PNSG 2320 Medical-Surgical Nursing Clinical II
COURSE SYLLABUS
Fall Semester 2022

The syllabus is subject to change. If changes are made, the student will be notified as soon as possible.

COURSE INFORMATION

Credit Hours/Minutes: 2/4500
Class Location: Various clinical sites
Class Meets: August 29, 2022 through September 12, 2022
Course Reference Number (CRN): 20223
EHR course enrollment key: 32BZGZE (PNSG 2320 Fall 2022)

INSTRUCTOR CONTACT INFORMATION

Instructor Name: Megan Guin, BSN, RN
Office Location: Swainsboro Campus, Building 8; Office 8101
Office Hours: Please schedule an appointment during clinical
Email Address: mguin@southeasterntech.edu
Phone: 478-289-2306
Fax: 478-289-2336
Preferred Method of Contact: EMAIL

All communication with faculty should be completed using STC email. Please note that emails sent during business hours will be answered within 24-48 hours. Emails sent during holidays and on weekends may not be answered until the next business day.

SOUTHEASTERN TECHNICAL COLLEGE'S (STC) CATALOG AND STUDENT HANDBOOK

Students are responsible for all policies and procedures and all other information included in Southeastern Technical College's Catalog and Handbook (https://catalog.southeasterntech.edu/college-catalog/downloads/current.pdf).

REQUIRED TEXT

1. Fundamentals of Nursing Care: Concepts, Connections, and Skills, 3rd Edition, FA Davis by Burton, Smith & Ludwig
2. Nursing Care Plans, 10th Edition, Doenges, Morehouse et al.
3. Davis's Nursing Skills **Videos** for LPN/LVN, 3rd Edition (This is not a book. Student has access to skills videos through FA Davis website.)
4. Pharmacology Clear and Simple, 3rd Edition, F.A. Davis, Watkins
5. Understanding Medical Surgical Nursing, 6th Edition, FA Davis, Williams and Hopper
6. Safe Maternity and Pediatric Nursing Care, FA Davis, Linnard-Palmer and Coats
7. Assessment Technologies Institute (ATI)

REQUIRED SUPPLIES & SOFTWARE

Full uniform (Purchased through Meridy's Uniforms)
Two Student Identification Badges that reflect the Practical Nursing Program
Skills Packs (Purchased through Meridy's Uniforms) which includes

- Stethoscope
- Blood Pressure cuff
- Pen light
- Scissors

Ear phones for any ATI assignments
Pens
Highlighters
2 Three Ring Binders
Clinical Notebook
Watch with seconds displayed
Basic Calculator
Laptop/Personal computer
Suggested specifications include:

- Processor i5 or i7
- Memory 8GB or higher
- Hard drive 250GB or larger
- DVD Drive either internal or external

Webcam with microphone
Internet speed of 5 Mbps. (10Mbps or more is recommended). Test your internet speed using www.speedtest.net)
Students should not share login credentials with others and should change passwords periodically to maintain security.

COURSE DESCRIPTION

This **Second** clinical course, in a series of four medical-surgical clinical courses, focuses on clinical client care including using the nursing process, performing assessments, applying critical thinking, engaging in client education and displaying cultural competence across the life span and with attention to special populations. At the completion of the four-part sequence of these medical surgical clinical courses students will have completed a minimum of 300 clock hours of clinical experience including 225 clock hours of comprehensive medical-surgical, 37.5 clock hours of pediatric experiences and 37.5 clock hours of mental health experiences. Topics include: health management and maintenance; prevention of illness; care of the individual as a whole; hygiene and personal care; mobility and biomechanics; fluid and electrolytes; oxygen care; perioperative care; immunology; mental health; and oncology. In addition pathological diseases, disorders and deviations from the normal state of health, client care, treatment, pharmacology, nutrition and standard precautions with regard to cardiovascular, hematological, immunological, respiratory, neurological, sensory, musculoskeletal, endocrine, gastrointestinal, urinary, integumentary and reproductive systems.

MAJOR COURSE COMPETENCIES

1. Clinically-based Experience
2. Clinically-based Nursing Care Associated with the Cardiovascular System
3. Clinically-based Nursing Care Associated with the Hematological and Immunological Systems
4. Clinically-based Nursing Care Associated with the Respiratory System
5. Clinically-based Nursing Care Associated with the Endocrine System
6. Clinically-based Nursing Care Associated with the Gastrointestinal System

7. Clinically-based Nursing Care Associated with the Urinary System
8. Clinically-based Nursing Care Associated with the Neurological System
9. Clinically-based Nursing Care Associated with the Sensory System
10. Clinically-based Nursing Care Associated with Mental Health Concerns
11. Clinically-based Nursing Care Associated with the Musculoskeletal System
12. Clinically-based Nursing Care Associated with the Integumentary System
13. Clinically-based Nursing Care Associated with Oncology Concerns
14. Clinically-based Nursing Care Associated with the Reproductive Systems

PREREQUISITE(S)

Program admission

COURSE OUTLINE

Clinically-Based Experience
Learning Outcomes for all clinical based experience:

Order	Description	Learning Domain	Level of Learning
1	Integrate techniques to promote health management and maintenance and prevention of illness in each of the competencies listed above.	Psychomotor	Complex Response
2	Use approaches for caring for the individual as a whole with respect to each of the competencies listed above.	Psychomotor	Mechanism
3	Demonstrate competence in caring for individuals with pathological disorders that affect the each of the competencies listed above.	Psychomotor	Guided Response
4	Use nursing observations and interventions related to each diagnostic study and procedure related to each of the competencies listed above.	Psychomotor	Mechanism
5	Apply the nursing process with emphasis on assessment and client education related to each of the competencies listed above.	Psychomotor	Mechanism
6	Demonstrate an understanding of and ability to perform treatments related to each of the competencies listed above.	Psychomotor	Guided Response
7	Perform administration of prescribed medications related to each of the competencies listed above.	Psychomotor	Guided Response
8	Perform administration of prescribed diet related to each of the competencies listed above.	Psychomotor	Guided Response
9	Implement standard precautions as they relate to each of the competencies listed above.	Psychomotor	Mechanism
10	Demonstrate clinically relevant care for individuals related to each of the competencies listed above with respect to the life span.	Psychomotor	Guided Response
11	Display cultural competence as applicable to each of the competencies listed above.	Affective	Responding

Order	Description	Learning Domain	Level of Learning
12	Demonstrate clinically relevant care for individuals related to each of the competencies listed above as applicable to special populations.	Psychomotor	Guided Response

GENERAL EDUCATION CORE COMPETENCIES

Southeastern Technical College has identified the following general education core competencies that graduates will attain:

1. The ability to utilize standard written English.
2. The ability to solve practical mathematical problems.
3. The ability to read, analyze, and interpret information.

STUDENT REQUIREMENTS

COVID-19 MASK REQUIREMENT

Students participating in clinical learning experiences are required to follow the **specific screening and PPE protocols of the clinical facility.** Full PPE with N95 mask is required for suspected or confirmed COVID patients.

COVID-19 SIGNS AND SYMPTOMS

We encourage individuals to monitor for the signs and symptoms of COVID-19 prior to coming on campus.

If you have experienced the symptoms listed below or have a body temperature 100.4°F or higher, we encourage you to self-quarantine at home and contact a primary care physician's office, local urgent care facility, or health department for further direction. Please notify your instructor(s) by email and do not come on campus or go to the assigned clinical site for any reason.

COVID-19 Key Symptoms
Fever or felt feverish
Chills
Shortness of breath or difficulty breathing, not attributed to another health condition
New loss of taste or smell
Cough: new or worsening, not attributed to another health condition
Sore throat, not attributed to another health condition
Muscle or body aches
Headache
Nausea or vomiting
Diarrhea
Congestion or runny nose (not attributed to any other health condition)

COVID-19 Key Symptoms
Fatigue
In the past 14 days, if you:
Have had close contact with or are caring for an individual diagnosed with COVD-19 at home (not in healthcare setting), please do not come on campus and contact your instructor (s).

COVID-19 SELF-REPORTING REQUIREMENT

Students, regardless of vaccination status, who test positive for COVID-19 or who have been exposed to a COVID-19 positive person, are required to self-report using https://www.southeasterntech.edu/covid-19. Report all positive cases of COVID-19 to your instructor and Stephannie Waters, Exposure Control Coordinator, swaters@southeasterntech.edu, 912-538-3195.

PROGRESSION TO CLINICAL COURSE

In order for a student to progress to this clinical, he or she must have a final grade of 70% or greater in the lecture course, PNSG 2210, score a 100% on the calculation exam within the three attempts allotted, and demonstrate proficiency related to various Lab/Nursing Skills as required by state standards (Refer to Lab Skills Checklist).

A passing grade of 70% in this clinical, along with a passing grade in PNSG 2220 is required in order to pass the semester and progress in the practical nursing program.

DAILY REQUIREMENTS

The daily requirements for PNSG 2320 should be kept neat and orderly by the student. The instructor will pick up completed time sheets, preceptor evaluations and student evaluations when making clinical rounds at the facility. Failure to complete the assignment/requirement as outlined above may result in the student's inability to attend clinical until the assignment/requirement is completed and/or points deducted from the clinical grade.

EHR DOCUMENTATION

Documentation in EHR is due by midnight of each clinical day. EHR may not allow charting past this deadline. If documentation is not submitted into EHR by the deadline, a grade of "0" may be given for the required assignments. Students completing 12-hour clinical shifts will remain at the clinical facility to complete documentation requirements for the last two (2) hours of the shift (1700-1900). The student must go to the cafeteria (or other designated area) of the hospital with their laptop, connect to the WIFI and complete documentation requirements. Students should have the nursing preceptor sign the clinical time sheet following completion of the shift. The faculty will use the rubrics to determine the student's grade based on the points as outlined. It is advised that the student use the rubric when completing the clinical assignments to ensure all components are accurately completed. It is the student's responsibility to complete the documentation requirements. If there are no clients available or scheduled in the assigned clinical area, the student must notify the instructor immediately. If two or more students are assigned to the same clinical facility on the same day, the students are not to complete clinical documentation on the same client as their classmates.

ATI ASSIGNMENTS

ATI assignments listed on the lesson plan must be completed by the due date provided: **09/12/2022 by 2359.**

Scores earned on the first attempt of each ATI module will be used to calculate the average of ATI assignments which count 5% of the course grade. For assignments that score strong, satisfactory, or needs improvement, students will receive 100 for strong, 90 for satisfactory, and 70 for needs improvement. For ATI modules that have a pre-test, a lesson, and a post-test, students should complete the lesson followed by the post test. Students should not complete the pre-test.
ATI products will be integrated into each course according to the PN ATI Curriculum Matrix. The syllabi will outline when the student will complete each ATI assignment. The use of these products allows for formative and summative evaluations and assists the faculty in making the necessary changes to the curriculum

PRECEPTOR EVALUATIONS
Approved nursing preceptors may be used at STC clinical sites. The preceptor will complete the Preceptor Evaluation Tool at the end of each clinical day and place it in a sealed envelope provided by the instructor. The student's grade is assigned by Southeastern Technical College Faculty with input from clinical preceptors.

HEALTH DOCUMENTATION AND CPR
All students must have current immunizations with current PPD, and an active American Heart Association Health Care Provider Basic Life Support and First Aid card. It is the student's responsibility to keep these items up-to-date at their cost. If any of these items are expired, the student will not be allowed to go to clinical and will be counted absent.

SPECIAL NOTE: During this course, occurrences may be issued for failure to meet classroom/lab requirements (tardiness, uncompleted/late work, and etc.).

FIT TESTING
All students who have a clinical component are required by the TCSG infection control policy to get fit tested. The instructor will complete the fit test for the student. The fit testing must be complete in order to begin clinical time.

Student Success Plan
The Student Success Plan documents deficiencies in performance and provides a means for improvement. A success plan should be initiated for the following reasons:

- If the student has (1) a cumulative unit exam average of < 70% after the completion of 25% of the unit exams or (2) a skill(s) performance deficiency.
- The faculty will initiate individual counseling session and complete the Student Success Plan.
- if the student has (1) a cumulative unit exam average of < 70% after the completion of 50 % of the unit exams or (2) a skill(s) performance deficiency,
- The faculty will initiate individual counseling session, as well as review and update the Student Success Plan and submit an Early Alert.
- if the student exhibits behavior outside the expected:
    - codes of conduct outlined in professional codes of ethics, professional standards,
    - All procedures/requirements/policies outlined in program handbooks/documents,
    - STC e Catalog and Student Handbook, and/or
    - Clinical facility policies and procedures.

The faculty will initiate an individual counseling session and complete an Academic Occurrence Notice and the Student Success Plan.
(T)echnical College System of Georgia (E)arly (A)lert (M)anagement (S)ystem (TEAMS) & The Student Success Plan are designed to ensure that students are well informed about strategies for success, including college

resources and assistance. One of the responsibilities of the Program faculty is to monitor the academic progression of students throughout the curriculum. The faculty believes that the student is ultimately responsible for seeking assistance; however, faculty will meet or refer students who are having academic difficulties.

- TEAMS is designed to provide assistance for students who may need help with academics, attendance, personal hardships, etc.

Student Support

Specific information about the Student Support services listed below can be found at STC Website (www.southeasterntech.edu) by clicking on the Student Affairs tab.

- Tutoring
- Technical Support
- Textbook Assistance
- Work-Study Programs
- Community Resources

Additional ATTENDANCE Provisions

Health Sciences

Requirements for instructional hours within Health Science and Cosmetology programs reflect the rules of respective licensure boards and/or accrediting agencies. Therefore, these programs have stringent attendance policies. Each program's attendance policy is published in the program's handbook and/or syllabus which specify the number of allowable absences. All provisions for required make-up work in the classroom or clinical experiences are at the discretion of the instructor.

This class requires 75 clinical hours (4500 minutes) during the semester. A clinical absence will require an excuse or appropriate documentation and all missed clinical time must be made up as required to fulfill the curriculum requirements. Absences must be discussed with faculty, Program Director and/or Special Needs Coordinator dependent on the circumstances of the absence. Students who do not make up all clinical time missed will be issued a final clinical grade of zero and will be unable to progress in the program. The date and site for makeup time will be specified by the instructor and are non-negotiable. See Clinical Rules for further attendance policies.

STUDENTS WITH DISABILITIES

Students with disabilities who believe that they may need accommodations in this class based on the impact of a disability are encouraged to contact the appropriate campus coordinator to request services.
Swainsboro Campus: Daphne Scott dscott@southeasterntech.edu 478-289-2274, Building 1, Room 1210.
Vidalia Campus: Helen Thomas hthomas@southeasterntech.edu , 912-538-3126, Building A, Room 165

SPECIFIC ABSENCES

Provisions for Instructional Time missed because of documented absences due to jury duty, military duty, court duty, or required job training will be made at the discretion of the instructor.

PREGNANCY

Southeastern Technical College does not discriminate on the basis of pregnancy. However, we can offer accommodations to students who are pregnant that need special consideration to successfully complete the course. If you think you will need accommodations due to pregnancy, please make arrangements with the appropriate campus coordinator.
Swainsboro Campus: Daphne Scott dscott@southeasterntech.edu 478-289-2274, Building 1, Room 1210.
Vidalia Campus: Helen Thomas hthomas@southeasterntech.edu , 912-538-3126, Building A, Room 165

It is strongly encouraged that requests for consideration be made PRIOR to delivery and early enough in the pregnancy to ensure that all the required documentation is secured before the absence occurs. Requests made after delivery MAY NOT be accommodated. The coordinator will contact your instructor to discuss accommodations when all required documentation has been received. The instructor will then discuss a plan with you to make up missed assignments.

WITHDRAWAL PROCEDURE

Students wishing to officially withdraw from a course(s) or all courses after the drop/add period and prior to the 65% point of the term in which student is enrolled (date will be posted on the school calendar) must speak with a Career Counselor in Student Affairs and complete a Student Withdrawal Form. A grade of "W" (Withdrawn) is assigned for the course(s) when the student completes the withdrawal form.
Students who are dropped from courses due to attendance after drop/add until the 65% point of the semester will receive a "W" for the course.
Important – Student-initiated withdrawals are not allowed after the 65% point. Only instructors can drop students after the 65% point for violating the attendance procedure of the course. Students who are dropped from courses due to attendance or academic deficiency after the 65% point will receive either a "WP" (Withdrawn Passing) or "WF" (Withdrawn Failing) for the semester and will be unable to progress in the practical nursing program.
Informing your instructor that you will not return to his/her course, does not satisfy the approved withdrawal procedure outlined above.
There is no refund for partial reduction of hours. Withdrawals may affect students' eligibility for financial aid for the current semester and in the future, so a student must also speak with a representative of the Financial Aid Office to determine any financial penalties that may be accessed due to the withdrawal. A grade of "W" will count in attempted hour calculations for the purpose of Financial Aid.

Remember - Informing your instructor that you will not return to his/her course does not satisfy the approved withdrawal procedure outlined above.

ACADEMIC DISHONESTY POLICY

The Southeastern Technical College Academic Dishonesty Policy states that all forms of academic dishonesty, including but not limited to cheating on tests, plagiarism, collusion, and falsification of information, will call for discipline. The policy can also be found in the Southeastern Technical College Catalog and Student Handbook.

PROCEDURE FOR ACADEMIC MISCONDUCT

The procedure for dealing with academic misconduct and dishonesty is as follows:

1. **First Offense**
   Student will be assigned a grade of "0" for the test or assignment. Instructor keeps a record in course/program files and notes as first offense. The instructor will notify the student's program advisor, academic dean, and the Registrar at the student's home campus. The Registrar will input the incident into Banner for tracking purposes.
2. **Second Offense**
   Student is given a grade of "WF" (Withdrawn Failing) for the course in which offense occurs. The instructor will notify the student's program advisor, academic dean, and the Registrar at the student's home campus indicating a "WF" has been issued as a result of second offense. The Registrar will input the incident into Banner for tracking purposes.
3. **Third Offense**
   Student is given a grade of "WF" for the course in which the offense occurs. The instructor will notify

the student's program advisor, academic dean, and the Registrar at the student's home campus indicating a "WF" has been issued as a result of third offense. The Vice President for Student Affairs, or designee, will notify the student of suspension from college for a specified period of time. The Registrar will input the incident into Banner for tracking purposes.

STATEMENT OF NON-DISCRIMINATION

As set forth in the student catalog, Southeastern Technical College does not discriminate on the basis of race, color, creed, national or ethnic origin, gender, religion, disability, age, political affiliation or belief, genetic information, veteran status, or citizenship status (except in those special circumstances permitted or mandated by law).

The following individuals have been designated to handle inquiries regarding the nondiscrimination policies:

American With Disabilities Act (ADA)/Section 504 - Equity- Title IX (Students) – Office of Civil Rights (OCR) Compliance Officer	**Title VI - Title IX (Employees) – Equal Employment Opportunity Commission (EEOC) Officer**
Helen Thomas, Special Needs Specialist Vidalia Campus 3001 East 1st Street, Vidalia Office 165 Phone: 912-538-3126 Email: Helen Thomas hthomas@southeasterntech.edu	Lanie Jonas, Director of Human Resources Vidalia Campus 3001 East 1st Street, Vidalia Office 138B Phone: 912-538-3230 Email: Lanie Jonas ljonas@southeasterntech.edu

ACCESSIBILITY STATEMENT

Southeastern Technical College is committed to making course content accessible to individuals to comply with the requirements of Section 508 of the Rehabilitation Act of Americans with Disabilities Act (ADA). If you find a problem that prevents access, please contact the course instructor.

GRIEVANCE PROCEDURES

Grievance procedures can be found in the Catalog and Handbook located on Southeastern Technical College's website.

ACCESS TO TECHNOLOGY

Students can now access Blackboard, Remote Lab Access, Student Email, Library Databases (Galileo), and Banner Web via the mySTC portal or by clicking the Current Students link on the Southeastern Technical College (STC) Website (www.southeasterntech.edu).

TECHNICAL COLLEGE SYSTEM OF GEORGIA (TCSG) GUARANTEE/WARRANTY STATEMENT

The Technical College System of Georgia guarantees employers that graduates of State Technical Colleges shall possess skills and knowledge as prescribed by State Curriculum Standards. Should any graduate employee within two years of graduation be deemed lacking in said skills, that student shall be retrained in any State Technical College at no charge for instructional costs to either the student or the employer.

GRADING SCALE

Assessment	Percentage
Daily Average (8 clinical days)	75%
Reflection (2 reflections)	20%
ATI Assignments	5%

Letter Grade	Range
A	90-100
B	80-89
C	70-79
D	60-69
F	0-59

PNSG 2320 Medical/Surgical Nursing Clinical II
Fall Semester Lesson Plan

Date/Day	Chapter/Lesson	Content	Assignments & Tests Due Dates	Competency Area
See Clinical Schedule		CLINICAL	Complete all clinical assignments as detailed on documentation requirements. **ATI Assignments: (Due 09/12/2022 @ 2359) First attempt score taken.** 1. Nurse's Touch: Becoming a Professional Nurse: Professional Behaviors in Nursing 2. Nurse's Touch: Nursing Informatics and Technology: Virtual Social Networks	Course: 1-14 Core: 1-3

COMPETENCY AREAS: (WILL VARY FOR EACH COURSE/TAKEN FROM STATE STANDARDS)

1. Clinically-based Experience
2. Clinically-based Nursing Care Associated with the Cardiovascular System
3. Clinically-based Nursing Care Associated with the Hematological and Immunological Systems
4. Clinically-based Nursing Care Associated with the Respiratory System
5. Clinically-based Nursing Care Associated with the Endocrine System
6. Clinically-based Nursing Care Associated with the Gastrointestinal System
7. Clinically-based Nursing Care Associated with the Urinary System
8. Clinically-based Nursing Care Associated with the Neurological System
9. Clinically-based Nursing Care Associated with the Sensory System
10. Clinically-based Nursing Care Associated with Mental Health Concerns
11. Clinically-based Nursing Care Associated with the Musculoskeletal System
12. Clinically-based Nursing Care Associated with the Integumentary System
13. Clinically-based Nursing Care Associated with Oncology Concerns
14. Clinically-based Nursing Care Associated with the Reproductive Systems

GENERAL CORE EDUCATIONAL COMPETENCIES:

1. The ability to utilize standard written English.
2. The ability to solve practical mathematical problems.
3. The ability to read, analyze, and interpret information.

Disclaimer Statements

Instructor reserves the right to change the syllabus and/or lesson plan as necessary
The official copy of the syllabus will be given to the student during face to face class time the first day of class. The syllabus displayed in advance of the semester in a location other that the course you are enrolled in is for planning purposes only.

Documentation Requirements for PNSG 2320

Required Documents/Forms for each PNSG 2320 clinical day:

- **Completed time sheet**. Signed by the student nurse and the preceptor at the end of each day. Time sheets are considered an official document. Incomplete time sheets or time sheets with errors may not be accepted and may be returned to the student to complete on their own time. (Example: Student may have to travel to a clinical site on an off day to have preceptor complete time sheet)
- **Preceptor Evaluation Form** signed by the preceptor for the day and placed in a sealed envelope provided by instructor. The preceptor must sign the back of the envelope across the seal. Any seal that is broken will not be accepted. It is the student's responsibility to ensure the correct preceptor form is used for the corresponding clinical rotation. The student is required to complete the top portion of the evaluation (student name and clinical site-no abbreviations) prior to submitting the evaluation to the preceptor. Incomplete/incorrect preceptor forms may result in a ten (10) point deduction from the daily clinical grade.
- After each clinical day, the student will complete the **Southeastern Technical College Student Evaluation of Clinical Experience form.** The student will submit the evaluation form daily with his/her clinical paperwork. The student is required to complete the top portion of the evaluation (student name, semester, course, and clinical site-no abbreviations) prior to submitting the evaluation to the instructor. Incomplete student evaluation forms may result in a ten (10) point deduction from the daily clinical grade.

These requirements for PNSG 2320 should be kept neat and orderly by the student. The instructor will pick up completed time sheets, preceptor evaluations, and student evaluations each week when making clinical rounds at the facility. Failure to complete the forms as outlined above may result in the student's inability to attend clinical until the assignment/requirement is completed and/or points deducted from the clinical grade.

Required EHR documentation for each PNSG 2320 Clinical Day:

Choose **ONE** client for the day to complete the required documentation: (See rubric for details)

- Notes:
  - History and physical note
  - Nurse's notes
- Flowsheets
  - Admission
  - Assessment
- Medication Orders & MAR
- Care plan

The student must log into ATI, access EHR, and enroll in the course using the course enrollment key provided

by the instructor.
Once the student is enrolled in the course, the student will see the list of activities for the clinical course. The student will choose the activity and create a patient. Enter the patient's age. In the comment section, enter the name of the clinical facility. Please remember, Protected Health Information (PHI) for a real client should never be entered into an academic EHR.

Documentation in EHR is due by midnight of each clinical day. EHR may not allow charting past this deadline. If documentation is not submitted into EHR by the deadline, a grade of "0" may be given for the required assignments.

Students completing 12-hour clinical shifts will remain at the clinical facility to complete documentation requirements for the last two (2) hours of the shift (1700-1900). The student must go to the cafeteria (or other designated area) of the hospital with their laptop, connect to the WIFI and complete documentation requirements.

Students should have the nursing preceptor sign the clinical time sheet following completion of the shift.

The faculty will use the rubrics to determine the student's grade based on the points as outlined. It is advised that the student use the rubric when completing the clinical assignments to ensure all components are accurately completed.

It is the student's responsibility to complete the documentation requirements. If there are no clients available or scheduled in the assigned clinical area, the student must notify the instructor immediately.

If two or more students are assigned to the same clinical facility on the same day, the students are not to complete clinical documentation on the same client as their classmates.

Weekly Reflections:

Type a **detailed reflection** of your clinical week.

- Do not use any client names or identifying information in this reflection
- At least 1 page typed 12 Calibri font doubled spaced
- Each question must be answered to receive full credit
- Place in Blackboard drop box by due date on syllabus

Week 1 Reflection (Due **09/01/2022 at 2359** in Blackboard dropbox)

1. **Teamwork and Collaboration:**
    a. The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes. Describe the team members involved and the interaction that required collaboration. What was the outcome and consensus? Discuss what members should have been involved and explain why that member was needed in the decision-making process.

Week 2 Reflection (Due **09/12/2022 at 2359** in Blackboard dropbox)

1. **Evidence Based Practice**:

a. The use of current knowledge from research and other credible sources to make clinical judgements and provide client-centered care. Discuss the application of evidence-based practice while caring for the patient. If EBP was not utilized in the chosen patient situation, what could have been done differently in the provision of care?

ATI Assignments: (First Attempt) Due **09/12/2022 at 2359**

1. Nurse's Touch: Becoming a professional nurse: Professional behaviors in nursing
2. Nurse's Touch: Nursing Informatics: Virtual Social Networks

Southeastern Technical College Practical Nursing Clinical Course Evaluation Form

Name: _____ Course: PNSG 2320 Semester: Fall 2022 Total hours: _____

	Documentation	Care Plan	Preceptor Evaluation	Daily Average
Clinical Day 1				
Clinical Day 2				
Clinical Day 3				
Clinical Day 4				
Clinical Day 5				
Clinical Day 6				
Clinical Day 7				
Clinical Day 8				

Assessment	Percentage	Points Earned
Daily Average **(8 Clinical Days)**	**75%**	
Reflection **(2 Reflections)**	**20%**	
ATI Assignments (First Attempt) 1. Nurse's Touch: Becoming a Professional Nurse: Professional Behaviors in Nursing 2. Nurse's Touch: Nursing Informatics and Technology: Virtual Social Networks	**5%**	
Clinical Grade		
Clinical Occurrence		
Final Clinical Grade		

Comments_____

_____

_____

Student Signature_____ Date_____

Instructor Signature_____ Date_____

PRECEPTOR/INSTRUCTOR EVALUATION
PNSG 2255, 2310, 2320

Student: _____ **Clinical Site:** _____

Please fill this evaluation out and place it in the envelope provided. Seal the envelope and sign your name across the seal. The student will return the sealed envelope to the instructor.

Please provide comments for any scores less than 2.

Score	Description
4	Student **exceeds all** expectations. Demonstrates **comprehensive** understanding of concepts and applies them to client care, is safe, and shows initiative.
3	Student **meets all** expectations. Demonstrates **above average** understanding of concepts and applies them to client care, is safe, and shows initiative.
2	Student **meets most** expectations. Requires minimum guidance when applying concepts to client care, is safe, and shows initiative. Demonstrates **average** fundamental level of understanding of concepts.
1	Student **meets minimum** expectations. Requires frequent guidance when applying concepts to client care. Demonstrates **minimum** fundamental understanding of concepts and applies them to client care, is safe, and shows initiative.
0	Student **does NOT meet** expectations. Requires consistent guidance when applying concepts to client care, is not safe, and lacks initiative.
N/O	Not observed/No opportunity

Items scored	Score	Comments
QSEN Concept: Client Centered Care: **Deliver quality nursing care to clients and their families from diverse backgrounds in a variety of settings.**	X	
Perform a basic health assessment that includes physiological, psychological, sociological, and spiritual needs of clients and in a variety of settings.		
Demonstrate delivery of age appropriate communication in the health care settings.		
QSEN Concept: Teamwork and Collaboration: **Participate as a member of the inter-professional healthcare team in the delivery of safe, quality client-centered care.**	X	
Identify strengths, limitations, and values in functioning as a member of the health care team.		
QSEN Concept: Quality Improvement: **Participate in activities that improve and promote quality of care in health care settings.**	X	
Implement nursing actions that improve client outcomes.		
QSEN Concept: Safety: **Apply strategies that minimize risk and provide a safe environment for clients, self, and others.**	X	
Communicate observations and concerns related to hazards to the health care team.		
Implement actions that minimize safety risks and environmental hazards.		
QSEN Concept: Informatics: **Utilize client care technology in the provision of safe, quality client-centered care.**	X	
Implement appropriate use of technology in the health care setting.		

Grade is assigned by Southeastern Technical College Faculty with input from clinical preceptors.

_____ _____

Preceptor Signature/Date **STC Faculty/Date**

Practical Nursing Care Plan Rubric

The purpose of the nursing care plan assignment is to provide an opportunity for students to systematically make decisions regarding patient outcomes by utilizing the steps of the nursing process; assessment, diagnosis, planning, implementation, evaluation.

	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F
Assessment: Includes subjective, objective, and historical data that support an actual or at risk for nursing diagnosis	Includes all pertinent data related to diagnostic statement and does not include data not related to nursing diagnosis. All data is referenced correctly as either subjective or objective.	Includes pertinent data related to the diagnostic statement but, also includes non-related data. Most of the data is referenced correctly as either subjective or objective.	Does not include all data related to the diagnostic statement. May also include non- related data. Data is not referenced as subjective or objective.	Assessment portion is incomplete or unrelated to the diagnostic statement.	Not Done
Diagnosis: Develop one (1) nursing diagnosis statement based on presented data that identifies a health problem. Correctly stated and prioritized as number one problem the patient is facing. Diagnosis should include 3 parts: 1. Nursing diagnosis 2. Related to 3. As evidenced by (Risk for diagnosis does not require evidence)	Nursing diagnosis statement is a formulation of an appropriately worded, 3-part NANDA-approved nursing diagnosis and demonstrates priority of care for the assigned patient. OR: 2-part NANDA approved nursing diagnosis is formulated for risk of diagnosis.	Nursing diagnosis statement is a formulation of an appropriately worded, 3-part NANDA-approved nursing diagnosis but has not demonstrated priority of care for the assigned patient. OR: 2-part NANDA approved nursing diagnosis is formulated for risk of diagnosis.	Nursing diagnosis statement is a formulation of an inappropriately worded or 2-part statement. Statement is an unapproved nursing diagnosis or does not demonstrate priority of care for the assigned patient.	Incorrect diagnostic statement for presented data. OR: Diagnostic statement is incomplete; missing 1 or more parts.	Not Done
Planning: Develop one (1) measurable patient outcome that prevents, reduces, or resolves the identified patient health problem (nursing diagnosis label)	Outcome is specific, measurable, attainable, relevant, timely.	The outcome is missing one of the following elements: specific, measurable, attainable, relevant, timely.	The outcome is missing two of the following elements: specific, measurable, attainable, relevant, timely.	The outcome is missing three of the following elements: specific, measurable, attainable, relevant, timely.	Not Done
Implementation: Write four (4) nursing interventions with supporting rationale (4) to meet the identified patient health needs.	Interventions clearly and correctly identified. Specific to the patient situation and nursing diagnosis statement and meets patient health needs. Required number of patient specific nursing interventions identified.	Interventions pertain to patient situation or nursing diagnosis statement and meets patient health needs but lack some specificity. 3 of the 4 required interventions are listed.	Interventions pertain to nursing diagnosis statement in an indirect way; does not completely meet patient health needs; 2 of the 4 required interventions are listed.	Interventions are not appropriate to meet patient health needs. 1 of the 4 required interventions are listed.	Not Done

	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F
Evaluation: Identify subjective and objective data to establish the patient outcome has been met or not met. If unable to evaluate, identify optimal subjective and objective data that support a met outcome	Evaluative statement is present. Data is referenced correctly as either Subjective or Objective. All pertinent subjective and objective data support a met outcome OR an unmet outcome.	Evaluative statement is present but vague. Includes non-related data. Most of the data is referenced correctly as either Subjective or Objective	Evaluative statement does not completely support the outcome. Data is not referenced as subjective or objective.	No evaluative criteria stated or inappropriate.	Not Done

Additional requirements:

1. Reference: Must cite reference used for care plan. May use any Practical Nursing textbook or other reputable books. Student must include name of book, author, edition, and page number.
   - 5 points deducted from overall care plan grade if reference is not documented in its entirety from approved source.
2. Spelling and grammatical errors may result in point deduction from overall care plan grade
   - 0 no spelling / grammar errors
   - -10 1-6 spelling / grammar errors
   - -20 6-12 spelling / grammar errors
   - -30 13 or more spelling / grammar errors

Practical Nursing Daily Clinical Rubric PNSG 2310, 2320, 2330, 2340

Performance Criteria	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F (0 points)
1. Assessment Narrative Complete on one (1) client in EHR as the History and physical note to include a full set of vital signs. (BP, pulse, respirations, temp, pulse ox, height, weight)	Assessment narrative is completed in its entirety including full set of vital signs. The charting format is used correctly. The narrative has a logical flow. Assessment narrative is completed using appropriated medical terminology and redundant words, phrases, and other distracting information are omitted.	Assessment narrative is nearly complete with the exception of one area. Assessment narrative has a mostly logical flow.	Assessment narrative is partially complete with the exception of two areas. Assessment narrative has a fairly logical flow.	Assessment narrative is barely complete with the exception of three or more areas. Assessment narrative does not have a logical flow.	Not Done
2. Nurse's notes Nurse's notes completed on one (1) client in EHR detailing care, complaints, and tasks completed throughout the shift. Nurse's notes should include start of care and end of care note.	The charting format is used correctly. Charts descriptively using appropriated medical terminology. Charts client's response, abnormal findings or changes in condition. Follow up to pain, prn meds, and urgent situations. Start of care and end of care note	Includes majority of pertinent data related to client's condition, abnormal findings, or changes in condition, but also includes non-related data. Follow up to pain, prn meds, urgent situations documented most of the time. Either start of care or end of care note missing.	Includes minimal pertinent data related to client's condition, abnormal findings, or changes in condition. May also include non-related data.	Does not include pertinent data related to client's condition, abnormal findings, or changes in condition. May also include non-related data. Follow up to pain, prn meds, urgent situations not documented.	Not Done

	included in documentation.		Follow up to pain, prn meds, urgent situations documented some of the time. Both start of care and end of care note missing.		
3. Assessment Flowsheet Complete on one (1) client in EHR	Assessment Flow Sheet is completed in its entirety. The charting format is used correctly. Client's abnormal findings are charted.	Assessment flowsheet is nearly complete with the exception of one system.	Assessment flowsheet is partially complete with the exception of two systems.	Assessment flowsheet is barely complete with the exception of three or more systems.	Not Done
4. Admission FlowSheet Complete on one (1) client in EHR	Admission flow sheet is completed by documenting in the following: **1.)** History of present illness/injury **2.)** Allergies **3.)** Home Medication List **4.)** Past Medical History **5.)** Past Surgical History The charting format is used correctly.	Admission flowsheet is nearly complete with the exception of one area	Admission flowsheet is partially complete with the exception of two areas.	Admission flowsheet is barely complete with the exception of three or more areas.	Not Done
5. Medication Administration Students must document 5 medications daily; Medications administered by the student to one	Medication administration is completed in its entirety. The charting format is used correctly.	Medication administration is nearly complete with the exception of one-two areas.	Medication administration is Partially complete with the exception	Medication administration is barely complete with the exception of five or more areas.	Not Done

client during the clinical day are placed in EHR as an order then documented on the MAR. For each medication, student must document: Medication classification, indication, and nursing considerations. ***If the student administers less than 5 medications during the clinical day, they should include commonly given medications to equal a total of at least 5 medications. If the student does not administer any medications, the student must document (5) of the most commonly administered medications of the clinical facility.			of three-four areas.		

Spelling and grammatical errors may result in point deduction from overall documentation.

- -0 no spelling / grammar errors
- -10 1-6 spelling / grammar errors
- -20 6-12 spelling / grammar errors
- -30 13 or more spelling / grammar errors

Practical Nursing Reflection Rubric

Reflections offer the opportunity to reflect on personal experiences and observations. Maintain a formal tone as you write the reflection. You can write in first person for a reflective paper. Paper must be at least 1 full page. Answer each question in a separate paragraph.
Weekly Reflection topic are found in the syllabus and are specific to each course.

	A (25 points)	B (20 points)	C (15 points)	D (5 Points)	F (0 points)
Detailed Reflection	All questions answered in its entirety. Reflection displays pertinent data related to reflection topic.	Most of the topic questions are answered in its entirety. Reflection displays both non-related and related data about the reflection topic.	One topic question is partially answered. Reflection displays only non-related data.	Reflection is not related to the topic question. Reflection displays non-related data.	Not Done
Clarity	Reflection has a logical flow	N/A	N/A	Reflection does not have a logical flow.	Not Done
Font	Use of appropriate 12 Calibri	N/A	N/A	N/A	Font is not 12 Calibri
Reflection Length	At least 1 page double spaced	Reflection is not a full page. Reflection is ¾ page, double spaced	Reflection is not a full page. Reflection is ½ page, double spaced	Reflection is not a full page. Reflection is ¼ page, double spaced	Not Done

Spelling and grammatical errors may result in point deduction from overall reflection grade

- 0 no spelling / grammar errors
- -10 1-6 spelling / grammar errors
- -20 6-12 spelling / grammar errors
- -30 13 or more spelling / grammar errors

Weekly reflections (Word documents) should be submitted to the respective drop boxes. Do not submit PDF versions of the file.