PNSG 2330 Medical-Surgical Nursing Clinical III
COURSE SYLLABUS
Fall Semester 2021

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 site
Class Meets: 10/6/21-12/7/21 intertwined with PNSG 2340 and 2415
Course Reference Number (CRN): 20301
Course Enrollment Key: 42CUGEV

INSTRUCTOR CONTACT INFORMATION

Instructor Name: Rachel Sikes, BSN, RN
Office Location: Gillis Building, Room 715
Office Hours: Please schedule an appointment during clinical rotations
Email Address: Rachel Sikes (rsikes@southeasterntech.edu)
Phone: 912-538-3209
Fax Number: 912-538-3106
Tutoring Hours: Please schedule an appointment
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

Ear phones for any ATI assignments
Pens
Highlighters
2 Three Ring Binders
Stethoscope
Blood pressure cuff
Pen Light
Watch with seconds displayed
Basic Calculator
Scissors

COURSE DESCRIPTION

This first 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
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

Regardless of vaccination status, masks or face coverings must be worn at all times while in a classroom or lab of Southeastern Technical College. This measure is being implemented to reduce COVID-19 related health risks for everyone engaged in the educational process. Masks or face coverings must be worn over the nose and mouth, in accordance with the Centers for Disease Control and Prevention (CDC). A student's refusal to wear a mask or face covering will be considered a classroom disruption and the student may be asked to leave campus and/or receive further discipline.

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 for any reason.

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

Surgical masks are required at all times while in the clinical facility

<u>*Full PPE with N95 mask is required for suspected or confirmed COVID patients*</u>

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 2230, 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 2230 is required in order to pass the semester and progress in the practical nursing program.

DAILY REQUIREMENTS

The daily requirements for PNSG 2330 should be kept neat and orderly by the student. The instructor will pick up completed time sheets, preceptor evaluations, student evaluations, and medication templates 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 will 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 hospital 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 EHR 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.

ATI Assignments are due 10/22/21

PRECEPTOR EVALUTATIONS

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

The Technical College System of Georgia (TCSG) and its constituent Technical Colleges do not discriminate on the basis of race, color, creed, national or ethnic origin, gender, religion, disability, age, political affiliation or belief, genetic information, disabled veteran, veteran of the Vietnam Era, spouse of military member, or citizenship status (except in those special circumstances permitted or mandated by law). This nondiscrimination policy encompasses the operation of all technical college-administered programs, federally financed programs, educational programs and activities involving admissions, scholarships and loans, student life, and athletics. It also applies to the recruitment and employment of personnel and contracting for goods and services.

All work and campus environments shall be free from unlawful forms of discrimination, harassment and retaliation as outlined under Title IX of the Educational Amendments of 1972, Title VI and Title VII of the Civil Rights Act of 1964, as amended, the Age Discrimination in Employment Act of 1967, as amended, Executive Order 11246, as amended, the Vietnam Era Veterans Readjustment Act of 1974, as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Americans With Disabilities Act of 1990, as amended, the Equal Pay Act, Lilly Ledbetter Fair Pay Act of 2009, the Georgia Fair Employment Act of 1978, as amended, the Immigration Reform and Control Act of 1986, the Genetic Information Nondiscrimination Act of 2008, the Workforce Investment Act of 1998 and other related mandates under TCSG Policy, federal or state statutes. The Technical College System and Technical Colleges shall promote the realization of equal opportunity through a positive continuing program of specific practices designed to ensure the full realization of equal opportunity.
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 BannerWeb 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
Average of daily clinical rubrics	40%
Average of preceptor evaluations	30%
Average of care plans	30%

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

PNSG 2330 Medical/Surgical Nursing Clinical III
Fall Semester 2021 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 form provided by instructor. **ATI Assignments: : Due 10/22/21** 1. Nurse's Touch: Professional Communication: Organizational Communication (minimum score of 90) 2. Practice Assessment: PN Comprehensive A (minimum score of70)	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 2330

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 that 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.**

Daily requirements for each Medical/Surgical 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.
- The student will complete **five (5) handwritten drug cards** using the ATI active learning template: medication. Follow the medication list provided for each clinical rotation.

The daily requirements for PNSG 2330 should be kept neat and orderly by the student. The instructor will pick up completed time sheets, preceptor evaluations, student evaluations, and medication templates 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.

Documentation in EHR is due by midnight of each clinical day. EHR will 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 hospital 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 EHR 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.

In addition to the daily requirements for each PNSG 2330 clinical day, please see below for specific requirements based on specific clinical assignment:

Hospital Assignments for each day assigned to ER/MED-SURG hospital department:

Choose **ONE** client for the day to complete the required documentation:

- **Patient information**
  - Must include the name of clinical facility and the client's chief complaint
- Results (if applicable)
- Notes:
  - **History and physical note** (this is the narrative of the assessment flowsheet)
  - Type a **detailed reflection** (at least 1 page typed 12 Calibri font doubled spaced) of your clinical day. Do not use any client names or identifying information in this summary. (Please note that this reflection is not part of the medical record) The reflection should be typed into a word document then copy and paste the document into EHR under the "notes" section. This should include four (4) areas:
    - Clinical environment
    - Tasks completed/skills performed
    - What did you like about the clinical experience
    - What did you dislike about the clinical experience
- Flowsheets
  - **Admission**
  - **Vital signs**
    - Document vital signs according to facility policy and as needed
  - Daily Care (if applicable)
  - Intake & Output (if applicable)
  - Interventions (lines,drains)
    - Complete if applicable to your client
      - Wounds/incisions/ostomies
      - Respiratory interventions
      - Blood administration
      - Stroke scale
      - Restraints
      - Behavioral health
      - Preoperative checklist
- **Orders**
  - Medications administered by the student are placed in EHR as an order.
- **MAR**
  - Medications administered by the student are documented on the MAR.
- **Patient education**
- SBAR (if applicable)
- **Discharge**
  - Treat this discharge flowsheet as the last contact you had with your client. How did you leave the client?
- **Care plan**

Doctor’s Office, Wound Care Center, Clinic, Nursing Home, Health Department, Hospice, Hospital department (OR, Senior care unit, Behavioral health):

Choose **ONE** client for the day to complete the required documentation:

- **Patient information**
  - Must include the name of clinical facility and the client’s chief complaint
- Results (if applicable)
- Notes:
  - Type a **detailed reflection** (at least 1 page typed 12 Calibri font doubled spaced) of your clinical day. Do not use any client names or identifying information in this summary. (Please note that this reflection is not part of the medical record) The reflection should be typed into a word document then copy and paste the document into EHR under the “notes” section. This should include four (4) areas:
    - Clinical environment
    - Tasks completed/skills performed
    - What did you like about the clinical experience
    - What did you dislike about the clinical experience
- Flowsheets
  - **Admission**
  - **Vital signs**
    - Document vital signs according to facility policy and as needed
  - **Assessment**
    - Focused assessment
- **Orders**
  - Medications administered by the student are placed in EHR as an order.
- **MAR**
  - Medications administered by the student are documented on the MAR.
- **Patient education**
- SBAR (if applicable)
- **Discharge**
  - Treat this discharge flowsheet as the last contact you had with your client. How did you leave the client?

Medical Surgical Clinical III Medication List

Complete five (5) handwritten drug cards per day using the ATI active learning template: medication.

1. Lithium
2. Phenytoin
3. Scopolamine
4. Dantrolene
5. Sumatriptan
6. Allopurinol
7. Chlorpromazine
8. Celecoxib
9. Amphetamine
10. Tizanidine
11. Carisprodol
12. Hydroxychloroquine
13. Diclofenac sodium
14. Amitriptyline
15. Colchicine
16. Acyclovir
17. Carbamazepine
18. Levetiracetam
19. Lamotrigine
20. Topiramate
21. Citalopram
22. Phenobarbital
23. Valproic acid
24. Lorazepam
25. Diazepam
26. Donepezil
27. Memantine
28. Benztropine
29. Levodopa/carbidopa
30. Ropinirole
31. Clopidogrel
32. Baclofen
33. Gabapentin
34. Duloxetine
35. Azathioprine
36. Haloperidol
37. Risperidone
38. Quetiapine
39. Ziprasidone
40. Fluoxetine

PRECEPTOR/INSTRUCTOR EVALUATION
PNSG 2330, 2340, 2415

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	
Demonstrate an understanding of the nursing process.		
Provide relevant health education based on client's developmental level and cultural preferences.		
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	
Collaborate with multidisciplinary health care team to provide quality care.		
QSEN Concept: Quality Improvement **Participate in activities that improve and promote quality of care in health care settings.**	X	
Verbalizes understanding of collecting and recording data for quality improvement purposes.		
Identify methods to monitor continuous quality improvement.		
Concept: Professionalism **Practice in a professional manner while providing client-centered nursing care.**	X	
Identify legal aspects that guide nursing practice.		
Display professional accountability and responsibility in the delivery of client centered care.		
Concept: Leadership **Demonstrate the ability to serve as a team leader overseeing client care delivered by team members.**	X	
Apply organizational, time management and priority setting skills necessary to provide safe, quality client-centered care.		
Delegate tasks within the health care settings that is appropriate in the delivery of client centered care.		
Identify ways to resolve client care issues within the health care team.		

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.	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.	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.	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
Evaluation: Identify subjective and objective data to establish the patient outcome has been met or not met.	Evaluative statement is present. Data is referenced correctly as either Subjective or Objective. All pertinent subjective and objective	Evaluative statement is present but vague. Includes non-related data. Most of the data is referenced	Evaluative statement does not completely support the outcome. Data is not referenced as	No evaluative criteria stated or inappropriate.	Not Done

	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F
If unable to evaluate, identify optimal subjective and objective data that support a met outcome	data support a met outcome OR an unmet outcome.	correctly as either Subjective or Objective	subjective or objective.		

Additional requirements:

1. Reference: Must site reference used for care plan. May use any Practical Nursing textbook or reputable website. (.org, .edu, .gov)
   - 5 points deducted from overall care plan grade if no reference documented from approved source
2. Spelling and grammatical errors may result in point deduction from overall care plan grade
   - 0 no spelling / grammar errors
   - -1 1-3 spelling / grammar errors
   - -2 4-6 spelling / grammar errors
   - -3 7-9 spelling / grammar errors
   - -5 10 or more spelling / grammar errors

Southeastern Technical College Practical Nursing Daily Clinical Rubric PNSG 2255, 2310, 2320, 2330, 2340

Performance Criteria	A (10 Points)	B (7 Points)	C (5 Points)	D (3 Points)	F (0 points)
1. Patient Information Complete on one (1) client in EHR	Patient Information is completed in its entirety. The charting format is used correctly.	Patient Information is nearly complete with the exception of one area.	Patient Information is partially complete with the exception of two areas.	Patient Information is barely complete with the exception of three or more areas.	Not Done
2. Assessment Narrative Complete on one (1) client in EHR as the History and physical note (ER/MED-SURG hospital department ONLY)	Assessment narrative is completed in its entirety. The charting format is used correctly. The narrative has a logical flow and correct grammar, spelling, and abbreviations are used. 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. 1-3 grammatical, spelling, or abbreviation errors noted. 1-3 unapproved terms used. Assessment narrative has a mostly logical flow.	Assessment narrative is partially complete with the exception of two areas. 4-6 grammatical, spelling, or abbreviation errors noted. 4-6 unapproved terms used. Assessment narrative has a fairly logical flow.	Assessment narrative is barely complete with the exception of three or more areas. 7-10 grammatical, spelling, or abbreviation errors noted. 7-10 unapproved terms used. Assessment narrative does not have a logical flow.	Not Done
OR					
2. Assessment Flowsheet Complete on one (1) client in EHR (Clinic/outpatient setting ONLY)	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
3. Reflection Type a detailed reflection (at least 1 page typed 12 Calibri	Reflection is completed in its entirety. The charting format is used correctly.	Reflection is nearly complete with the exception of one area.	Reflection is partially complete with the exception of two areas.	Reflection is barely complete with the	Not done

font doubled spaced) of your clinical experience. Do not use any client names or identifying information in this summary. This summary should be typed into a word document then copy and paste the document into EHR under the "notes" section. This should include four (4) areas: Clinical environment Tasks completed/skills performed What did you like about the clinical experience What did you dislike about the clinical experience	The summary uses correct grammar, spelling, and abbreviations. Charts descriptively using appropriated medical terminology.	1-3 grammatical, spelling, or abbreviation errors noted. 1-3 unapproved terms used.	4-6 grammatical, spelling, or abbreviation errors noted. 4-6 unapproved terms used.	exception of three or more areas. 7-10 grammatical, spelling, or abbreviation errors noted. 7-10 unapproved terms used.	
4. Admission Complete on one (1) client in EHR • Informant • Admission problems • History of present illness/injury • Allergies • Admission data • Additional demographic info	Admission flow sheet is completed in its entirety. The charting format is used correctly.	Admission flowsheet is nearly complete with the exception of one-two areas.	Admission flowsheet is partially complete with the exception of three-four areas.	Admission flowsheet is barely complete with the exception of five or more areas.	Not Done
5. Admission Complete on one (1) client in EHR • Home medication list • Past Medical history	Admission flow sheet is completed in its entirety. The charting format is used correctly.	Admission flowsheet is nearly complete with the exception of one-two areas.	Admission flowsheet is partially complete with the exception of three-four areas.	Admission flowsheet is barely complete with the exception of five or more areas.	Not Done

• Past surgical history • Family history • Immunization screen • Social/environmental safety screening • Substances used					
6. Vital Signs Complete on one (1) client in EHR	Vital signs flow sheet is completed in its entirety. The charting format is used correctly. Vital signs are documented according to facility policy and as needed.	Vital signs flow sheet is nearly complete with the exception of one area.	Vital signs flow sheet is partially complete with the exception of two areas.	Vital signs flow sheet is barely complete with the exception of three or more areas.	Not Done
7. Medication Administration Medications administered by the student during the clinical day are placed in EHR as an order then documented on the MAR. *If the student does not administer medications during the clinical day, the student must document (5) of the most commonly administered medications of the clinical facility.	Medication administration is completed in its entirety. The charting format is used correctly. Client's abnormal findings are charted.	Medication administration is nearly complete with the exception of one area.	Medication administration is Partially complete with the exception of two areas.	Medication administration is barely complete with the exception of three or more areas.	Not Done
8. Patient Education Complete on one (1) client in EHR	Patient education tab is completed in its entirety. Student identifies priority education need of client. The charting format is used correctly.	Patient education tab is nearly complete with the exception of one area.	Patient education tab is partially complete with the exception of two areas.	Patient education tab is barely complete with the exception of three or more areas.	Not Done

9. Discharge Complete on one (1) client in EHR. Treat this discharge flowsheet as the last contact you had with your client. How did you leave the client?	Discharge tab is completed in its entirety. The charting format is used correctly.	Discharge tab is nearly complete with the exception of one-two areas.	Discharge tab is partially complete with the exception of three-four areas.	Discharge tab is barely complete with the exception of three-four areas.	
10. Drug cards Completes assigned drug cards (5) (handwritten) using the ATI template. Each category listed (Complications, Contraindications, Interactions, Nursing Interventions, and Client education) must have at least (4) written points and should be prioritized.	ATI Active learning templates are handwritten and completed in its entirety.	ATI Active learning templates are handwritten but missing completion in one area.	ATI Active learning templates are handwritten but missing completion in two areas.	ATI Active learning templates are handwritten but is missing completion in three or more areas.	Not Done