #1 ___ #2 ___ #3 ___ #4 ___ TD: ___
Hib: #1 ___ #2 ___ Or #3 ___
IPV: #1 ___ #2 ___ #3 ___ #4 ___
PCV: #1 ___ #2 ___ #3 ___
MMR: #1 ___ #2 ___
VAR: #1 ___ #2 ___ HPV: ___
MCV4: #1 ___ ages 11-18 (meningitis vaccine)

Family Hx: neuro, cardio, respiratory, GI, renal/urinary,
Repro, musculoskeletal, endocrine, integumentary,
Psych/social/developmental
Describe _____

Child's Past Hx/illnesses: rubella, rubeolla, mumps,
chicken pox, Frequent colds, sore throats, pneumonia,
ear infections , pertussis, kidney infections, vomiting,
diarrhea, seizures, constipation, rheumatic fever,
diabetes, juvenile arthritis, scarlet fever, TB,
sickle cell anemia, bleeding trauma, injuries ,
burns, other

Describe: _____
Hospitalizations/diagnosis _____
Date, reason, length: _____
Transfusions _____
Gamma globulins _____

Allergies:

Drugs: _____
Foods: _____
Contactants: i.e. latex/smoke, soap: _____

REVIEW OF SYSTEMS

Developmental mile stones:

INFANT- 12MO ABILITY TO HOLD HEAD UP, ROLLOVER, GRASP AND SIT.

Birth-1mo: nipples well, moves all extremities, behavior reflex controlled,(i.e., moro, babinski, palmar grasp, dance or step), holds hands in a fist, flexed extremities, lifts head slightly off bed when prone, comforts to touch, prefers to look at faces and black and white geometric designs
Delays _____

Family Anticipatory Guidance: Car seats, baby on back or side to sleep, safety-falls from heights, immunization schedule, sibling jealousy, stimulation
Teaching needs _____

1mo: responds to sounds by blinking, crying, quieting, likes mobiles, changing respirations, showing startle response, lifts head momentarily when in prone position, follows eyes to midline, eye movements relatively coordinated when following moving objects.
Delays? _____

2mo: posterior fontanel closes, prone position lifts head, neck & upper chest with support on forearms , coos , responds to voices, smiles responsively , follows light to periphery, objects from hand to mouth
Delays? _____

Family Anticipatory Guidance: Infant car seat, stimulation-talking, pacifiers, later bottle tooth decay, fever information, safety –rolling over
Teaching needs _____

3 mo: head control, tonic neck reflex disappearing
Delays? _____

4mo: coos, squeals, and babbles, turns toward speaker , repeats sound, teething begins, rolls over one way (abdomen to back) , smiles when spoken to, readily brings objects from hand to mouth, neonatal reflexes fading i.e., rooting, moro, tonic neck
Delays? _____

Family Anticipatory Guidance: teething, colds, fevers, safety-baby proof home, choking, aspiration, falls
Teaching needs? _____

6-8 mo: rolls, crawls on hands and knees, sits, tolerates pureed foods, turns to sound, grasps & reaches for objects unilaterally, feeds self crackers, beginning/or exhibits stranger anxiety, developing pincher grasp (8mo), transfers objects from one hand to the other, likes small and complex objects.

Delays? _____

Family Anticipatory Guidance: cup, finger foods, safety-pool and tub, no use of infant walker, teething, no bottle in bed-bottle tooth decay, poisons-safety, talk to child, CPR class
Teaching needs _____

TODDLER-12MO-3YR. WALKING, FEEDING AND LANGUAGE ABILITIES.

12-15 mo: anterior fontanel starts closing, Babinski disappears (12mo), stands alone, use of spoon & cup, follows simple commands, recognizes meaning of no, well developed pincher grasp(12mo),can undress self.
Delays? _____

18mo: walks backwards, food jags common, pulls a toy along the ground, begins to have temper tantrums, security in favorite toy or blanket, parallel play (enjoys playing alone but near others).
Delays? _____

Family anticipatory Guidance: Discipline and praise, sun screen, kitchen safety-pans to back of stove, poisons, climbing out of crib, helmet when riding with adult on bike, Talk to and name objects, dental hygiene, involved in solitary play, maintain regular bed time, Toilet training, involved in parallel play, read to child, no bottle
Teaching needs _____

24mo: uses spoon, puts 2 words together, builds tower of four blocks, learning to dress self, about 20 word vocabulary, obeys simple commands, issues of independence/dependence

2.5-3yr: climbs stairs, kicks ball, throws ball over hand, jumps.
Delays? _____

Family Anticipatory Guidance: decreased appetite, read to child, brushing teeth, toilet training, issues of independence/dependence, control TV watching, socialization with other children, pedestrian safety skills, playgrounds
Teaching needs _____

PRESCHOOL- 3-5 YR. USE OF LANGUAGE, HAS REACHED APPROPRIATE LEVEL OF INDEPENDENCE (DRESSING, FEEDING ETC.)

3yr: tolerates all food textures, simple conversation, rides tricycle, stands on one foot, has self-care skills (feeding, dressing) knows own name, age & sex, asks what and why questions, early imaginative behavior

4yr. builds tower of ten blocks, bicycle with training wheels

4.5-5yr: dresses self, including front buttons, balances on one foot with eyes closed

Delays _____

Family Anticipatory Guidance: safety-car seat, rules regarding strangers, street safety, firearms, matches, household chores i.e.-picking up clothes, preschool opportunities (mother's day out, head start, Sunday school), parent education classes

Teaching needs _____

SCHOOL AGE 6-11 HAS REACHED AGE APPROPRIATE GRADE LEVEL, HAS FRIENDS

6-7yr: very active, growth spurt, tests how fast can run or throw

8yr uses logic, peer group becoming important, identifies with children of same sex, has a best friend, views parents as ordinary people

10yr-11 eye hand coordination developed , active physically, secondary sex characteristics begins to appear, peer group important- beginning to mix genders some what

Family anticipatory guidance: Age appropriate sex education materials, sports injury protection, helmets, teaching drug, smoking, alcohol avoidance developmental independence- allowance, choice of when to complete household chores

Delays/Teaching needs _____

ADOLESCENCE 12-18 HAS REACHED AGE APPROPRIATE GRADE LEVEL, HAS PEER RELATIONSHIPS, HAS AGE APPROPRIATE LEVEL OF INDEPENDENCE

12-14yr. Completion of secondary sex characteristics, boys (voice changes, nocturnal emissions, girls (onset of menses-12 average age), rapid growth, tires easily

Adolescent Anticipatory Guidance: self-protection techniques, seek help if abused, three meals per day, if sexually active, safe sex information

Delays/Teaching needs _____

PSYCHOSOCIAL

School level _____ learning difficulties _____

Coping Patterns:

Habits (e.g. thumb sucking, favorite toy/blanket):

Participation in decision making _____

Leisure activities (toys, music, coloring) _____

Identification of stressors/fears _____

Beliefs (Health, cultural, spiritual) _____

Cultural practices/family _____

Developments Stage (Erikson) _____

Motivation, Thought Processes, Attention Span

Mood/Behavior/Affect _____

Self-Concept (Body Image, Sexuality, Self Esteem)

Parents Responsibilities _____

Family's coping mechanisms _____

Supportive Relationships _____

Health Perception/Maintenance (View of health situation)

Child _____ Parent _____

Medication _____ Diagnostics _____

NEUROLOGICAL

Oriented to Person, Place & Time _____

Level of Consciousness _____ Pupil Response _____

Recent loss of consciousness _____

Speech Pattern clear for age _____ Facial Symmetry _____

Memory: Immediate _____ Recent _____ Remote _____

Vision: Difficulty/correction _____ Squinting _____ Rubbing _____

Cross eyed (strabismus) _____ Lid Edema _____ Tearing _____

Sclera: Clear _____ White _____ Jaundice _____

Hearing difficulty/correction _____

Coordination/Balance _____ Reflexes for age _____

Fontanel soft & flat for age _____

Sleep Pattern _____ Night mares _____

Pain/Discomfort: Headache _____ Dizziness/Syncope _____

Numbness _____ Tingling _____ paresthesia _____ paralysis _____

Describe _____

Change in usual behavior _____ Seizures/Tremors _____

Diagnosis Studies (CT Scan, etc.) _____

Medications _____

CARDIOVASCULAR

Apical rate _____ Rhythm _____

Radial rate _____ Rhythm _____

Brachial rate _____ Rhythm _____

Volume of Peripheral Pulses: Radial L _____ R _____

Brachial L _____ R _____ Femoral L _____ R _____ Pedal L _____; R _____

(4+ = Bounding, 3+ = Normal, 2+ = Diminished, 1+ = Weak/Thready, 0+ = Absent)

BP _____ Position: Sitting, Lying, Standing

Arm: L or R

Any significant change? _____

Apical/Radial Deficit _____

Extra Heart Sounds _____

Pain/Discomfort (Chest pain) _____

Neck Vein Distention at 45degrees _____

Shortness of Breath _____

Edema: _____ Non-pitting _____ Pitting _____

(1+=1/4" 2+=1/4 -1/2" 3+=1/2-1" 4+=>1")

Location/Description _____

Wt. Gain (Time frame) _____

Skin: Temp _____ nailbeds pink _____ clubbing _____

Capillary Refill <2sec _____ <3sec _____ >3sec _____

Color _____ Diaphoresis: Y N

Varicosities: Y N Location _____

Therapeutic Procedures (pacemaker, telemetry, hx. blood transfusions.) _____

Diagnostic Studies (ECG, Cardiac enzymes, CBC, Electrolytes, etc.)

Medications _____

RESPIRATORY

Rate _____ Rhythm _____ Depth _____
Pattern _____ Chest Symmetry _____
Breath Sounds clear bilaterally _____ adventitious _____
type, location _____
Chest Pain (onset, duration, associated symptoms, efforts to
treat) _____
Respirations unlabored _____ Shortness of air (dyspnea) _____
(onset, pattern, severity) _____
Use of accessory muscles _____ nasal flaring _____ O2 sat _____
retractions _____ splinting _____ Stridor _____ Coughing _____
(onset, nature, pattern, severity) _____
Sputum (amount, color, consistency) _____
Peripheral Findings (clubbing, cyanosis) _____
Therapeutic Procedures (e.g. RT, tent, apnea monitor,
humidifier) _____
Diagnostic Studies (e.g. Blood gases, sputum culture, CXR,
sweat test, etc.) _____
Medications _____

ENDOCRINE

Temp Intolerance: _____ Heat _____ Cold _____
Hair distribution _____ Fat distribution _____
Energy Level _____
Excessive: thirst _____ urination _____ sweating, _____
salty taste to skin _____
Early signs of puberty _____ Late signs _____
Therapeutic Procedures _____
Diagnostic Studies (ie Blood glucose) _____
Medications _____

REPRODUCTIVE

Breast (symmetry, pain, discharge) _____
External genitalia: Appropriate for age _____ inflammation _____
swelling _____ bleeding _____ discharge _____ skin changes _____
Testes descended x2 _____
Amenarchal _____ menarchal _____ dysmenorrhea _____
Gravida _____ Para _____
Contraceptive Method _____
Therapeutic Procedures _____
Diagnostic Studies _____
Medications _____

GASTROINTESTINAL

Teeth _____ Gums _____ Mucosa _____
Diet _____ snacks _____ Appetite:%eaten:
Breakfast _____ Lunch _____ Dinner _____
Total Fluid intake (past 24 hours): _____
Oral _____ IV _____ Other _____ Breast _____
Bottle _____
Wt. Loss (last 3mo) _____
Nausea/Vomiting/Dysphagia _____
Contour (distention) _____ Bowel Pattern _____
Last BM _____
Diarrhea _____ Constipation _____ Blood in stools _____
Bowel Sound four quadrants:
present _____ absent _____
Stools (character, color, frequency, incontinence,
impaction, fatty) _____

Flatulence: Absent _____ Present _____
Rectal Conditions (hemorrhoids, fistulas, bleeding,
prolapse) _____
Therapeutic Procedures (i.e. NG, PEG,
Button) _____
Diagnostic Studies (i.e. I&O, UGI, Stools for occult blood,
Endoscopy) _____
Medications _____

GENITOURINARY

Urine: Color _____ Character _____ Odor _____
Voiding Pattern (frequency, urgency hesitancy,
incontinence, diaper etc.) _____
Urinary Output: Past 24hours _____
Appropriate for age _____
(Infant 2ml/kg/hr.; child 0.5-1ml/kg/hr.;
adolescent 40-80ml/hr.)
Pain/Discomfort (Dysuria) _____
Therapeutic Procedures (foley, irrigations, etc.) _____

Diagnosis Studies (i.e. IVP, UA, Creatinine, BUN specific
gravity) results _____
Medications _____

MUSCULOSKELETAL

Posture, Mobility, Gait _____
 Muscle Strength/Weakness: Moves Extremities to Command
 (0 = no movement 1 = weak 2 = strong)
 RA: _____ LA: _____ RL: _____ LL: _____
 Gait and ambulation appropriate for age _____
 ROM: Full _____ or
 Limited: _____ (explain) _____
 Joint Swelling/Creptus _____

Ability to perform Activities of Daily Living (ADL's). Check the appropriate spaces:

Bathing Dress Eating Toilet Mobility

Independent					
Needs Assistance					
Unable					

Risk Assessment for Falls: Check all that apply:

- _____ Age (ie crib)
- _____ Unsteady gait/dizziness/imbalance
- _____ Impaired memory or judgment
- _____ Weakness
- _____ History of falls
- _____ Medications (sedatives, hypnotics, tranquilizers, analgesics)
- Assistive Devices (W/C, walker, bedside commode)

Therapeutic Procedures (i.e. PT, CPM, traction, etc.) _____

Diagnostic Studies (i.e. MRI, X-ray, etc.) _____

Medications _____

PAIN ASSESSMENT

Location _____ Onset _____
 Quality _____ Radiation _____
 Duration _____
 Relieved by Medication _____ Type _____
 Diversion _____ Type _____
 Wong-Baker FACES Scale rating 0-5 _____
 Numerical 10 pt. intensity - word modifiers scale 0-10 _____
 Oucher scale, pictures of children's faces 0-10 _____ (age 3-12)
 FLACC scale _____ (infant, sedated)

INTEGUMENTARY

Skin: Warm _____ Dry _____ Intact _____
 Firm _____ Elastic _____ Temp _____
 Tenting _____ Texture _____
 Color (normal for ethnicity) _____
 Erythema _____ Jaundice _____ Pallor _____ Flushing _____
 Rashes (describe, location) _____
 Petechiae _____ Bruises _____ Lesions _____
 Drainage _____ Wounds _____
 IV Site location _____ Swelling _____ Redness _____
 IV/dressing current _____
 Incision/Dressing (description, location) _____

Pain? (incisional, trauma) _____
 Scalp: Clear _____ Hair _____ Lice _____
 Nailbeds: Pink _____ Other _____ Nails :Smooth _____
 Other _____

Pressure Sore Risk Assessment (PSRA)

Circle numbers that apply under each heading. If score is <14, report to HCP & implement nursing care plan.

Physical condition	Mental condition	Activity
4(good)	4(alert)	4(ambulatory)
3(fair)	3(apathetic)	3(walk/help)
2(poor)	2(confused)	2(chair/help)
1(very bad)	1(stuporous)	1(bedfast)

Mobility

- 4(full)
- 3(very limited)
- 2(slightly limited)
- 1(immobile)

Incontinence

- 4(not)
- 3(occasionally)
- 2(urine)
- 1(urine & stool)

Total Score = _____

Therapeutic Procedures (i.e. heat/cold therapy, topical, etc.) _____

Diagnostic Studies (i.e. biopsy, culture, etc.) _____

Medications _____