Course Syllabus for RNSG 2562

Clinical Nursing – Registered Nurse Training

Barbara Rhine, MSN, RN
Nursing Instructor

Clinical Nursing – Registered Nurse Training

COURSE NUMBER
RNSG 2562

COURSE TITLE
RNSG 2562 – Clinical Nursing – Registered Nurse Training

COURSE CREDITS
5 Semester Credit Hours
Consists of: Lecture Hours/Week – 0
Lab Hours/Week – 15

PREREQUISITES/SKILLS REQUIRED

Program Prerequisites:

<table>
<thead>
<tr>
<th>Course Code</th>
<th>Course Title</th>
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</thead>
<tbody>
<tr>
<td>PSYC 2301</td>
<td>Introduction to Psychology</td>
</tr>
<tr>
<td>ENGL 1301</td>
<td>Composition I</td>
</tr>
<tr>
<td>BIOL 2302</td>
<td>Anatomy and Physiology I</td>
</tr>
<tr>
<td>BIOL 2420</td>
<td>Microbiology and Clinical Pathology</td>
</tr>
<tr>
<td>COSC 1401</td>
<td>Computer Applications</td>
</tr>
</tbody>
</table>

Semester I Courses:

<table>
<thead>
<tr>
<th>Course Code</th>
<th>Course Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNSG 1423</td>
<td>Introduction to Professional Nursing</td>
</tr>
<tr>
<td>RNSG 1460</td>
<td>Clinical Nursing (RN Training)</td>
</tr>
<tr>
<td>RNSG 1119</td>
<td>Nursing Skills I</td>
</tr>
</tbody>
</table>
BIOL 2402 Anatomy and Physiology II
PSYC 2314 Lifespan Growth and Development

Semester II Courses:
- RNSG 2504 Care of Client with Common Health Needs
- RNSG 1129 Nursing Skills II
- RNSG 1461 Clinical-Nursing (RN training)
- RNSG 1311 Nursing Pathophysiology

Semester III Courses:
- RNSG 2514 Care of Client with Complex Health Needs
- RNSG 2560 Clinical-Nursing (RN training)
- XXX X Humanities/Fine Arts Elective*

Minimum grade of “C” in RNSG 2514, RNSG 2460. Concurrent enrollment in RNSG 2535 & 2207

CATALOG DESCRIPTION
A health-related work-based experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional. Utilizes assessment skills, critical thinking, and independent nursing intervention to care for individuals experiencing acute/chronic episodes of illness and/or multi-system failure. Focus is on caring, health promotion, health restoration and professional values within a legal/ethical framework. Emphasis is on collaborative clinical decision-making, nursing leadership, skills, and client management in the delivery of nursing care. Content includes applicable competencies in basic workplace skills.

FACULTY INFORMATION
Barbara Rhine, MSN, RN
Office Address: 3201 Coggin Ave

Brownwood, TX 76801
Office Hours via Skype or Face-to-Face: Tuesdays – 0900-1100 (email for appointment) Wednesdays – 0900-1100

Contact Methods:
E-mail: brhine@rangercollege.edu

COURSE SCHEDULE
Various clinical rotation sites in Brown, Coleman, Comanche, Eastland, & Erath Counties TBA due to availabilities
Monday ER BRMC 5pm-10pm Wednesday 6 am-6pm BRMC, Eastland (7a-7p)12 shift or Outpatient 7a
Thursday 6am-12 noon 13pm-6pm mall or TBA location (Simulations Skills lab Brownwood) Stephenville 12 hr shifts am or pm
Friday or Saturday Stephenville 12 hr pm
Campus location: Skills lab Brownwood, Classroom or Lecture Hall (if available) Brownwood or Stephenville TBA Students must accrue 125 hours of hands on clinical hours. Observation rotations are not considered hands. Students must be assigned a patient area or patient care load by instructor or RN preceptor.
Clinical days: BRMC Monday 5 pm-10pm ER only/Wednesday 6 AM-17 PM
Precepted Clinical Days –TBA Stephenville,Coleman & Eastland
Dialysis =Wednesday- 6 AM-12 Noon
Solaris Hospice- 0745 AM-1700 PM
Comanche Hospice- 0725-1700 PM
Wound Care Center- 0800 AM- 1500 PM
TBA-Early Campus (Heartland Mall) location: Classroom or Lecture Hall (if available)
TBA-Post conference Wednesday 1530-1730 Heartland Mall Early BLVD or Brownwood RC A.D.N skills lab 3201 Coggin Ave
TBA-Stephenville RC Campus (Old Piggly Wiggly) 1835 W. Lingleville Rd.,

TEXTBOOKS & OTHER REQUIRED MATERIALS, ACCESS, & RESOURCES

Textbooks & Other Required Materials, Access, & Resources

Uniform - see Clinical Attire in Undergraduate Nursing Handbook.
Bandage scissors, watch, stethoscope, and penlight.


Coursepoint for Brunner&Suddarth's Med Surg Nursing
978-1-4698-5274-4 isbn
http://www.lww.com/Category/nursing


Neehr Perfect Online Documentation program


PrepU for Brunner and Suddarth's Textbook of Medical Surgical Nursing, 13th Edition LWW
http://thepoint.lww.com/Book/Show/430400


Text ISBN: 9781455706617

Remember – all e-books are optional and an additional expense.


Optional Text:

*ISBN: 9781433805615*

Computer Access:
Students taking this course must have access to Range College Blackboard platform. Traditional, online, and Web-supported courses should have a computer that meets the minimum requirements listed in the Ranger College Handbook.

Resources:
In this course, students are required to access various websites and professional databases to complete certain lecture discussions and course assignments.

Computer Access:
Students taking this course will need access to Neehr Perfert, vSim nursing pharmacology and the Ranger College Blackboard profile. Traditional, online, and Web-supported courses should have a computer that meets the minimum requirements listed in the Ranger College Handbook.

Resources:
In this course, students are required to access various websites and professional databases to complete certain lecture discussions and course assignments.

**RANGER COLLEGE ASSOCIATE DEGREE NURSING PROGRAM OBJECTIVES**

By the end of this program, a graduate student nurse will be able to act as a:

<table>
<thead>
<tr>
<th>NURSING ROLES</th>
<th>ESSENTIAL COMPETENCIES</th>
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</thead>
<tbody>
<tr>
<td><strong>Member of the Profession:</strong></td>
<td>1. Function within the nurse’s legal scope of practice and in accordance with the policies and procedures of the employing health care institution or practice setting;</td>
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<td></td>
<td>2. Assume responsibility and accountability for the quality of nursing care provided to patients and their families;</td>
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<td>3. Participate in activities that promote the development and practice of professional nursing; and</td>
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<td>4. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning.</td>
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</table>
| **Provider of Patient-Centered Care:** | 1. Use clinical reasoning and knowledge based on the diploma or associate degree nursing program of study and evidence-based practice outcomes as a basis for decision-making in nursing practice;  
2. Determine the physical and mental health status, needs, and preferences of culturally, ethnically, and socially diverse patients and their families based upon interpretation of comprehensive health assessment findings compared with evidence-based health data derived from the diploma or associate degree nursing program of study;  
3. Analyze assessment data to identify problems, formulate goals/outcomes, and develop plans of care for patients and their families using information from evidence-based practice in collaboration with patients, their families, and the interdisciplinary health care team;  
4. Provide safe, compassionate, comprehensive nursing care to patients and their families through a broad array of health care services;  
5. Implement the plan of care for patients and their families within legal, ethical, and regulatory parameters and in consideration of disease prevention, wellness, and promotion of healthy lifestyles;  
6. Evaluate and report patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice, and plan follow-up nursing care;  
7. Develop, implement, and evaluate teaching plans for patients and their families to address health promotion, maintenance, and restoration; and  
8. Coordinate human, information, and materiel resources in providing care for patients and their families. |
<p>| <strong>Patient Safety Advocate:</strong> | 1. Demonstrate knowledge of the Texas Nursing Practice Act (NPA) and the Texas Board of Nursing Rules that |</p>
<table>
<thead>
<tr>
<th>Member of the Health Care Team:</th>
<th>1. Coordinate, collaborate, and communicate with patients, their families, and the interdisciplinary health care team to plan, deliver, and evaluate patient-centered care;</th>
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<td></td>
<td>2. Serve as a health care advocate in monitoring and promoting quality and access to health care for patients and their families;</td>
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<td></td>
<td>3. Refer patients and their families to resources that facilitate continuity of care; health promotion, maintenance, and restoration; and ensure confidentiality;</td>
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<td></td>
<td>4. Communicate and collaborate in a timely manner with members of the interdisciplinary health care team to promote and maintain the optimal health status of patients and their families;</td>
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<td></td>
<td>5. Communicate and manage information using technology to support decision-making to improve patient care;</td>
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<td></td>
<td>6. Assign and/or delegate nursing care to other members of the health care team based upon an analysis of patient or unit need; and</td>
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<td></td>
<td>7. Supervise nursing care provided by others for whom the nurse is responsible by using evidence-based nursing practice.</td>
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</table>
COURSE OBJECTIVES/STUDENT LEARNING OUTCOMES
Upon completion of this course, the student will be able to produce competent clinical judgment, ethical-legal, evidenced-based practice, leadership and management, patient-centered care, professionalism, safety and team/collaboration through exemplars presented in the Ranger College Clinical Nursing – Registered Nurse Training course under the direction of the Associate Instructor and the evaluation of the RN preceptor through care of groups of patients with no less than 125 hours of hands on clinical training. Emphasizing the role development of the professional nurse.

METHODS OF ASSESSING LEARNING OUTCOMES
Weekly formative evaluations of student performance and documentation. All clinical documentation must be submitted within 36 hours of each shift. Late submissions will not be graded. Summative evaluation at mid-term and end of semester.

TEACHING STRATEGIES
This course utilizes a variety of teaching methods, and clinical learning sites to meet the students’ learning objectives.

Internet technology is utilized to provide additional sources of information, prepare and submit student assignments, provide ongoing student-faculty and student-student interaction and dialogue, and facilitate peer support. This technology can provide broader, current resources and research information; thus, students are required to access various websites and professional databases to complete certain lecture discussions and course assignments.

CONTENT/TOPICAL OUTLINE & CALENDAR

<table>
<thead>
<tr>
<th>Content Outline</th>
<th>Objectives</th>
<th>Learning Activities</th>
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</thead>
<tbody>
<tr>
<td>Week 1</td>
<td></td>
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<tr>
<td>On-Campus</td>
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<tr>
<td>Clinical review</td>
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<td>of senior</td>
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<tr>
<td>skills/simulations</td>
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<td>Week 2</td>
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<tr>
<td>Clinical</td>
<td>Research</td>
<td></td>
</tr>
<tr>
<td>Orientation/simulations</td>
<td>Article</td>
<td>Critique Due 9/11</td>
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<tr>
<td>Week 3</td>
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<tr>
<td>Clinical</td>
<td></td>
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<tr>
<td>orientation/simulations</td>
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<td>Week 4</td>
<td>All course objectives</td>
<td>Dependent on individual rotation</td>
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<tr>
<td>Clinical</td>
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<td>experience in</td>
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<td>acute care</td>
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<td>setting</td>
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<td>Week 5</td>
<td>All course objectives</td>
<td>Dependent on individual rotation</td>
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<tr>
<td>Clinical</td>
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<tr>
<td>experience in</td>
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<td>acute care</td>
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<td>setting</td>
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<td>Week 6</td>
<td>All course objectives</td>
<td>Dependent on individual rotation</td>
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<tr>
<td>Clinical</td>
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<td>experience in</td>
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<td>acute care</td>
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<td>setting</td>
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<tr>
<td>Week 7</td>
<td>All course objectives</td>
<td>Dependent on individual rotation</td>
</tr>
<tr>
<td>Clinical</td>
<td>LAST WEEK NEEHR</td>
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<tr>
<td>experience in</td>
<td>PERFECT CHART</td>
<td></td>
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<tr>
<td>acute care</td>
<td>SUBMISSIONS</td>
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<td>setting</td>
<td>REQUIRED</td>
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<td></td>
<td>CRITICAL</td>
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<td></td>
<td>THINKING/REFLEC</td>
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<td>TION CONTINUES</td>
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<td></td>
<td>Q SHIFT</td>
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<tr>
<td>Week 8</td>
<td>All course objectives</td>
<td>Dependent on individual rotation</td>
</tr>
</tbody>
</table>

The table shows the schedule of content outline, objectives, and learning activities for each week of the course. The content includes on-campus clinical review, clinical orientation, research article critique, and clinical experience in acute care settings. The objectives range from all course objectives to specific tasks like Perfect Chart Submissions and Critical Thinking/Reflection Continues Q Shift. The learning activities are monitored through weekly and summative evaluations, emphasizing formative assessment and late submissions are not graded.
<table>
<thead>
<tr>
<th>Clinical experience in acute care setting</th>
<th>Week 9</th>
<th>Clinical experience in acute care setting</th>
<th>All course objectives</th>
<th>Dependent on individual rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experience in acute care setting</td>
<td>Week 10</td>
<td>Clinical experience in acute care setting</td>
<td>All course objectives</td>
<td>Clinical Portfolio DUE Fri @ 1200 pm at mall Digital (Jump drive)Clinical Activities Portfolio</td>
</tr>
<tr>
<td>Clinical experience in acute care setting</td>
<td>Week 11</td>
<td>Clinical experience in acute care setting</td>
<td>All course objectives</td>
<td>Dependent on individual rotation</td>
</tr>
<tr>
<td>Weekly Clinical</td>
<td>Week 12</td>
<td>Clinical experience in acute care setting</td>
<td>Evaluations Wednesday &amp; Thursday</td>
<td>Grades will not be submitted until the end of the course. *Note: RNSG 2535 and RNSG 2562 must be successfully completed simultaneously to receive credit in both courses and to graduate.</td>
</tr>
</tbody>
</table>

### COURSE/CLINICAL POLICIES

#### 1. Clinical Participation
Strict clinical attendance and active participation is expected for all venues. Course participation is considered an independent student activity - NOT a group activity (unless otherwise indicated by your course instructor/preceptor/teaching assistant).

#### 2. Make-Up Policy
A student not present at an assigned nursing clinical may receive a grade of zero (0) or (U) for that day. Allowances to make-up to make up clinical are determined according to clinical and the nature of the extenuating circumstance:

- a. Absence is due to serious illness/hospitalization of the student or an immediate* family member. Documentation by a health care provider will be required at the time the student requests a make-up exam for the day of illness.
- b. Absence is due to a death in the immediate* family. Documentation will be required.
- c. An absence that the faculty and/or Department Head deems as unavoidable.

To be eligible for a make-up clinical in the above circumstances, the student must notify their instructor and the nurse manager prior to the absence, and must make arrangements within 48 hours after the absence for availability of sites. Faculty has the right to offer an alternative form of the clinical and/or to deduct up to 10 points from grade due to missed clinical.

*Immediate: Family member living in the same household or outside household totally dependent on the student for care such as a spouse, parent, child, sibling, grandparent or grandchild.

#### 3. Academic Dishonesty
Nursing students are expected to maintain an environment of academic integrity.
Actions involving scholastic dishonesty violate the professional code of ethics and are disruptive to the academic environment. Students found guilty of scholastic dishonesty are subject to disciplinary action, including dismissal from the Associate Degree Nursing Program and Ranger College in accordance with outlined criteria. Procedures for discipline due to academic dishonesty have been adopted as published in the Ranger College Student Handbook. Examples of scholastic dishonesty include, but are not limited to:

**CHEATING:** Copying from another student’s test. Possessing or using, during a test, materials which are not authorized. Using, buying, stealing, transporting, or soliciting a test, draft of a test, test facsimile, answer key, care plans, or other written works.

**PLAGIARISM:** Using someone else’s work in your academic assignments without appropriate acknowledgment.

**COLLUSION:** Collaborating with another person in preparing academic assignments without authorization.

4. **Student Behavior Policy**
Students are expected to observe the following guidelines for classroom or campus testing behavior:

a. Neither children nor pets may be brought to classes or clinical agencies under any circumstance. Children must not be left unattended in any area of the building.
b. All buildings housing the Associate Degree Nursing Program are nonsmoking facilities.
c. No food or drinks are allowed in classrooms.
d. Students are expected to be seated by the designated starting time for classes.
e. A student deemed disruptive by a faculty member may be asked to leave the classroom or testing area.
f. Cell phones must be turned off during class (unless instructed otherwise) or campus testing. In addition, pager/beepers, if used, must be set on silence. Messages received during lecture may be returned during class breaks.
g. Respectful, formal communication skills are used in online forums.

5. **Available Support Services**
Library facilities are available at the main Ranger campus, the Brownwood campus (Heartland Mall), and the Brownwood Public Library. Reference materials are also available online as well.

6. **ADA Statement:**
Ranger College provides a variety of services for students with learning and/or physical disabilities. The student is responsible for making the initial contact with the Ranger College Counselor. It is advisable to make this contact before or immediately after the semester begins.

7. **Grading System/Exams/Course Assignments**
Course grades are dependent upon meeting the learning objectives and completing course requirements. Each
student will receive the actual grade earned based on graded activities according to the designated evaluation criteria and percentages. Criteria for grading assignments are listed below. **Scores and final course grades will not be rounded up.**

The grading scale is listed below:

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Grade</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>90-100</td>
<td>A</td>
<td>5</td>
</tr>
<tr>
<td>80-89</td>
<td>B</td>
<td>4</td>
</tr>
<tr>
<td>70-79</td>
<td>C</td>
<td>3</td>
</tr>
<tr>
<td>60-69</td>
<td>D</td>
<td>2</td>
</tr>
<tr>
<td>&lt; 60</td>
<td>F</td>
<td>1</td>
</tr>
</tbody>
</table>

This course will be measured weekly through evals SCORED FROM 1-5 demonstrated by students clinical documentation and their evaluations by instructor, staff, or preceptors.

*Neehr Perfect documentation is mandatory and will be discussed in detail during the first week of this course, at this time students will be delivering care to groups 3-4 patients with all work submitted with 36 hours of end of shift.*

*Note: RNSG 2535 and RNSG 2562 must be successfully completed simultaneously to receive credit in both courses and to graduate.*

See Undergraduate Nursing Student Handbook for UNSATISFACTORY & UNSAFE Clinical Performance. Satisfactory Completion of written assignments.

**GUIDELINES FOR ASSIGNMENTS:**

1. Patient flow sheets on 3-4 patients in Neehr Perfect with 2 NCPs for PRIORITY Nursing Diagnosis on each in BLACKBOARD or Neehr Perfect but must be documented priorities with interventions and evaluation specific to diagnosis (no generalities must be specific).

2. 1 Weekly Concept/Care Map presented in BLACKBOARD on student’s patient of choice.

3. Critical Thinking prior to clinical in Neehr Perfect /BLACKBOARD

4. Reflective Journaling in group discussion on blackboard must be submitted daily immediately following each shift (No exceptions must be submitted same day).

5. When shift or class ends there is 48 hours window allowed to complete that individual day’s documentation/assignment.

These assignments should reflect college-level work, including proper grammar and spelling. Late submissions will not be graded.

The grading system used in this course, RNSG 2562 is:

P (pass), F (fail), NC*, W
**SAMPLE PLAN OF CARE**

<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Nursing Interventions</th>
<th>Rationales</th>
<th>Evaluations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt. will seek health-related information as needed by end of week.</td>
<td>· Show respect for the person, regardless of what their issues are.</td>
<td>· Health care providers are there to help, not judge. Respect is necessary for the experience of participation in health care decisions.</td>
<td>Pt. openly communicated with doctor during therapy about excessive traveling and spending. Admitted she had been skipping medication doses because she didn’t eat that many times a day (3 times/day). Promised to take as ordered.</td>
</tr>
<tr>
<td>Pt will be able to identify the risks involved in her actions before initiating them by end of month.</td>
<td>· Establish and encourage therapeutic communication by actively listening and participating in the patient’s life and therapy.</td>
<td>· Showing that you are involved shows the patient that their care and progress is important, and help is available.</td>
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<td></td>
<td>· Help the person identify and reduce the barriers to self-care.</td>
<td>· Identifying them sets them up as achievable goals to work towards improving.</td>
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<td></td>
<td>· Empower patient with their own care.</td>
<td>· If the patient feels empowered, they may be less likely to be overwhelmed by their manic or depressed states.</td>
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<td></td>
<td>· Discuss medication regimen and stress importance of regular evaluation to ensure that enhanced levels of self-care can be maintained.</td>
<td>· The patient needs to take medications as ordered, and have the effectiveness evaluated to see if changes should be made.</td>
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</table>

**Nursing Diagnosis**: Self-care deficit

**P**: problem Pt. is hypomanic; she is traveling a lot outside her means;

**E**: etiology Disease process (Bipolar I), minimal family support

**S**: signs and symptoms Excessive traveling and incurring expenses that she can’t afford; currently doesn’t have custody of her child; rapid
Admitting Diagnosis: Bipolar disorder type 1
Date Paper Submitted: 3-24-14

Student Name:
Patient’s Initials:                  Rm. #/site:
Date of Patient Care:
Admitting Diagnosis:
Date

Ranger College Associate Degree Nursing
Nursing Care Plan

Need:
Nursing Diagnosis:
P:
E:
S:
<table>
<thead>
<tr>
<th>Expected Outcomes</th>
<th>Nursing Interventions</th>
<th>Rationales</th>
<th>Evaluations</th>
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</table>
Critical Thinking Skill

Addresses program learning outcomes 1, 2, 3, 5, 6 and 7

Student_____________________________ Hospital Dept/ Site_________________________ Date________ Dx.

1. What are you on alert for today with this patient?

2. What are the important assessments to make?

3. What complications may occur?

4. What interventions will prevent complications?
5. What data did you use to make the above assumptions?

6. Other interventions that might be possible and their consequences:

   CLINICAL REFLECTIVE JOURNAL

   Student_________________________ Area______________ Date______________

1. Clinical Situation/Issue/Problem:
2. My Reaction to Situation:

3. My Analysis of Reaction:

4. What did I learn from this situation?
ALTERNATIVE REFLECTIVE JOURNAL RNSG 2562

1. What pleasant surprises did I discover today?
2. What lessons did my efforts teach me that I could build upon next week?
3. What could I have spent more or less time doing?
4. How did fear and uncertainty affect what I did and didn’t do?
5. What mental clutter can I clear?
6. What is the most reasonable steps I can take now create for next week?
7. Are my actions and plans aligned with both short-term goals and long term goals?
8. And as they say, just getting started is half the battle… Your turn… What would you add to the list?

RANGER COLLEGE RNSG – 2562 EMERGENCY DEPT CLINICAL WORKSHEET

Addresses program learning outcomes 1, 3, 4, 5 and 6

Goals:

1. Observe and help ED nurse provide nursing intervention and support to friends, peer, and family.

2. Identify common emergencies and their management in the ED.
3. Describe priority assessment and triage in the ED.

4. Describe medications frequently used in the ED.

Worksheet:

1. Describe the responsibilities of the ED nurse?

2. Describe priority assessment and triage when someone is brought to the ED.

3. Describe the problems; with the corresponding ND of the pt you had in the ED and the emergency care given.

1. Describe three strategies you used when dealing with family feeling emotional distress related to the threatening condition of their relative, peer, or friends.

5. What is EMTALA
6. What is the obligation of EMTALA

7. On another sheet of paper, fill out the following information for each medication administered by you or the nurse while caring for this patient:

Medication name: ____________________________ Classification ______________

Reason why the medication was ordered ______________________________________

Special instructions regarding the medication _______________________________

Assessments before and after giving the medication _____________________________

Administration: ___________________________________________________________

Evaluation _______________________________________________________________
3. Define and interpret the different acid-base balances seen in your pt.

4. Describe related nursing care for endotracheal intubation.

5. Investigate polices of the ICU.

6. Identify psychosocial needs of the ICU pt. and his family.

7. Examine special equipment used in the ICU.

8. Identify your patient problems. Write nursing diagnosis in order of priority, give nursing intervention with EB for these problems.

   Worksheet:

   1. List three unique characteristics of the ICU nurse.

   2. Explain the pathophysiology, assessment, and management of your patient.

      a) Pathophysiology:

      b) Assessment:

      c) Management:
3. Describe the nursing care given to your patient related to endotracheal intubation.

4. Describe the acid-base balance of your patient and support it with labs (ABG results).

5. Describe the equipment use during your shift:

6. Describe polices of the ICU related to:
   a) Family, peers, and friends visits:
   b) Family, peers, and friends participation in care.
   c) Sleep and rest place for Family, peers, and friends.

7. What psychosocial needs do you see specifically related to patient in ICU and his/her Family, peers, or friends.

8. a) List all problems related to your patient:
b) Write ND for these problems in order of priority:

d) List all nursing interventions with EB rationale.

e) On another sheet of paper, fill out the following information for each medication administered by you or the nurse while caring for this patient:

   Medication name: ______________________  Classification: ______________
   Reason why the medication was ordered: ________________________________
Special instructions regarding the medication _______________________
Assessments before and after giving the medication __________________
Administration: _________________________________________________
Evaluation: ___________________________________________________

9. How could this clinical experience be improved?

10. List references and other sources of information in an APA format

RANGER COLLEGE ADN

RNSG 2562
DIALYSIS CLINICAL WORKSHEET
Addresses program learning outcomes 1, 2, 3, 4, 5, 6, and 7

GOALS: The student will:

1. Identify unique characteristics specific to the roll of the Dialysis nurse
2. Describe the different types of dialysis.
3. Be acquainted with the dialysis procedure.
4. Understand the Pathophysiology, S/S, nursing care, and responsibility for a patient during dialysis.
5. Identify problems of patients undergoing dialysis. Write a Nursing Dx. And give three nursing intervention for this problem.

WORKSHEET:

1. Where does the word dialysis come from (Greek meanings of the prefix, root word, suffix, etc.)?
2. Compare and contrast the two types of dialysis: hemodialysis and peritoneal dialysis. Your answers should include the following:
   a. A diagram/picture of the dialysis machine
   b. Can the procedure be performed inpatient, outpatient or at home, etc.?
   c. Describe how the dialysis machine works? Does it involve diffusion, filtration, etc.? Describe the processes involved.
   d. Describe the accesses to hemodialysis and peritoneal hemodialysis. Include pictures/diagrams along with the advantages and disadvantages.
   e. What are the advantages of each procedure?
   f. What are the disadvantages or complications of each procedure?
   g. Describe the contents of the dialysis fluid (AKAS "solution").
3. How does nutrition affect dialysis (compare and contrast both types) a patient’s kidney function:
   a. Describe why water intake must be regulated during dialysis.
   b. Describe why potassium intake must be regulated during dialysis.
   c. Describe why phosphorus intake must be regulated during dialysis.
   d. How does protein intake change with dialysis?
e. Describe why sodium intake must be regulated during dialysis.
f. Describe why calorie intake must be regulated during dialysis.
g. Describe why vitamins and minerals are sometimes prescribed during dialysis.
4. What are typical medications prescribed for patients on dialysis?
5. What do the blood test results mean?
6. Can a patient exercise on dialysis?
7. Identify a specific problem related to a dialysis patient
   a. Write a nursing Dx. For this problem.
   b. Identify three nursing interventions.
8. How can this clinical experience be improved?
9. What reference did you use? APA format

RANGER COLLEGE
RNSG 2562
RESEARCH ARTICLE CRITIQUE

Purpose: To appraise the student use of nursing journals in recognizing current information on topics discussed in clinical.

Objectives: upon completion of this assignment the student will be able to:

1. Identify peer reviewed nursing research based articles.
2. Search for EB in the scientific literature.
3. Consider the rigor of scientific evidence and whether it has application in clinical.
4. Utilize information in critical thinking.

Instructions:

1. Topics selected are to be related to the evidenced based nursing practice
2. A total of 2 articles must be submitted on September 11 and October 30.
3. Peer-reviewed nursing journals used should be current within past 5 years.
4. Assignment must be type, on one page 81/2X11 using the APA format.
5. A copy of the article must be attached to the written assignment.

Criteria:

1. Reference information in APA format
2. Author credentials and other information if available.
3. Type of research: qualitative or quantitative
4. Describe the purpose of the study and why did you choose this article.
5. Identify the research question or hypotheses.
6. Describe the sample participants (inclusion and exclusion criteria).
7. Briefly describe the major findings of the study these are findings related to the purpose and research questions.
8. Describe the nursing implications (how the information from this article can be applied to your nursing practice.

Clinical Activities Portfolio

Definition:

Is a focused, purposeful collection of your work that represents your learning progress and achievement over time, demonstrating your growth and professional change.

Goals:

- Provide an overall view of your performance and growth.
- Develop a reflective practitioner through analysis and synthesis.
- Link theory to practice, and vice versa.
- Includes a complete clinical excursion.

Guidelines:

1. Show evidence that you have met all stated clinical objectives.
Include an essay that summarizes your thoughts about your learning, reference of meeting all objectives.

Self-reflection page for each section (your reflection on the experience).

Be creative, there is no standard typology.

Will be reviewed at mid-term.

Must include two or more of each clinical paperwork, and your clinical sign off sheet.

It’s necessary to be able to pass clinical at the end of the clinical rotation.

Rubric for Grading your Portfolio

<table>
<thead>
<tr>
<th>Grading criteria</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>0</th>
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<tbody>
<tr>
<td>Provide an overall view of your performance</td>
<td>Has 4 or more examples of work from beginning to end of the semester, that show growth of your thinking during the semester.</td>
<td>Has 3 examples of work from beginning to end of the semester, that show minimal growth of your thinking during the semester.</td>
<td>Has 2 examples of work from beginning to end of the semester, that show limited growth of your thinking during the semester.</td>
<td>No examples or the examples included do not reflect any growth.</td>
</tr>
<tr>
<td>Provide evidence of meeting clinical objectives</td>
<td>The essay addressed meeting all 11 clinical objectives</td>
<td>Clinical objectives only partially met. Not all (8-10) was addressed in assay.</td>
<td>Marginal meeting of clinical objectives. Essay addressed 5-7 of the clinical objectives.</td>
<td>Did not meet clinical objectives</td>
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<td>Develop critical thinking by looking at things in a new and different way. Paperwork give</td>
<td>Can see the whole picture, paperwork show evidence of critical thinking. Included at least 4 concept maps.</td>
<td>Can see the whole picture, paperwork show evidence of critical thinking, but included only 2 or 3 concept maps.</td>
<td>See all the parts but not able to connect the parts 50% of the time. Included 1 to 2 concept maps.</td>
<td>Able to see only one part of the whole, even though some concept maps were included</td>
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<td>examples of linking theory to practice.</td>
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<td>Includes VCE</td>
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<td>Included 3-4 VCE done during the semester, demonstrating increased critical thinking.</td>
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<td>Included 1-2 VCE done during the semester, demonstrating increased critical thinking.</td>
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<td>Included 1 VCE done during the semester, but no difference in critical thinking.</td>
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<td>Essay</td>
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<tr>
<td>Demonstrates evidence of analysis and synthesis reflecting your thoughts regarding your learning in about 50% during the semester. Each section has a self-reflection.</td>
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<td>Beginning to show evidence of analysis and synthesis reflecting your thoughts regarding your learning in about 25% during the semester. Each section has a self-reflection.</td>
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<td>Show no evidence of analysis and synthesis reflecting your thoughts regarding your learning during the semester. Each section has no self-reflection.</td>
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<td>Grammar and organization</td>
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<td>Portfolio very organize, easy to evaluate, no grammatical errors.</td>
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<tr>
<td>Portfolio very organize, easy to evaluate. A few grammatical errors.</td>
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<td>Some organization is present, but lots of grammatical errors.</td>
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<td>No evidence of organization, papers randomly placed and lots of grammatical errors.</td>
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**CLINICAL LAB POLICIES**

- Students are never to discuss events or scenarios occurring during lab clinical simulation experiences except during debriefing sessions. “What happens in clinical simulation during lab stays in clinical simulation during lab…” There is zero tolerance for academic dishonesty.
- Students are to dress for lab as if attending clinical. Scrubs, name badges and uniform policies are enforced.
• Faculty are responsible for supervising all students brought to the lab for training.
• Universal Precautions are to be followed at all times as are all safety guidelines used in the clinical setting. Sharps and syringes are to be disposed of in appropriate containers. Anyone sustaining an injury must report it immediately to their instructor.
• Equipment may not be removed from the lab for practice nor are the labs to be used for practicing clinical skills unless supervised by faculty or staff.
• Students may be recorded during scenarios. Viewing of videos recorded during training are only permitted with faculty members. The videos are the property of the nursing program and students may not possess lab videos recordings.
• Coats, backpacks and other personal belongings are not to be in the lab during clinical simulation and should be secured as directed by the instructor.
• All electronic devices are forbidden during clinical experiences during lab. (Cell phones, pagers, any type of recording device, etc.).
• After a simulation take your personal belongings with you (i.e. papers, pens, stethoscopes, pen lights etc.).
• Food and drink are not permitted in the labs.
• If you have a latex allergy, inform your instructor before beginning simulation.
• Makeup days may not be available for students absent the day of simulation.

Standard Precautions
The Center for Disease Control and Prevention (CDC) Recommended Standard Precautions are outlined below. It is the student’s responsibility to maintain compliance with these recommendations in all clinical settings.

Standard Precautions
Because the potential diseases in a patient’s blood and body fluids cannot be known, blood and body fluid and substance precautions recommended by the CDC should be adhered to for all patients and for all specimens submitted to the laboratory. These precautions, called “standard precautions,” should be followed regardless of any lack of evidence of the patient’s infection status. Routinely use barrier protection to prevent skin and mucous membrane contamination with:
  a. secretions and excretions, except sweat, regardless of whether or not they contain visible blood
  b. body fluids of all patients and specimens
  c. non-intact skin
  d. mucous membranes

Hand Hygiene
  a. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn and/or immediately prior to any client interaction or nursing intervention. Perform hand hygiene immediately after gloves are removed, between patient contacts and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. It may be necessary to
wash hands between tasks and procedures on the same patient to prevent cross contamination of different body sites.
b. Use a plain (non-antimicrobial) soap for routine hand washing.
c. Use an antimicrobial agent or waterless antiseptic agent for specific circumstances (e.g., control of outbreaks or hyperendemic infections) as defined by the infection control program.

Gloves
Wear gloves (clean non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another patient. Perform hand hygiene immediately to avoid transfer of microorganisms to other patients or environments.

Mask, Eye Protection, Face Shield
Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose and mouth during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.

Gown
Wear a gown (a clean nonsterile gown is adequate) to protect skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments.

Patient Care Equipment
Handle used patient care equipment soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of microorganisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed and single use items are properly discarded.
Environmental Control

Ensure that the hospital has adequate procedures for the routine care, cleaning and disinfection of environmental surfaces, beds, bed rails, bedside equipment and other frequently touched surfaces and that these procedures are being followed.

Linen

Handle, transport, and process used linen soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures and contamination of clothing and avoids transfer of microorganisms to other patients and environments.

Occupational Health and Blood-borne Pathogens

a. Take care to prevent injuries when using needles, scalpels and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments and when disposing of used needles. Never recap used needles or otherwise manipulate them with both hands or any other technique that involves directing the point of a needle toward any part of the body; rather, use either a one-handed scoop technique or a mechanical device designed for holding the needle sheath. Do not remove used needles from disposable syringes by hand and do not bend, break or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades and other sharp items in appropriate puncture-resistant containers located as close as practical to the area in which the items were used. Place reusable syringes and needles in a puncture resistant container for transport to the reprocessing area.

b. Use mouthpieces, resuscitation bags or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable.

Patient Placement

Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is not available, consult with infection control professionals regarding patient placement or other alternatives.

Student Occurrence

Any student involved in a clinical occurrence (e.g. needle stick, patient or student fall/injury, medication error, etc.) must adhere to the following protocol for reporting the occurrence:

1. Notify the nurse responsible for the patient immediately.
2. Notify the clinical instructor, preceptor and/or faculty member as quickly as possible after the occurrence happens. The clinical instructor, preceptor & faculty will provide information on appropriate actions to be taken.
3. Notify the charge nurse.
4. Be prepared with details necessary for filling out a report and to sign the report as a witness or the person responsible for the occurrence.
5. Meet any Ranger College or facility policy regarding occurrences.

RANGER COLLEGE ASSOCIATE DEGREE NURSING

Weekly Clinical Evaluation Form Criteria

The faculty of Ranger College, Associate Degree Nursing, have identified outcomes and associated criteria student learning which utilize the competencies of the National League for Nursing (NLN) as their foundation.

The intent of the listed criteria is to assist the student in becoming a proficient and competent nurse. The criteria listed to identify expectations are merely guidelines and not totally inclusive. These are criteria or expectations which give guidance and some of the specific behaviors which demonstrate acceptable performance. Since it would be impossible to list all the situations and examples encompassed by these outcomes, it is expected that the student will use these as the parameters for his/her nursing performance. If the student will conscientiously utilize this evaluation tool, he/she may be able to better learn and grow in his/her nursing skills and abilities. They are intended to be a help and not a hindrance to the student’s progress throughout the nursing curriculum.

In order to pass clinical, the student must perform consistently at a 3 (safe or assisted level) by the end of all first level courses and a 4 (supervised) by the end of all second level courses. The criteria defining the clinical outcomes will be evaluated weekly. The criteria rating scale ranges from dependent through independent performance. Student performance in meeting identified criteria will be progressively graded throughout the course, and the instructor(s)’ expectations will increase as the course progresses. Less instructor assistance and help should be required as the student progresses through each course of the program.

The student will be expected to meet the ethical, legal and safety criteria satisfactorily throughout the entire course. These criteria are bolded and will be required to be maintained at the highest level of expectations. One infraction in those areas may result in clinical failure.

One or more criteria rating less than a three (3) warrants a verbal or written counseling note. A student with two (2) or more consecutive ratings less than three (3) in any criteria or numerous ratings less than a three (3) in several criteria within the same day will constitute an issuance of a clinical contract. The purpose of the clinical contract and conference with faculty will be to clarify the student’s status and future expectations. Conference decisions and expectations of a student will be continued throughout the nursing curriculum. Therefore, the student conference will
remain in effect in succeeding nursing courses. If the student’s nursing education is interrupted, the conference(s) will remain in the student’s file and in effect upon the student’s resumption of his/her education. Inability to fulfill the contract or three (3) ratings less than a three (3) in a single category will result in clinical failure.

The nursing student is accountable to learn and practice on a contingency granted by the Texas State Board of Nursing while the individual remains a student within Ranger College, Associate Degree Nursing program. The instructors, staff, and preceptors will be utilized as a resources to validate the student’s expertise. The ultimate goal is that the student will be responsible to give independent, safe care utilizing his/her own critical thinking.

Rating System for Clinical Outcomes

The following-performance standards are defined in this way for levels of students’ competency identification:

Weekly Clinical Evaluation Form Criteria

INDEPENDENT (5) (Excellent) -Performs safely and accurately each time* behavior is observed without supportive cues* from the preceptor/instructor Demonstrates dexterity* -Spends minimal time on task* -Appears generally relaxed and confident during performance of task -Applies theoretical knowledge accurately with occasional cues -Focuses on client while giving care*

SUPERVISED (4) minimal supervision (Very Good) -Performs safely and accurately each time* behavior is observed -Requires a 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 most theoretical knowledge accurately with occasional cues -Focuses on client initially; as complexity increases, focuses on task*
ASSISTED (3) safe (Satisfactory) - 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 in completing tasks - Appears to waste energy (r/t to poor planning) - Identifies principles but needs direction to identify application - Focuses primarily on task or own behavior, not on client*

PROVISIONAL (2) marginal (Needs Improvement) - 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 or r/t to incompetence - Identifies most steps of principles; principles generally applied appropriately - Focuses entirely on task or own behavior*

DEPENDENT (1) marginal unsafe (Unsatisfactory) - 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* -

This rating tool was taken from the following publication:


**Ranger College ADN - Feedback Tool for Purpose of Weekly Evaluation**

Instructor, Teaching Assistant or Preceptor Instructions - (1) Complete this evaluation form at the end of the rotation/assignment; (2) Sign and Comment; (3) Return to Clinical Instructor, (4) Comment on the student’s weekly clinical self-evaluation form also (a separate document); and (5) Sign preceptor log for each clinical rotation (a separate document).

Student ______________________ Clinical Facility/Dept ______________________ Date __________
Please rate the student on the following behaviors utilizing the scale listed below.
1 = Unsatisfactory   2 = Needs Improvement   3 = Satisfactory   4 = Very Good   5 = Excellent

**Role – Member of a Profession**
- Followed attendance policy, good hygiene, appropriate clinical uniform (Pressed)/badge
  - 1 2 3 4 5
- Maintained confidentiality of client/family information
  - 1 2 3 4 5
- Utilizes/implements evidence-based practice and promotes life-long learning
  - 1 2 3 4 5
- Seeks appropriate feedback/instruction
  - 1 2 3 4 5
- Consistently maintains professionalism in conduct and communication
  - 1 2 3 4 5

**Role – Provider of Patient-Centered Care**
- Analyzes the various needs for health promotion and illness prevention concepts
  - 1 2 3 4 5
- Assesses client/family learning needs and provides instruction/teaching
  - 1 2 3 4 5
- Adapts nursing care to the changing needs of clients
  - 1 2 3 4 5
- Performs comprehensive and on-going assessments and documents
  - 1 2 3 4 5
- Utilizes nursing process as basis for decision-making
  - 1 2 3 4 5

**Role – Patient Safety Advocate**
- Demonstrates ability to make safe client-centered decisions
  - 1 2 3 4 5
- Safely administers medications and treatments following the 6 rights
  - 1 2 3 4 5
- Safely performs client care following National Patient Safety Goals/Standards
  - 1 2 3 4 5

**Role – Member of the Health Care Team**
- Utilizes appropriate interpersonal skills to collaborate with health care team
  - 1 2 3 4 5
- Employs therapeutic communication techniques
  - 1 2 3 4 5

35
Analyzes the need for cost containment and efficient use of resources  1  2  3  4  5
Promotes team collaboration and communication  1  2  3  4  5

Comments 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<tr>
<th>EFFECTS TO PATIENT</th>
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<tr>
<td>POTENTIAL EFFECTS OF ERROR TO PATIENT</td>
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<tr>
<td>WHAT ADDITIONAL CARE/MONITORING IS REQUIRED?</td>
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<tr>
<td>WHAT CAN BE DONE TO PREVENT ERRORS FROM OCCURRING?</td>
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</tbody>
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Student Signature______________________________ Interviewer Signature__________________________

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**PRECEPTOR CLINICAL LOG**

<table>
<thead>
<tr>
<th>Student _____________________________</th>
<th>Clinical Instructor ______________________________</th>
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<tr>
<th>Date</th>
<th># of Hours</th>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>Clinical Agency</th>
<th>Preceptor Signature Comments</th>
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</thead>
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37
1. Followed 6 Rights of Medication Administration
2. Had no medication errors
3. Had no safety issues
4. Student needed prompting to

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3. Had no safety issues
4. Student needed prompting to

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Ranger College Summative Clinical Evaluation Form

RNSG 2562

This clinical evaluation tool is designed to foster the student's use of self-evaluation skills as they examine their own nursing practice with instructor assistance. Student should be familiar with the evaluation criteria from all previous nursing courses and utilize them for self-evaluation in the clinical settings. It is also the responsibility of the student to continue to demonstrate all these behaviors at a satisfactory level. All RNSG 2562 course objectives must be satisfactorily achieved in order for the student to pass the course. If there are any questions/concerns regarding the use of this form the student should contact his/her instructor.

Prior to MID-TERM each student will schedule a conference with the clinical instructor. Prior to the conference the student is expected to write a summary statement which includes:

a. self-evaluation of their progression to meet the course objectives,
b. identification of own strengths and weaknesses,

c. specific plans (methods) to facilitate attainment of the course objectives.

During this conference, both the instructor and student will review the student's summary statement in relation to the instructor's evaluation of the student's progression.

At the end of the semester a final cumulative evaluation summary will be written by both instructor and student. It is the responsibility of the student to schedule conferences with the instructor:

a. prior to mid-term and prior to end of course,

b. as necessary throughout the semester to meet own learning needs.

**ADN Clinical Evaluation Rating Scale**

Clinical evaluation for all students in the ADN program utilize the following numerical rating scale.
<table>
<thead>
<tr>
<th>Numerical Rating</th>
<th>Identifying Characteristics</th>
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<tbody>
<tr>
<td>5</td>
<td>Meeting objectives as demonstrated by criteria behaviors INDEPENDENT from faculty or staff. (Excellent) - Performs safely and accurately each time* behavior is observed without supportive cues* from the preceptor/instructor. Demonstrates dexterity* - Spends minimal time on task* - Appears generally relaxed and confident during performance of task - Applies theoretical knowledge accurately with occasional cues - Focuses on client initially; as complexity increases, focuses on task*</td>
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<td>4</td>
<td>Meeting objectives as demonstrated by criteria behaviors SUPERVISED minimal supervision with from faculty or staff (Very Good) - Performs safely and accurately each time* behavior is observed - Requires a 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 most theoretical knowledge accurately with occasional cues – Focuses on client initially; as complexity increases, focuses on task*</td>
</tr>
<tr>
<td>Numerical Rating</td>
<td>Identifying Characteristics</td>
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<td>3</td>
<td>Meeting objectives ASSISTED with demonstrated criteria behaviors performed safely with faculty or staff assistance (Satisfactory) - 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 in completing tasks - Appears to waste energy (r/t to poor planning or lack or practice) - Identifies principles but needs direction to identify application - Focuses primarily on task or own behavior, not on client*</td>
</tr>
<tr>
<td>Numerical Rating</td>
<td>Identifying Characteristics</td>
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<td>------------------</td>
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<td>2</td>
<td><strong>PROVISIONAL</strong> marginal (Needs Improvement) -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 or r/t to incompetence -Identifies most steps of principles; principles generally applied appropriately -Focuses entirely on task or own behavior*</td>
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<td>1</td>
<td><strong>DEPENDENT</strong> marginal unsafe (Unsatisfactory) -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*</td>
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Procedure for Implementing of Rating Scale

1. The numerical rate scale is used to evaluate the objectives for each nursing course.

2. This scale is used (minimal requirements), at mid-term, final evaluation and/or weekly formative clinical rotation evaluation.

3. A student receiving a rating of one (1) in any course objectives at anytime, must be conference/placed on probation (according to established policy), and/or may be withdrawn from the program.

4. At the time of final course evaluation, the student must achieve a minimum rating of three (3) in each course objective to meet the course requirement.

* It is the responsibility of both instructor and student to assure the safety of those patients assigned to the student’s care. If the student’s clinical performance threatens or violates patient’s physical, biological, or emotional safety, the instructor must remove the student from the clinical experience. Such behavior may result in automatic failure of the clinical component of the course.

Criteria Behavior & Elements

1. Criteria behaviors are those behaviors under each semesters skills checklists and/or course objective that explain what is required to meet the individual course objective.

2. Critical behaviors and skills checklists are those criteria behaviors considered critical in meeting the course objective. The critical behaviors/skills will be identified as follows asterisk *. RNSG 1460, RNSG 1461, RNSG 2560, RNSG 2562

3. Failure to meet critical behaviors/skills will result in failure of the clinical objective and thus failure of the course.
Definition of Unsafe Clinical Practice

The Ranger College Associate Degree Nursing Program identifies the safety need as a basic health need and defines the Safety Need as “the need for protection from stressors in the external environment which could cause harm.” These stressors are further identified as physical, biological and emotional.

The faculty believe that in every nursing action the primary concern of the nurse is the safety of the patient and all other individuals involved. Therefore, safety is emphasized throughout the program.

Unsafe clinical practice shall be deemed to be behaviors demonstrated by the student which threaten or violate the physical, biological or emotional safety of the patient(s) assigned to his/her care. The following examples serve as guides to these unsafe behaviors but are NOT TO BE CONSIDERED ALL INCLUSIVE.

Physical Safety

Unsafe behaviors: inappropriate use of siderails, wheelchairs, other mechanical equipment; lack of proper protection of the patient which potentiates falls, lacerations, burns, etc; performs nursing actions not yet authorized, lack of preparation for clinical day; fails to seek help when needed.

Biological Safety
Unsafe behaviors: fails to recognize violations in aseptic technique, violates "6 rights" in medication administration, comes to clinical unwell, performs nursing actions without appropriate supervision, fail to seek help when needed.

**Emotional Safety**

Unsafe behaviors: threatens or makes patient fearful; provides patient with inappropriate or incorrect information, performs nursing actions without appropriate supervision, fail to seek help when needed, demonstrates unstable emotional behaviors.

**Unprofessional Practice**

Unprofessional practice (include but are not limited to): Verbal and non-verbal language, actions or voice inflections which compromise rapport or working relations with patients, family members, staff or physicians, may potentially compromise contracted agreements and/or working relations with clinical affiliates or constitute violations of ethical/legal standards.
<table>
<thead>
<tr>
<th>Rotation to MIDTERM</th>
<th>Rotation to Course END</th>
<th>Student/ Faculty Comments</th>
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<tbody>
<tr>
<td>Student</td>
<td>Faculty</td>
<td>Student/Faculty</td>
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</table>
## Provider of Patient-Centered Care

II. Integrates critical thinking skills and a systematic problem-solving process as framework for providing care for adult clients with complex health care needs involving multiple body systems in intermediate and critical care settings.

### Criteria Behaviors:

<table>
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<tr>
<th>Assessment</th>
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<tr>
<td>1. Performs accurate prioritized assessments in a timely manner on adult clients.</td>
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</table>

### Diagnosis:

| 2. Integrates data to develop a list of appropriate prioritized nursing diagnoses for adult clients. |
| 3. Reprioritizes nursing diagnosis for each client in a timely manner as appropriate throughout care. |

### Planning:

| 4. Collaborates with clients and their families to formulate individualized plans of care including comprehensive outcome criteria. |
| 5. Integrates aspects of cultural diversity into individualized plans of care. |

### Implementation:
6. Implements prioritized plans of care for each adult client in an organized, timely manner.
7. * Performs complex nursing skills in a safe, effective, and timely manner.
8. Makes effective nursing judgments based on theoretical concepts and clinical data.

Evaluation
10. Evaluates ongoing assessment of data to analyze changes in the client status.
11. Evaluates goals and appropriately modifies the plan of care for clients in a timely manner.

III. Integrates therapeutic communication with clients and their families in various settings.

Criteria behaviors:
1. Modifies therapeutic communication skills for clients with complex needs and their families.

IV. Evaluates the effectiveness of the teaching learning process for clients with complex needs and their families to meet their need for health promotion, maintenance, and/or restoration.

Criteria behaviors:
1. Analyzes client and family needs to develop and implement individualized teaching learning plans for clients with complex health needs.

**Member of a Healthcare Team**

I. Initiates collaboration with members of the health care team to provide safe and effective care for clients with complex needs and their families.

1. Collaborates with the health care team to provide continuity of care for clients and their families.
2. Confers with health team members to facilitate continuity of care and initiates appropriate referrals based upon the client’s need.

II. Effectively manages materials and human resources in an organized manner while providing care for adult clients with complex health care needs.

Criteria behavior:
1. Utilizes appropriate resources to meet the needs of clients with complex health needs.
2. Prioritizes and organizes multiple tasks for maximum time efficiency.

III. Evaluates communication with members of the health care team.
Criteria behaviors:
1. * Reports and documents significant change in the client's status to appropriate individuals and take appropriate action.
2. Effectively organizes oral communication including change in shift report.
3. Record complete, accurate, on-going documentation for clients with complex health care needs.

IV. **Analyzes the roles of the professional nurse in the provision of care for adult clients and their families.**

Criteria behaviors:
1. Evaluates the supervising and delegation role of the nurse in the clinical setting, including assignment making.
2. Delegates nursing activities in compliance with the Nurse Practice Act.
3. Adheres to the principles of leadership and management when coordinating care provided by others.
4. Evaluates the effectiveness of care provided by other members of the health care team.
5. Provides ongoing education and evaluation of team members.

**Member of the Profession**

I. Integrates the role of member of the profession in own nursing practice.
Criteria behaviors:
1. *Accepts accountability for own actions and behavior.
2. Demonstrates initiative to meet own learning needs.
3. Modifies behaviors promptly based on faculty input and self evaluation.
4. *Reports any errors and/or omissions promptly according to RC and faculty guidelines.
5. Consistently role model professional behaviors.

**Patient Safety Advocate**

Integrates ethical principles and legal guidelines when making decisions where patients' and/or their families may be vulnerable.

Criteria behaviors:
2. Address ethical and legal concerns when providing care.
3. Adheres to laws governing practice of Nursing including, program policies, hospital policies, BNE standards of practice.
Evaluation Tool
RNSG 2562
PART II

First Evaluation Statement

Student Summary:

Instructor Summary:

Date of Conference: ________________________

I have read this form and discussed it with my clinical instructor.

__________________________________________  __________________________
Student Signature                           Instructor Signature
Final Cumulative Evaluation

Student Summary:

Instructor Summary:

Date of Conference: ________________________

I have read this form and discussed it with my clinical instructor.

________________________________________  __________________________________
Student Signature                        Instructor Signature
NON-DISCRIMINATION STATEMENT
Admission, employment, and program policies of Ranger College are non-discriminatory in regard to race, creed, color, sex, age, disability, and national origin.

SYLLABUS AND SCHEDULE CHANGES
The course syllabus and SCHEDULE are subject to change. Students will be notified during scheduled class or via Ranger College e-mail concerning any revisions to course syllabus.

STUDENT EVALUATION OF COURSE
Students are strongly encouraged to participate in a course evaluation at the end of the semester. Areas of evaluation include:

- Gaining factual knowledge
- Developing specific skills, competencies, and points of view needed by professionals in nursing
- Developing competent skills in verbal and written communication
- Learning how to find and use resources for answering questions or solving problems
- Learning to analyze and critically evaluate ideas, arguments, and points of view

WITHDRAWAL FROM CLASS
Students wishing to drop/withdraw from the class must do so before the final drop/withdrawal date. If the student does not drop/withdraw before the official last date, he/she will receive the grade earned. A “C” or better is needed in all nursing courses to pass. Failure to pass the lecture course will result in a failing grade in any corresponding clinical component.

EVACUATION
If you receive notice to evacuate the building, please evacuate promptly but in an orderly manner. Evacuation routes are posted in various locations indicating all exits, outside assembly areas, location of fire extinguishers, fire alarm pull stations and emergency telephone numbers (Call 911). In the event an evacuation is necessary: evacuate immediately, take all personal belongings with you; report to outside assembly area and wait for further information; students
needing assistance in the evacuation process should bring this to the attention of the instructor at the beginning of the semester.

**RECEIPT OF SYLLABUS FORM**
All students must complete the attached “Receipt of Syllabus” form and return it to the course instructor.
RECEIPT OF SYLLABUS FORM
FOR RNSG 2562

(Required of all students and filed by the course instructor)

Legibly print the following information:

Name: __________________________ Date:___________________________

“I have received and understand the information in the syllabus for RNSG 2562 and I agree
to abide by the stated policies.”

Signature of Student: _____________________________