

**BAKERSFIELD
COLLEGE
NURSING PROGRAM

NURSING B20/20L

CLINICAL ADDENDUM**

**Lupe Guillen, Instructor
Fall 2009**

COURSE DESCRIPTION: Refer to NB 20 & NB 21 syllabi for clinical course description

EVALUATION PROCESS

The evaluation process for the clinical lab is as follows:

At the end of each clinical rotation, the instructor will initiate the final evaluation of the student and the student will have the opportunity to evaluate the instructor as well as the clinical agency.

STUDENT EVALUATION:

The evaluation process for clinical labs is an ongoing process throughout the rotation. Feedback is provided in different forms including but not limited to comments on paperwork, conferences with the student, or group discussions. The student has the responsibility to seek out the instructor if more feedback or clarification is needed. A copy of the evaluation form/criteria is provided for you in your syllabus; this form will be completed by your clinical instructor at the end of each clinical rotation.

The student will need to bring the following with them to their evaluation appointment:

1. Skills checklist (found at the back of the lab syllabus)- this should be completed according to the instructions on the checklist. (To expedite completion of this form by the instructor the student can also place the completed checklist in their manila folder with their last care plan of the clinical rotation)
2. Completed self assessment form- this form can be found in lab syllabus

INSTRUCTOR/AGENCY EVALUATION:

At the end of each clinical rotation, the student will evaluate the instructor and the clinical lab agency using an online evaluation tool. A copy of the online tool can be found in your lab syllabus. Instructions for going online and completing the evaluation will be given at the time of the evaluation. NOTE: The evaluations provide the instructor with useful feedback that is considered when making changes to the rotation with the ultimate goal being to meet the student's needs. Therefore we ask that you answer questions thoughtfully and honestly. The instructor is not present while the student is completing the evaluation.

Bakersfield College Allied Health Programs

Student Evaluation of Laboratory Site

This is an evaluation of the clinical facility/agency used for your most recent laboratory rotation. The indicators below deal with the varied aspects of your experience, and will allow for the identification of your concerns.

Comments are particularly helpful and are mandatory if you select “disagree” or “strongly disagree”.

On your scantron please write:

1. The name and unit of the laboratory site you are evaluating
 2. The program in which you are enrolled
 3. The semester in which you are currently enrolled
 4. The dates of your assignment
 5. The name of your instructor
-
1. The instructor has a positive working relationship with the staff at this health care facility.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 2. The staff at this facility worked with the instructor to aid students in the learning process.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 3. I was able to meet laboratory objectives as stated in the syllabus.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 4. I felt comfortable and welcomed working on this unit.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 5. Appropriate and adequate equipment and supplies were available.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 6. Client selection for this laboratory experience provided variety and challenge for learning.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 7. Types of clients available allowed me to transfer classroom knowledge to the clinical setting.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 8. I would recommend this facility/agency for future laboratory rotations.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable

Revised 2003

Bakersfield College Allied Health Programs

Student Evaluation of Laboratory Instructor and Course

This is an evaluation of the laboratory instructor for your most recent laboratory rotation. The indicators below deal with the varied characteristics of this instructor and the rotation and will allow for the identification of your concerns. Comments are particularly helpful and are mandatory if you select “disagree” or “strongly disagree”.

On your scantron please write:

1. The name of the instructor you are evaluating
 2. The name of the course you are evaluating
 3. The name and unit of your assigned laboratory site
 4. The dates of your assignment
-
1. The instructor was helpful when students reported they were having difficulty.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 2. The instructor encouraged students to ask questions, to disagree, and to express their ideas.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 3. The instructor treated me courteously and fairly.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 4. The instructor demonstrated respect for individuals, regardless of their cultural background, ethnicity, race, gender, religion, disability, age, sexual orientation, or socioeconomic status.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 5. The instructor provided meaningful feedback to me.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 6. The instructor served as a positive role model in the clinical setting.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 7. The instructor demonstrated appropriate and current knowledge of this area.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 8. The instructor returned papers within a specified amount of time.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 9. This laboratory experience provided me the opportunity to achieve the stated laboratory objectives.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 10. The orientation provided helpful information for this rotation.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable
 11. The majority of post-conferences provided a meaningful learning experience.
a) strongly agree b) agree c) disagree d) strongly disagree e) not applicable

Revised 2003

**BAKERSFIELD COLLEGE NURSING PROGRAM
STUDENT SELF-ASSESSMENT
FOR
NURS B20 (GERIATRIC ROTATION)**

Student Name:

Date:

TWO THINGS I LEARNED DURING THIS ROTATION ARE:

1.

2.

**TWO AREAS (SKILLS, PERSONAL GROWTH, OR PAPERWORK) THAT I
COULD WORK ON ARE:**

1.

2.

**MY AREAS OF STRENGTH (SKILLS, PERSONAL GROWTH, OR PAPERWORK)
WOULD BE:**

1.

2.

**BAKERSFIELD COLLEGE NURSING PROGRAM
STUDENT SELF-ASSESSMENT
FOR
NURS B21 (MEDICAL-SURGICAL ROTATION)**

Student Name:

Date:

TWO THINGS I LEARNED DURING THIS ROTATION ARE:

1.

2.

**TWO AREAS (SKILLS, PERSONAL GROWTH, OR PAPERWORK) THAT I
COULD WORK ON ARE:**

1.

2.

**MY AREAS OF STRENGTH (SKILLS, PERSONAL GROWTH, OR PAPERWORK)
WOULD BE:**

1.

2.

Skills & Procedure Checklist

Skills to Practice until Mastery

During the semester there are several skills that you will need to master. To do so will require that you adhere to the recommended schedule.

- Some of these skills can be practiced in the skills lab or at home
- Some of these skills are not individually tested: proficiency will be expected by the master date.
- Demonstration of the skills may be requested at random.

PROCEDURE: **1. Watch video (either in class or schedule with lab assistant)**
2. Practice until mastery is achieved- (use critical elements from the lab syllabus).

<u>SKILL</u>	<u>MASTERY DATE</u>
Handwashing	08/28/09 - 09/04/09
*Body Mechanics	09/01/09 - 9/11/09
*Application of O2 via nasal cannula	10/01/09 - 10/16/09
Urinary Catheterization	
Dressing Changes	10/13/09 - 10/30/09
Nasogastric Tubes	
Isolation	

*Does not have a critical element sheet for these two skills – refer to your text, video or Skills on-line.

SELF DIRECTED SKILLS

Demonstration of these skills must be observed and signed off by an instructor or the lab assistant.
Schedule your lab practice time and test time early.

Procedure: 1. Watch video (in class or schedule with the lab assistant) or Skills on-line.
2. Practice as needed- (use critical elements from the lab syllabus).
3. Demonstrate and sign off (critical elements will be signed and dated)

<u>Skills</u>	<u>Start</u>	<u>Completion</u>
Vital Signs	08/28/09	09/11/09**
Bed Bath	09/04/09	09/18/09**
Oral Medications	09/10/09	09/25/09**
Injections	09/30/09	10/13/09**

**** All skills must be completed (signed off) by the date indicated in order to continue in clinical lab. If not signed off by assigned date, student will receive conference form for failing to complete assignment within designated timeframe (this is a component of *professionalism*). PLAN AHEAD AND GET DATES SCHEDULED EARLY!!!**

BAKERSFIELD COLLEGE
NURSING PROGRAM
LABORATORY SKILLS EVALUATION
NURSING B20 AND B21
SKILLS TESTING LIST

PROCEDURES

1. Handwashing
2. Oral temperature
3. Pulse
4. Respirations
5. Blood pressure
6. Head to toe Assessment
7. Oral medication administration- pill
8. Oral medication administration- liquid
9. Preparing medications- vial
10. Preparing medications- ampule
11. Injections- subcutaneous
12. Injections- intramuscular
13. Gloving
14. Insertion of a straight catheter- male
15. Insertion of a indwelling catheter- female
16. Insertion of a nasogastric tube
17. Dry dressing change
18. Wet-to-dry dressing change
19. Isolation technique
20. Bed Bath
21. Fingersticks

NOTE:

Critical elements for all skills found in the lab module are only for student use and reference. These critical elements do not need to be turned in to instructor but will be used by the student during practice time.

Lab Skills Checklist should be brought to all lab TESTING. Signature of the instructor on the lab skills check list indicates successful, satisfactory completion of the skill. The Lab Skills checklist will be turned in at the end of the semester and be placed in the student's file.

Nursing Skills Checklist (located in the back of your syllabus) is completed for each clinical rotation and is given to the clinical instructor at the time of the student's evaluation. Students should always check each facility's Policy and Procedure Manual prior to performing any of these skills.

BAKERSFIELD COLLEGE NURSING PROGRAM
NB20 and NB21 – Laboratory Skills

NAME: _____

Skills	Date	Signature of Instructor	Comments (Include VS values/Needs improvement/ Needs to repeat)
# 1-Handwashing			
#2-Oral temperature			
#3-Pulse			
#4-Respiration			
#5-Blood pressure			
#6-Head-to-toe assessment			
#7-Med- admin.- pill			
#8-Med.admin - liquid			
#9-Vial			
# 10-Ampule			
#11 -Injection Subcutaneous			
#12-Injection intramuscular			
#13-gloving			
# 14-Straight Catheter			
# 15- Indwelling Catheter			
# 16-Nasogasinc Tube			
# 17-Dry dressing			
#18-Wet-to-dry dressing			
# 19-Isolation			
#20-Bedbath			
Fingersticks			

Student Signature _____

INSTRUCTOR COMMENTS (Continued):

Clinical Objectives

BAKERSFIELD COLLEGE
ASSOCIATED DEGREE NURSING PROGRAM
CLINICAL OBJECTIVES FOR NURS B20

1. Operates within the boundaries of the Nurse Practice Act in the clinical setting.
2. Demonstrates nursing values in the clinical and classroom setting
3. Maintains confidentiality of the client at all times.
4. Identifies the essential elements of a legal informed consent
5. Demonstrate the ability to maintain client privacy in all health care settings.
6. Document in client records, appropriately, as determined by instructor, facility policies and procedures, and the law.
7. Demonstrates advocacy at a basic level in the clinical setting.
8. Identify a clinical situation that might involve an ethical decision.
9. Demonstrate beginning critical thinking when writing a care plan.
10. Demonstrate beginning critical thinking when caring for the adult client with a predictable outcome.
11. Complete a nursing health history on a given client.
12. Demonstrate the appropriate use of the nursing process in caring for all assigned clients.
13. Demonstrate the ability to write an individualized nursing diagnosis for a specified client.
14. Demonstrate the ability to write individualized short and long term goals, prioritize nursing diagnoses appropriately, and plan interventions based upon individualized client nursing diagnoses for expected outcome clients.
15. Identify interventions on a care plan as dependent, independent, or interdependent.
16. Identify which interventions might be delegated by the nurse.
17. Select appropriate implementation methods for an assigned client.
18. Evaluate a set of nursing actions selected for a client in the clinical setting.
19. Describe types of services available within their assigned clinical setting.
20. Describe types of services their assigned client may be referred to while hospitalized and upon discharge.
21. Demonstrate proper procedure for use of communication systems within assigned health care settings.
22. Utilize therapeutic communication skills with clients and families in assigned health care settings.
23. Demonstrate caring response to clients and families in assigned health care settings.
24. Identify basic learning needs of client, family, or peers and demonstrate ability to teach to that basic learning need.
25. Give examples of questions used in a cultural assessment that would identify significant values, beliefs, and practices critical to nursing care through life transitions. Utilize questions, when appropriate, in the clinical setting.
26. Plan nursing care which is adapted to a client's culture and ethnicity.
27. Develop an age appropriate care plan for a young, middle, and/or older adult.
28. Apply the nursing process when providing care for a client with a problem involving sexuality.
29. Plan nursing care, including appropriate nursing interventions, for the client experiencing a problem with sleep or rest.
30. List interventions in the nursing plan for spiritual care.
31. Perform a spiritual assessment of a peer, friend, or family member.
32. Notify clergy, as needed, for clients in assigned health care setting.
33. Verbalize the procedure for performing post mortem care in the assigned health care setting.
34. Assist with post mortem care as assigned.
35. As assigned, prepare and implement a care plan for a client who is dying or has had a significant loss in their life.

36. Review and demonstrate proper technique for hand washing.
37. Demonstrate principles of medical and/or surgical asepsis in appropriate situations.
38. Identify clients most at risk for acquiring an infection.
39. Demonstrate the ability to care for a client in isolation following appropriate guidelines.

40. Correctly apply and remove an isolation gown, mask, and gloves.
41. Correctly apply sterile gloves
42. Correctly open a sterile package.
43. Identify sterile objects correctly.
44. Place sterile objects onto a sterile field without contaminating the sterile field.
45. Pour a sterile solution into a sterile container without contaminating the sterile field.
46. Demonstrate the ability to use sterile asepsis in multiple situations.
47. Perform correct lifting procedures in the laboratory and in the clinical setting.
48. First in the nursing laboratory, review and/or practice positioning a partner in each of the following bed positions: Fowler's, supine, prone, lateral side-lying, Sim's, Semi-Fowlers (30 degrees). Evaluate body alignment, pressure points and comfort level after each position change. In assigned clinical setting, identify and use proper position and positioning devices.
49. Assist with ambulation: (1) in the skills laboratory review each of the following with a partner as the client: a) preparation for walking, b) ambulation with and without an ambulation belt, c) lowering a fainting client to the floor. (2) Assist with ambulation, as needed, in the clinical setting.
50. Assisting with exercise 1) in the skills laboratory, review how to perform passive ROM on a partner, attempt to put each joint on one side of the body through ROM. Switch places and have your partner perform passive ROM on you. 2) In clinical setting assist with ROM on assigned client, as needed.
51. Lifting and moving: 1) In skills laboratory incorporate good body mechanics as you review each of the following techniques with one or more partner(s): a) pulling a client up in bed (alone w/ client assistance, and with a partner) b) moving a bed, c) lifting a box. 2) Assist client with lifting and moving the client in the clinical setting.
52. Transfer techniques- in the skills laboratory, review each of the following techniques with a partner: 1) assisting a client to a sitting position in bed, 2) assisting a client to a sitting position on the side of the bed, 3) assisting a client to transfer from the bed to a chair, 4) assisting a client to transfer from a chair to a bed, 5) using a transfer board- transfer client to another bed or gurney.
53. Assess for alterations in body alignment and joint mobility in the skills lab and clinical setting.
54. Demonstrate correct application of restraints in the skills laboratory and, as needed, in the clinical setting.
55. Demonstrate the ability to properly use a thermometer in both the skills lab and clinical setting.
56. Demonstrate the ability to properly use a stethoscope.
57. Demonstrate the ability to take a radial and apical pulse.
58. Locate the pulse at all arterial site listed in the textbook.
59. Demonstrate the proper use of a pulse oximeter.
60. Demonstrate the ability to properly take a blood pressure in the skills lab and the clinical setting
61. Demonstrate proper technique for oral hygiene and care of dentures.
62. Demonstrate the correct method for giving a client a complete bed bath.
63. Demonstrate proper techniques for making an occupied and unoccupied bed.
64. Demonstrate proper technique for administering a backrub.
65. Identify common postural abnormalities.
66. Identify adventitious breath sounds.
67. Identify normal breath sounds.
68. Identify normal heart sounds.

69. Describe the techniques and the equipment needed for each system.
70. Prepare the environment for performing a physical examination.
71. Select a partner and perform a physical exam on the partner, note any abnormal findings.
72. Use physical assessment skills during routine nursing care.
73. Communicate abnormal findings to appropriate personnel.
74. Correctly calculate a prescribed drug dose.
75. Verbalize an understanding of correct procedures for administering oral medications.
76. Demonstrate in the skills laboratory correct preparation of oral medications.
77. Safely and properly administer drugs via oral and gastrointestinal tube routes using the 6 rights including proper documentation.
78. Calculate medication dosages in given situations both simulated and clinical.
79. Prepare injections in the clinical laboratory setting following guidelines for administration of injections. Properly administer an IM/Subcutaneous injection in the clinical setting.
80. Demonstrate dressing applications (wet to dry and dry) using sterile technique in the skills laboratory/ clinical setting.
81. Describe how to safely administer heat and cold applications and document the client's response. As needed, apply warm and cold applications safely in the clinical setting.
82. In the laboratory apply a straight abdominal binder and a t-binder.
83. Demonstrate the ability to use a Laboratory/ Diagnostic Test resource to review a client's lab/ diagnostic tests.
84. Review a particular client's labs/ diagnostic tests giving an educated guess for why value might be out of range of normal.
85. Demonstrate correct use of a glucometer for monitoring blood glucose.
86. Prepare and implement a nursing care plan for an immobile patient.
87. Prepare and implement a nursing care plan for a client with altered sensation.
88. Assess a client's elimination pattern.
89. Review the procedure for administration of an enema, as needed demonstrate the proper administration of an enema.
90. Assist clients at mealtime.
91. Feed a dependent client and discuss your actions in post-conference.
92. Properly place an NG tube and check for placement via aspiration and auscultation in the skills laboratory and /or clinical setting.
93. Review how to assist a client on and off a bedpan.
94. Demonstrate insertion of the indwelling catheter inn the female/male client in the skills laboratory and/or clinical setting.
95. Demonstrate proper care of an indwelling catheter and perineal care to the cient with an indwelling catheter.
96. Demonstrate collecting a urine specimen from client with continuous catheterization
97. Measure and record fluid intake and output for clients in the clinical setting.
98. Weigh and measure a client.

BAKERSFIELD COLLEGE
ASSOCIATE DEGREE NURSING PROGRAM
CLINICAL OBJECTIVES FOR NURS B21

1. Demonstrate an understanding of the roles and responsibilities of the medical- surgical nurse, in the clinical setting.
2. Demonstrate the ability to act as Provider of Care, Manager of Care, and Member of the Profession as a Level 1 student.
3. Demonstrate Level 1 critical thinking in the clinical setting.
4. Demonstrate caring and comfort in the clinical setting.
5. Demonstrate the ability to work as a member of a team in a variety of assigned settings, including the skills laboratory.
6. Demonstrate the ability to work as an integral part of a team by actively participating in the planning and implementing of an age appropriate activity in an assigned setting.
7. Identify a community based need for an assigned medical-surgical client, following their discharged from the acute facility. We mentioned in beginning of semester, now it is time to incorporate into planning.
8. Demonstrate therapeutic communication techniques in simulated and clinical situations.
9. Demonstrate the ability to establish a therapeutic relationship with their assigned clients in the clinical setting.
10. Verbalize and demonstrate ways to effectively communicate with the client who has a hearing deficit, cognitive impairment, or speech impairment (may be simulated or in clinical setting).
11. Demonstrate the ability to assess a client's level of pain using an objective pain scale and/or clinical indicators of pain.
12. Demonstrate the ability to design and implement basic interventions to relieve or alleviate pain.
13. Identify equipment needed to connect a nasal cannula and face mask in simulated or clinical setting. *Discussed in lecture, there are case studies in skills lab for objective 13 & 14.*
14. Demonstrate the ability to connect a nasal cannula and simple face mask as ordered by the physician.
15. Identify equipment needed to suction using any of the various methods of suctioning. Objectives 15 & 16 mentioned lightly, I did not go over.
16. Demonstrate the ability to do oral, oropharyngeal and nasopharyngeal suctioning in either a simulated or clinical setting.
17. Demonstrate the ability to complete a Level 1 respiratory assessment either simulated or in the clinical setting.
18. Complete a focused assessment for the client experiencing atelectasis or pneumonia, either simulated or in the clinical setting.
19. Prepare and implement an appropriate Level 1 care plan for the client experiencing atelectasis or pneumonia.
20. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for the client with atelectasis or pneumonia.
21. Demonstrate the ability to complete a Level 1 focused cardiovascular assessment, either simulated or in the clinical setting.
22. Return demonstrate Basic Life Support and maintain a valid BLS card.
23. Activate code blue in the clinical setting when required. *Please go over for floor.*
24. Complete a focused assessment on the client experiencing hypertension, arteriosclerosis, atherosclerosis, or the various peripheral venous diseases, either simulated or in the clinical setting.
25. Prepare and implement a Level 1 care plan for the client experience hypertension, arteriosclerosis, atherosclerosis or the various peripheral venous diseases, when assigned.

26. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for the client experiencing hypertension, arteriosclerosis, atherosclerosis or the various peripheral venous diseases.
27. Complete a focused assessment on the client experiencing anemia, either simulated or in the clinical setting.
28. Prepare and implement a Level 1 care plan for the client experiencing anemia.
29. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for the client experiencing anemia.
30. Complete an assessment, including health history, of the eyes, ears, and nose either simulated or in the clinical setting.
31. Complete a focused assessment, including health history, on the client experiencing altered sensation either simulated or in the clinical setting.
32. Prepare and implement a care plan for the client with altered sensation: hearing, vision, or smell.
33. Obtain a health history focused on the gastrointestinal system.
34. Demonstrate physical assessment techniques for a focused assessment of the gastrointestinal system.
35. Complete a focused assessment on the client experiencing GERD, gastritis, or Irritable Bowel Syndrome, as assigned
36. Prepare a Level 1 care plan for a client with GERD, gastritis, or Irritable Bowel Syndrome, as assigned.
37. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for a client experiencing an alteration in gastrointestinal function.
38. Obtain a health history focused on the endocrine system.
39. Demonstrate physical assessment techniques for a focused assessment of the endocrine system.
40. Complete a focused assessment on the client experiencing diabetes.
41. Prepare a Level 1 care plan for a client with diabetes.
42. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for a client experiencing diabetes and complications related to diabetes.
43. Obtain a health history focused on the renal system.
44. Demonstrate physical assessment techniques for a focused assessment of the renal system.
45. Complete a focused assessment on the client experiencing urinary incontinence, cystitis, urethritis or pyelonephritis, as assigned.
46. Prepare a Level 1 care plan for a client with urinary incontinence, cystitis, urethritis or pyelonephritis, as assigned.
47. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for a client experiencing urinary incontinence, cystitis, urethritis, or pyelonephritis.
48. Obtain a health history focused on the neurological system.
49. Demonstrate physical assessment techniques for a focused assessment of the neurological system.
50. Identify clinical manifestations of a CVA, given a simulated case study or an assigned client.
51. Complete a focused assessment on the client experiencing Alzheimers, Parkinsons, or Huntington's Chorea, as assigned.
52. Prepare a Level 1 care plan for a client with Alzheimers, Parkinsons, or Huntington's Chorea., as assigned.
53. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for a client experiencing Alzheimers, Parkinsons, or Huntington's Chorea.
54. Obtain a health history focused on the fluids and electrolytes.
55. Complete a focused assessment on the client experiencing fluid volume excess and deficit, as assigned.
56. Prepare a Level 1 care plan for a client with fluid volume excess and deficit, as assigned.

57. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for a client experiencing fluid volume excess and deficit.
58. Obtain a health history focused on the immune and integumentary systems.
59. Demonstrate physical assessment techniques for a focused assessment of the integumentary system.
60. Complete a focused assessment on the client experiencing HIV, pressure ulcers, and/or an infection of the integumentary system, as assigned.
61. Prepare a Level 1 care plan for a client with HIV, pressure ulcers, and/or an infection of the integumentary system, as assigned.
62. As part of the care plan, identify tasks that might be delegated to a CNA or LVN while caring for a client experiencing HIV, pressure ulcers, and/or an infection of the integumentary system.

Clinical Setting Guidelines

NURS B20\B21 Lab Expectations/Calendar

The clinical objective for NB20 lab is for the student to keep the same resident throughout the rotation. You will be building a care plan for that resident throughout the rotation. Starting with a very basic care plan and each week you will be changing, expanding, and developing the plan to make it appropriate for your resident. For both NB20 & NB21, the final draft of your care plan will include Part I through Parts VII. The terms we use for each of these care plans are:

Abbreviated Care Plan also called a “weekly”: This includes Parts I thru Parts IV plus Part V-A (Systems Assessment) for everyday that you care for any patient.

Nursing Process: A complete nursing process is equal to Part I thru Part VII. However, since we are going to be developing the completed Nursing Process, we will be adding new “parts” each week. It will be important to watch the calendar and know what “Part” is due each week.

Part V-A: This form is to be used to complete your Systems Assessment of your resident. You will be completing one of these each day on each patient you are caring for this semester.

Things to know:

ALL paperwork except your assessment that is done on Tuesday must be typewritten by Tuesday when it will be turned in for grading. (You may turn in handwritten paperwork to be checked for completeness on Monday am, but it must be typed when turned in for grading). All paperwork, including medication cards, should always be turned in to the instructor in a **manila envelope** with the student’s name on the outside. Paperwork will be graded each week and returned to the student before the next paperwork is due. Students should look at corrected paperwork and make adjustment/corrections to their care plans before the next due date. When turning paperwork in to the instructor in the geriatric rotation **include all of the old graded papers with the new corrected forms in the manila envelope. Paperwork will not receive a grade if ALL old and new paperwork are not in the envelope.**

Things to do in clinical:

Every Monday at 7:00am you will be turning in your paperwork to your clinical instructor to be checked for completeness. It is your responsibility to look at the calendar and know what is due each week. Ask your instructor if you are unclear about the expectations.

Every Monday night you will type and print out the paperwork, including the assessment (Part V-A) that you did on your resident on Monday. In addition, you should make any modifications, corrections, additions to the rest of your care plan and print a new copy to be turned in Tuesday.

FYI- It is okay to make 2 copies of the assessment and use it for Tuesday’s assessment (just leave the items that will change blank and fill them in with ink on Tuesday i.e. vital signs, % of food eaten etc).

Every Tuesday in post conference- Turn in corrected completed paperwork that is due. Refer to the calendar to make sure you included all items that are due. Include in the manila envelope: new paperwork, highlighted med cards, and ALL previously graded paperwork.

Grading: All papers turned in will be graded as a Weekly grade or Process grade. Points available will be dependent upon what is required each week. A 75% average will be expected for the 2 weeks of paperwork. A 75% is required on the “Nursing Process” to be given credit for NURS B20 and B21. **No weeklies, processes, or any part of the process will be accepted LATE!!**

STUDENT OBJECTIVES FOR THE GERIATRIC ROTATION

The student should complete at least the following objectives during the geriatric clinical rotation:

- Shave a resident
- Care for a totally dependent resident
- Assess residents and develop nursing diagnoses as appropriate for the geriatric client
- Implement and evaluate care plan interventions
- Administer medications as assigned
- As a team plan and carry out an activity appropriate for the geriatric client
- Assist with feeding residents breakfast and lunch
- Shower a resident
- Help with transferring and/or moving a geriatric client
- Develop time management skills in the long term care setting

CALENDER FOR GERIATRIC ROTATION

Clinical Dates	Clinic Activities	Care Pan Requirements
09/21/09 09/22/09	<p>Monday –Assignment of resident, tour of facility, orientation to geriatrics. Begin paperwork at designated facility, complete at home. Introduce yourself to resident.</p> <p>Tuesday- Patient care. It might be helpful to “buddy” with your resident’s CNA for awhile to learn facility routine. Complete physical assessment.</p>	<p>Monday – Have forms Part’s I-IV with you to begin completion of Process. You will be reviewing your resident’s chart today and can fill in your paperwork. You will do all you can at the facility and complete it at home (i.e. looking up medical dx at home and highlighting med cards)</p> <p>Tuesday- Complete Parts I-IV and one Part V(a) (written)</p>
09/28/09 09/29/09	<p>Both Monday and Tuesday you will be doing total patient care on your resident plus you need to complete a physical assessment each day.</p> <p>FYI – We start oral medication administration this week – check assignment sheet to see if your have been assigned to give meds to your resident</p> <p>After working with your resident and doing your initial assessment decide on 4 appropriate nursing dxs, if educated guesses that you have made are not accurate then change your diagnoses on Thursday night.</p>	<p>Monday – Turn in paperwork to check for completeness in the morning. Today this includes Parts I – IV and Two Part’s III (A). Part IV will be an educated guess based upon the resident’s medical record. Part V (A) head to toe assessment will be completed during clinic.</p> <p>Monday night – Type Part V-(A) assessment and make corrections to care plan. In addition, you will need to complete (1) one – Part V for one of your nursing diagnoses from Part IV.</p> <p>Tuesday – Make additions/corrections during clinic. Turn in completed paperwork at post conference. This will include: Parts I-IV, Two Part III-A, One Part V-(A) and One Part V from one of your diagnoses.</p>
10/05/09 10/06/09	<p>Monday – Do total patient care. Give oral meds with instructor (if assigned).</p> <p>Tuesday– Do total patient care, give oral meds with instructor (if assigned), team project</p>	<p>Monday– Turn in paperwork to be check for completeness. This week includes: Part I – Part IV plus Part V for all 4 nursing diagnoses. (This means you will have 4 Part V’s)</p> <p>Tuesday – No paperwork due today. Final draft of care plan due on Friday 10/09/09 by 1200. Do all evaluations, bibliography and diet explanation.</p>
10/09/09		<p>Friday– Turn in corrected and completed care plan with all components completed by 1200. Remember to reference all rationales. Include in your folder your completed skills inventory checklist for your clinical instructor to sign.</p>

****NOTE:** As you build your care plan, Parts I – III will probably not change much unless your resident has a new medical diagnosis or a new physician order. What you will be working on each week is developing the Nursing Dx’s (Part V). The first week you will begin the process by identifying the 4 Nursing Diagnoses that you feel are appropriate for your resident(Part IV) and expanding on 1 of them.(One part V). The following week you will be developing the other 3 diagnoses. *Note: Nursing process must be submitted on the date due. If the process paper, or any part of the process paper is late, 5 points, will be deducted from the score for each school day late.*

GUIDELINES FOR PAPERWORK IN MED-SURG ROTATION

1. For each client that you care for during the Med-Surg rotation you will complete a **“weekly care plan.”** This includes **Parts I through Parts IV and two (2) systems assessment V-(a)**. One systems assessment for **each day** that you care for the client. **Parts I through Parts IV** will be completed and ready for the instructor to review the first morning before caring for the client (this will be on **Monday morning**). Paperwork may be handwritten for Monday morning check. After caring for your client on the second day the completed typed **revised** “weekly care plan” will be due at the end of the day on Tuesday. A handwritten systems assessment (V-A) will be included for the Tuesday systems assessment.
2. If a patient is **unexpectedly** sent home the second day or not in the department. A new client will be assigned *with attempts* to have similar diagnosis as the previous patient. All forms for patient #1 are due upon arrival to the floor. The student is to have a copy of the NB21 (Abbreviated Weekly pg 34, 35, & 36 in this syllabus) easily available to obtain the new patient information. Hand written completion of the form is requested and to be turned in by the end of the day. Weekly/Abbreviated Grading will be a result of the forms submitted for both clients by the end of the second day.
3. Once during the rotation you will be completing a nursing process paper. It is your choice as to which client you use for the process paper, the exception being there will be no process papers done on the first week in the Medical-surgical clinical setting. You **must let your clinical instructor** know by the end of clinic day on **Monday** if you intend to write your nursing process on the client you are caring for that day. Choosing the client by Monday allows the student time to evaluate the interventions they have been implementing. The client is to be available for both days in order to evaluate interventions.
4. The Medical Surgical Nursing Process Paper will include: **Parts I through Parts VII and two (2) systems assessment V-(a)**; one system assessment for each day you cared for the client. **Part VI** for the Medical Surgical rotation is a **laboratory and diagnostic test** review for your client; see “Instructions for Completing Labs.”
5. The Nursing Process paper will be due on that Friday by 12:00 at the designated place indicated by Ms Guillen/Mrs. Anderson at PC and Mrs. Hill/Mrs. Julee at BC. **Note:** Nursing process must be submitted on the date due. If the process paper, or any part of the process paper is late, **5 points**, will be deducted from the score for each school day late.

Medical-Surgical Process

The Medical Surgical process has a maximum of 100 points with a minimum of 75 points (75%). If the Med-Surg process falls below 75%, you must do another Med-Surg process within one week unless otherwise instructed. The old process must be turned in with the new. If the second process grade falls below 75%, you will receive a **NO CREDIT** for Nursing 21 and cannot progress into second semester. Refer to the new grading sheet received, titled: “Medical-Surgical Nursing, Grade Sheet: Process.”

Instructions for Completing Labs in Medical-Surgical Rotation

INSTRUCTIONS FOR COMPLETING LABS

1. Review all of your clients labs and begin correlating the lab chosen by the physician with your client's condition.
2. When reporting the lab values for the nursing process you will be only reporting on portions of the CBC, Chemistry Panel, UA, Drug Levels and Diagnostic tests. This the beginning level for understanding laboratory values and we want you to focus on the basic values that we have included in your paperwork. As you progress through the Bakersfield College ADN Program you will be building upon this basic knowledge of labs.
3. To report and review your clients labs look up their labs in the laboratory/diagnostic section of their medical chart, then:
 - a. If the client has several of the same lab (ie CBC's done each day since admission), use the 3 most recent lab values for reporting.
 - b. If your client has had any of the lab tests identified in the paperwork you will first need to give an explanation of that particular lab ordered and that make an "educated guess" use research to consider your patient's medical/surgical condition and/or their history.
 - c. Next report only the lab values included in your paperwork, including:
 - i. Reference range – this is the documented range for the lab that has run the test, it is included when the lab reports the client's value.
 - ii. Under the 3 dates – Report your client's values for 3 different dates/times, report what your client has had done, with 3 labs being the maximum to report.
 - iii. Under "Identify ↑↓ WNL Significance" state your **impression**, why do you think this lab is abnormal for your client. Your lab book is very helpful here; it will give you several suggestions for each abnormal value. Do not make a list of all reason, look at the suggestions and decide why the value is abnormal in this client: This may again be an "educated guess," but it's part of the learning process.
4. To report diagnostic tests such as x-rays or CT scans you will need to complete the chart that is included for diagnostic testing. This information can be found on the hospital form on which the diagnostic test is being reported.

Suggested Activities in the Laboratory Area

Be at the agency as indicated by your Clinical Instructor. Come in full uniform –Name Tag, Pens, scissors, small notebook. Listen quietly to report.

Check Kardex (if applicable) and the client's chart for current orders, med, etc. Greet client and begin with visual assessment. In general, how does the client look? Any immediate needs? Proceed to check all equipment – IV, NG, Foley, O2, Drains, etc. Make sure all are hooked up according to current doctor's orders and are functioning correctly. Check dressings, casts, incisions, to get a baseline for the day's observation.

Take vital signs and document immediately. Provide A.M. care if not already given (offer bedpan, wash face, hands, brush teeth).

Breakfast – know diet ordered and diet received. Record amount taken and mL's of liquid intake. Offer oral hygiene before breakfast.

Bed bath – Set up basin if client is self care. May shower as indicated. When providing bath include nail care, skin care, hair care, back rub, shave – offer assistance in this areas for self care client. If there is some reason care was not provided, notify the instructor as to the reason why – in a timely manner.

Linen change – Be sure client is comfortable and in good alignment with lights adjusted for comfort. Keep bedside table and over bed table **clean**. Keep water, call light and all necessary articles within client's reach. Make sure bed is in low position, side rails up (when appropriate). Report any pain or abnormalities to the appropriate person.

Chart all data as instructed. Remember – you are a guest! Do not impede the work of the staff. Do not overburden the staff with questions that can be answered by your instructor. Do not stand in the hall or “hang out”. Document or “hang out” in your client's room. When you take a break ask a classmate to keep an eye on your client and notify your instructor.

At the end of the day, report off to the caregiver that will assume care of your client. Do this before post conference. Before leaving the unit to go to post conference, make sure your client is clean and comfortable with all safety precautions in place.

Tips for Clinical Laboratory Success

The Following are some suggestions that will help you during your clinical rotations.

- **Refer to lab module and syllabus for paperwork guidelines
ASK THE INSTRUCTOR QUESTIONS, AFTER READING GUIDELINES IF NECESSARY
 - **Review rules for writing goal statements BEFORE you turn in the paperwork
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - **Review the steps for writing a diagnostic statement and use them
 - **Pay attention during orientation and refer to your orientation packet
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - **Take initiative: Think out the issue, arrive at a possible solution-run it by your instructor – That's critical thinking
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - **Being prepared not only means having your paperwork completed but also look up new things found in your paperwork (ie care of an NG/GT, case care, isolation, etc)
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - ** Utilize your instructor, not the staff when you have a question – we are the one whom need to evaluate your performance.
 - ** Chart your VS & Notes immediately.
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - **Although there is a lot required, try to enjoy clinic and have fun.
 - **A position attitude is a must – complaining doesn't accomplish anything.
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - ** You will be learning to develop assertiveness and confidence, use it.
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
 - **Remember, we will not allow you to harm anyone, so be confident in yourself.
ASK THE INSTRUCTOR QUESTIONS IF NECESSARY
- **In an effort to support and evaluate the skills learned, the following skills should be accomplished during one or both rotations (We can find opportunities for these skills)*
- GERI – Shave a male resident, Tub bath, Shower, Feed a resident, and Provide total care to a dependent resident*
- MED/SURG – O2 administration and set-up, SAO2 monitoring, Neuro/Circulation checks, and cast care.*

Instructions & Grading Criteria for
Weekly Care plans And Process Paper
B20 & B21

Explanation of Paperwork

(Weekly/Process paper)

1. **Client's initials (never full name)/ height/ weight/ age and gender/ ethnicity/ religious preference/ marital status and family structure/ occupation/ (Part I)** - Look at admitting face sheet/ demographic page. Often this is found in the beginning of the chart or under "admission" tab in chart.
2. **Admitting Diagnosis (Part I)** - Usually this is found with physician's history and physical ("progress notes" or physician's "history and physical") section of chart. Also you may find a listing on admission sheet. This is the reason the patient is admitted to the facility at this time. In long term care, the reason they are unable to continue living at home as well, one and the same (Alzheimer's or Pneumonia).
3. **Recent Surgical Procedures(s)/ Date(s) (Part I)** - Can be found in physician's history and physical or on admitting assessment done by nurse. If none are found in the chart, you should ask the patient when you start working with patient on clinic day. Recent surgery= within last 5 years
4. **Past Medical History (Part I)** - May also be found in physicians history and physical section or admitting assessment (database) done by the nurse. This will include chronic conditions, past injuries, and any other condition that may affect the care of your patient.
5. **Substance Abuse (Part I)** - May be found in admitting assessment or physician H & P, it may need to be completed after meeting your patient for the first time and doing your initial assessment.
6. **Allergies (Part I)**- This may be found in several places on admission history and physical done by the physician or the nursing admission H & P, it might also be on the Physician Order sheet. You should also include your resident's allergic reaction (ask the resident or look in the chart).
7. **Current Physician's Orders (Part I)**- You will find current doctor's/physician's orders on the "Physician's Order" sheet (there is a specific section in the medical record for these orders). Current orders are any orders that are still in effect since the client's admission. This means the order has not been discontinued. (Has the time frame run out? Or already been completed; such as a lab was already done, a one-time medication already given.)
Separate all medication orders from the other physician orders; you will be putting all medication orders on **Part III** of your care plan. If your client has an IV the solution, the solution and rate can go at the end of this section.
8. **Pathophysiology Concept Map (Part II)** – Look this up at home in your Lemon-Burke Medical-Surgical Nursing book. This does not need to be your only resource; you just need to use some valid resource that gives you enough information about their **medical** disease process. Complete the required sections: Pathophysiology of the **medical** disease, etiology, chronicity and prognosis, its signs and symptoms, risk factors, potential complications, medical interventions, and nursing interventions. If the client has multiple medical conditions you will need to research the top two (2) relevant diseases (usually this will include their admitting diagnosis and any diagnosis they are primarily being treated for – your clinical instructor can help you in prioritizing these diagnoses. You will be completing as much of the Pathophysiology Concept Map as you can for the chosen medical diagnoses, it is important to focus attention on nursing interventions. **Highlight** all pertinent information related to your client (e.g. risk factors, signs & symptoms, medical interventions etc.).
9. **Current Medication Orders (Part III)** – You will find current medication orders on the "Physician order" sheet (there is a specific section in the medical record for these orders). The current medication orders are dated and are all orders still in effect since the client's admission. The pharmacological classification must be listed in the classification column provided.
In addition to writing the medications in the medication section, a medication card for each of the prescribed medications must be turned in with the weekly assignment/care plan & process paper. These may be preprinted medication cards which should have your name written on top of the card and they

should have all pertinent information highlighted. Pertinent information that must be highlighted includes: trade name, generic name, classification, action, method of administration, contraindication, min/max dosage, adverse reactions, indications, and nursing implications. You may turn in handwritten med cards that include all this same pertinent information about your client's medication.

10. Prescribed Medications: TACTIS (Part IIIA) - For Nursing Process Papers only- a TACTIS will be completed for two (2) of your client's medications (the 2 medications that you choose should be medications that your client receives routinely, not PRN's). The TACTIS must be filled in completely including Trade/ Generic names, dose/ route/ frequency, Pharmacological classification, Why is this patient receiving this medication, Therapeutic classification, action, contraindications, toxic/ side effects, interventions (nursing, labs, parameters, monitoring) and any safety concerns while administering. Must include reference, including page #, at the bottom of page.

11. Nursing Diagnosis Section (Part IV) – Abbreviated Nursing Care Plan/Weekly.

a. How do I come up with these?

Remember; before you meet or take care of your resident (the night before when you collect data) you are making an **educated guess**, given on the information you currently have about the client (i.e. medical diagnoses, current doctors orders, current medication orders, past medical/surgical history). A (actual) nursing diagnostic statement includes R/T and AEB.

1. Choose 4 nursing diagnosis using the information you have available to you. Look in up the medical diagnoses and see what kinds of problems your client may be experiencing given his current medical condition). The problems may be actual or high risk.
2. Prioritize the diagnosis, using your current knowledge of the client. The actual problems (nursing diagnoses) are prioritized before the high risk problems this semester.
3. Make a ST goal for each of the diagnoses (Remember the goals are patient centered, specific, measurable, contain an action verb, a time frame, and it is reasonable for your resident).
4. Decide on 2 interventions (things you might be doing for the client while you are caring for them) that could help with reaching goals.
5. Go to bed and get some sleep!!!

12. Nursing Diagnosis Long Forms (Part V)

Geriatric rotation: After your first week of clinic and you've cared for the client you will start to expand your care plan. The first week you will be taking at least one of your nursing diagnoses that is on your "weekly" and expand them using the "long form". See your geriatric calendar to know how many of these Part V forms you will need to turn in each week. A total of four (4) Part V long forms will be due at completion.

Medical-Surgical clinical rotation: Four (4) **Part V** forms will be due with the completion of the process paper. One (1) Part V form for each nursing diagnoses you have chosen in the abbreviated/weekly nursing care plan and implemented in the care of the client for the two days you were assigned to the client.

Nursing Diagnoses Etiology:

The diagnostic statement should include the problem/need (for example-constipation) and its etiology (for example- related to low fluid intake). The problem is either actual or high risk. Make sure that you have validated this diagnosis from **your assessment** of the patient.

R/T

This is what you are identifying as the "cause" of the problem or need. Your nursing diagnosis book can help you in identifying potential causes by looking at the "related factors" under each of the identified nursing diagnosis. You are not limited to using only what the book has identified "related factors", however, remember the cause is something the nurse can address (no medical diagnosis). A nurse can state R/T airway inflammation but cannot state R/T asthma.

AEB (as evidence by):

The evidenced by / manifested by section should contain the clustered/ validated data obtained to determine the nursing diagnosis. The nursing health history, physical assessment, and collection of any x-rays, tests, and laboratory data (although in geriatrics you will not have many of these on the chart) are all components of the nursing assessment that provides you evidence of your nursing diagnoses. These can also be found in the “defining characteristics” section of your nursing diagnoses book. The AEB should list the major defining characteristics that you have identified in your assessment of the patient.

Goal:

You now need both a long and a short term goal for each “actual” diagnosis and one goal for a “risk” diagnosis. Review your goals that you had written on your weekly and ask yourself if all the components are included to make it a well written goal. Each goal must be patient centered, have a time frame, be specific, be measurable, include an action verb, and reasonable for your patient. Each STG is a baby step to the LTG.

Implementation (Interventions):

List the independent, interdependent and dependant actions you will take to achieve your goal. There may be many nursing actions for each need, but you must cover the problem thoroughly, not leaving out the obvious. This section can include medications which may given related to the problem (Acute Pain and “administer pain medication as ordered”). A minimum of 4 nursing interventions are needed but you may include more if appropriate.

Scientific Rationale (Principle):

List the scientific principle- **quote it to be exact**. This explains how or why the intervention you have chosen will help solve the problem. You will need a scientific principle for **EACH** intervention. (A good place to look is your Potter and Perry textbook).

Reference #, with page number, is required for each rationale or cite source with page #.

Evaluation

Includes actual data (such as vital signs, pain scale, I/ O’s, diagnostic studies) and a description of whether or not the nursing interventions were effective towards meeting the stated goal for the nursing diagnosis. If they were not effective, state what you could have done differently. This column should reflect what you did and how it worked. For Geriatric rotation: you may not have any evaluations that first week; however, as you start implementing them, then you need to be documenting the effectiveness of your interventions. By the last week you should have implemented and evaluated most, if not all, of your interventions. In Medical Surgical each section must be completed. Note in the boxes whether the goals were accomplished and what progress is being made towards the LTG. **EVALUATIONS ARE NOT ONLY A STATEMENT OF WHAT YOU HAVE DONE, YOU MUST EVALUATE HOW THE INTERVENTION THAT YOU HAVE IMPLEMENTATED HAS HELPED IN REACHING THE PATIENT’S GOAL. You must evaluate the “effectiveness of the nursing interventions”.**

13. Systems Assessment: Part V-(a)

To be completed each day you are with the client. There are two (2) system assessment(s) to be turned in each week, one for Monday and one for Tuesday. For the **Abbreviated care plan/weekly**, the Monday assessment will be typed and the Tuesday assessment will be handwritten.

For the completed Geriatric and Medical Surgical Nursing Process paper both Monday and Tuesday’s assessment will be turned in typed.

The instructor is to be notified of abnormalities of great concern immediately (i.e. abnormal vital signs, including pain, parameters out of the normal during the assessment (discuss this with your instructor for guidance).

14. Part VI: Diet (Part VI) [Geriatric Rotation only] or Adult Laboratory/Diagnostic Tool (Part VI) [Medical-Surgical rotation only]

Due with the final draft of your Geriatric Nursing process paper is the diet. It must be described, including the reason for the diet being used for the resident, the listing of foods that are included and excluded from the diet. If TPN or enteral nutrition is being given, this needs to be described and/ or defined. (The actual components need to be listed). **Reference your sources - often you can use diet manuals at the facility.** This is our method of including nutrition as a thread throughout our curriculum.

Medical – Surgical [M-S] process paper Part VI Adult Laboratory/Diagnostic Tool is to be completed. Refer to *Instructions for Completing Labs* in your syllabus.

15. Bibliography (Part VII)

Must have at least four (4) references. They are to be written in alphabetical order (see sample provided). Any research used must be referenced in care plan and listed on bibliography. This includes medical/ surgical diagnosis, scientific rationale and diet definition. If specific quotes are used, must have quotations and page number. Bibliography to be typed in APA format.

*** **Note:** Nursing process must be submitted on the date due, see geri clinical expectations for due dates. If the process paper, or any part of the process paper is late, **5 points,** will be deducted from the score for each school day late. ***

Correct spelling and punctuation is part of professionalism. Please ensure name is on all papers that are turned in, and turn in always in a manila envelope.

Bakersfield College Associate Degree Nursing Program
Nursing B20 and Nursing B21
Grade Sheet: Weekly/Abbreviated Care Plan

Student Name: _____ **Date:** _____

Grading Criteria	Possible Points	Points Earned	Comments
Demographic Page (Part I) <ul style="list-style-type: none"> • PMH (past medical history) • HPI (history of present illness) • Current MD orders • All blanks complete or explained (not available/ NA) 	5		
Pathophysiology (Part II) <ul style="list-style-type: none"> • Definition, etiology, signs and symptoms • Definitions of procedures/ surgeries • References included 	10		
Medications (Part III) <ul style="list-style-type: none"> • List of all current meds • Frequency, route and classification are included • Med cards are attached and highlighted 	10		
Abbreviated Nursing Care Plan (Part IV) <ul style="list-style-type: none"> • Prioritized appropriately (2pts) • Nursing dx (appropriate for assessment, statement includes R/T and E/B or M/B) (12pts) • Goal for each dx (8pts) • 2 interventions/ dx (8pts) 	30		
Systems Assessment (Part V-A) <ul style="list-style-type: none"> • Complete for patient 	5 2.5/ day		
Total	60		

**Bakersfield College Associate Degree Nursing Program Nursing B20: Geriatric Nursing
Grade Sheet: Process**

Grading Criteria	Possible Points	Points Earned	Comments
Demographic Page (Part I) <ul style="list-style-type: none"> • PMH (past medical history) • HPI (history of present illness) • Current MD orders • All blanks complete or explained (not available/NA) 	5		
Pathophysiology (Part II) Work up all diagnosis [Top 2 Dx] <ul style="list-style-type: none"> • Definition, etiology, signs and symptoms • Definitions of procedures/surgeries • References included 	10		
Medications (Part III) <ul style="list-style-type: none"> • List of all current meds • Frequency, route and classification are included • Med cards are attached and highlighted 	6		
TACTIS (Part III - A) <ul style="list-style-type: none"> • Complete top 2 medications • Allergies • Reference with page # 	4		
Nursing Diagnostic Statements (Part V) <ul style="list-style-type: none"> • Complete (R/T & E/B or M/B) • Prioritized appropriately (Part IV) 	20		
Goals (Part V) <ul style="list-style-type: none"> • Realistic (Client centered, measurable/observable, time element) • Short and long term 	6		
Interventions and Rationales (Part V) <ul style="list-style-type: none"> • Appropriate to client/ goal • Realistic • Minimum of 4 per diagnosis • Rationales are referenced 	20		
Evaluation (Part V) <ul style="list-style-type: none"> • States client's response and if goal was achieved • Draws conclusions • Considers changes or additions to plan or care, given evaluation 	16		
Systems Assessment (V-a) <ul style="list-style-type: none"> • Complete each day 	5 (2.5/day)		
Diet (Part VI) <ul style="list-style-type: none"> • Describe diet • Reason Diet being used for client • Listing of foods: included & excluded from the diet • Reference your source 	5		
Bibliography <ul style="list-style-type: none"> • Minimum 4 references 	3		
Total	100		

Students Name: _____

**Bakersfield College Associate Degree Nursing Program
Nursing B21: Medical- Surgical Nursing
Grade Sheet: Process**

Grading Criteria	Possible Points	Points Earned	Comments
Demographic Page (Part I) <ul style="list-style-type: none"> • PMH (past medical history) • HPI (history of present illness) • Current MD orders • All blanks complete or explained (not available/NA) 	5		
Pathophysiology (Part II) Work up all diagnosis [Top 2 Dx] <ul style="list-style-type: none"> • Definition, etiology, signs and symptoms • Definitions of procedures/surgeries • References included 	10		
Medications (Part III) <ul style="list-style-type: none"> • List of all current meds • Frequency, route and classification are included • Med cards are attached and highlighted 	10		
TACTIS (Part III - A) <ul style="list-style-type: none"> • Complete top 2 medications • Allergies • Reference with page # 	4		
Nursing Diagnostic Statements (Part V) <ul style="list-style-type: none"> • Complete (R/T & E/B or M/B) • Prioritized appropriately (Part IV) 	20		
Goals (Part V) <ul style="list-style-type: none"> • Realistic (Client centered, measurable/observable, time element) • Short and long term 	6		
Interventions and Rationales (Part V) <ul style="list-style-type: none"> • Appropriate to client/ goal • Realistic • Minimum of 4 per diagnosis • Rationales are referenced 	16		
Evaluation (Part V) <ul style="list-style-type: none"> • States client's response and if goal was achieved • Draws conclusions • Considers changes or additions to plan or care, given evaluation 	12		
Systems Assessment (V-a) <ul style="list-style-type: none"> • Complete each day 	5 (2.5/day)		
Labs (Part VI) <ul style="list-style-type: none"> • Explanation of lab given • Explanation of why <i>client</i> needs this lab • Why abnormal for <i>this</i> client? 	10		
Bibliography <ul style="list-style-type: none"> • Minimum 4 references 	2		
Total	100		

Students Name:


BAKERSFIELD COLLEGE ADN PROGRAM NURS B20/21 (Abbreviated Weekly)
PART I: DEMOGRAPHICS & CURRENT PHYSICIAN ORDERS


Room # / Initials	Ht	Wt (kgs)	Age / Gender	Immunization / Date	Advanced Directive	Code Status	Admit Date	Date(s) of Care
				<input type="checkbox"/> Influenza <input type="checkbox"/> Pneumovax <input type="checkbox"/> Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full <input type="checkbox"/> DNR <input type="checkbox"/> Directed <input type="checkbox"/> CPR <input type="checkbox"/> Drugs <input type="checkbox"/> Ventilator <input type="checkbox"/> Defibrillate		
Admitting Diagnosis								
Recent Surgical Procedure(s) / Date(s) (Within in the past five years, or relevant to current diagnoses)								
Past Medical History								
Substance Use (Include type, frequency, and duration)								
Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Elicit drugs <input type="checkbox"/> Yes <input type="checkbox"/> No _____ OTC <input type="checkbox"/> Yes <input type="checkbox"/> No _____								
Allergies / Reactions								
Ethnicity	Religious Preference		Marital Status / Family Structure			Occupation		

PART I- CURRENT PHYSICIAN ORDERS

DATE		DATE	


PART II: PATHOPHYSIOLOGY CONCEPT MAP


S/S




Disease Process _____

Describe Pathophysiology



↓

DIAGNOSTICS:



COMPLICATIONS:

PART III- MEDICATION ORDER SHEET

DATE	DRUG	CLASSIFICATION	DATE	DRUG	CLASSIFICATION

SYSTEMS ASSESSMENT (Narrative)

Part V-(a)

VS	
General Appearance:	
Neurological:	
Cardiovascular:	
Respiratory:	
Gastrointestinal:	
Genitourinary:	
Musculoskeletal:	
Integumentary:	
Psychosocial:	

Part IV: Abbreviated Nursing Care Plan

Priority #1	<p>Nursing Diagnosis: R/T</p> <p style="text-align: center;">AEB/MB</p> <p>ST Goal:</p> <p>Interventions: 1.</p> <p style="text-align: center;">2.</p>
	<p>Nursing Diagnosis: R/T</p> <p style="text-align: center;">AEB/MB</p> <p>ST Goal:</p> <p>Interventions: 1.</p> <p style="text-align: center;">2.</p>

** -Note if there are any of the interventions that the RN could delegate.