PNSG 2035 Nursing Fundamentals Clinical
COURSE SYLLABUS
Fall Semester 2023 (202412)

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
Clinical Location: 100 % FTF
Meadows Park Health and Rehabilitation – 119 Meadows Pkwy Vidalia, Ga
Oxley Park Health and Rehabilitation – 181 Oxley Drive Lyons, Ga
Appling Nursing and Rehabilitation Pavilion – 163 E. Tollison Street Baxley, Ga
Class Meets: **10/26/2023 to 11/08/2023** Monday, Tuesday, Wednesday, and Thursday: 0645-1715 at assigned facility.
Course Reference Number (CRN): **20313**
EHR (Electronic Health Record) Course Enrollment Key: **394UYMH**

INSTRUCTOR CONTACT INFORMATION

Primary Instructor Name: Sheila Van Dyke, BSN, RN
Email Address: Sheila Van Dyke svandyke@southeasterntech.edu
Campus/Office Location: Vidalia Campus, Gillis Building, Room 706
Office Hours: Monday – Thursday 0730 – 0900 and 1600 – 1700
Phone: 912-538-3105
Fax: 912-538-3106
Tutoring Hours: Please schedule an appointment

Secondary Instructor Name: Megan Guin MSN, RN
Email Address: Megan Guin mguin@southeasterntech.edu
Office Location: Vidalia Campus; Gillis Building, Office 834
Office Hours: Monday-Thursday, 0730-0900; 1600-1700
Phone: 478-289-2306
Fax: 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 Student Handbook (http://www.southeasterntech.edu/student-affairs/catalog-handbook.php).

REQUIRED TEXT

1. Fundamentals of Nursing Care: Concepts, Connections, and Skills, 4th Edition, FA Davis by Burton, Smith & Ludwig
2. Davis Advantage for Understanding Medical Surgical Nursing, 7th Edition, FA Davis, Williams and Hopper
3. Safe Maternity and Pediatric Nursing Care, 2nd Edition, FA Davis, Linnard-Palmer and Coats
4. Nursing Care Plans, 10th Edition, Doenges, Morehouse et al.
5. Pharmacology Clear and Simple, 4th Edition, FA Davis, Watkins
6. Davis's Nursing Skills **Videos** for LPN/LVN, 4th Edition (This is not a book. Student has access to skills videos through FA Davis website)
7. Davis's Drug Guide for Nurses, 18th Edition, FA Davis, Vallerand and Sanoski
8. Assessment Technologies Institute (ATI)

REQUIRED SUPPLIES & SOFTWARE

Pen, pencil, paper, highlighter, calculator, 3-ring binder, computer access and headphones.

Laptop/personal computer is required. Refer to handbook.

COURSE DESCRIPTION

An introduction to nursing practice in the clinical setting. Topics include but are not limited to: history taking; physical assessment; nursing process; critical thinking; activities of daily living; documentation; client education; standard precautions; hygiene and personal care; mobility and biomechanics; fluid and electrolytes; oxygen care; and perioperative care.

MAJOR COURSE COMPETENCIES

1. Clinically-Based Experience

PREREQUISITE(S)

Program Admission, PNSG 2030, and PNSG 2010

COURSE OUTLINE

Clinically-Based Experience

Order	Description	Learning Domain	Level of Learning
1	Perform history taking skills.	Psychomotor	Guided Response
2	Perform patient assessments.	Psychomotor	Guided Response
3	Implement the nursing process.	Cognitive	Application
4	Implement critical thinking.	Cognitive	Application
5	Demonstrate techniques to promote health management and maintenance and prevention of illness.	Psychomotor	Guided Response

Order	Description	Learning Domain	Level of Learning
6	Perform nursing care with respect to activities of daily living.	Psychomotor	Guided Response
7	Demonstrate appropriate documentation.	Psychomotor	Guided Response
8	Implement client education.	Cognitive	Application
9	Develop approaches for caring for the individual as a whole.	Psychomotor	Guided Response
10	Demonstrate the nursing process with emphasis on assessment and client education.	Psychomotor	Guided Response
11	Perform standard precautions.	Psychomotor	Guided Response
12	Relate clinically relevant care for individuals with respect to the life span.	Cognitive	Application
13	Display cultural competence and maintain patient confidentiality.	Affective	Responding

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.

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 Fundamentals of Nursing, PNSG 2030, 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 2030 is required in order to pass the semester and progress in the practical nursing program.

BLACKBOARD DOCUMENTATION

See lesson plan for specific due dates. Blackboard will not allow submissions past the due date. If assignments are not submitted into blackboard by the due date, a grade of “0” may be given for the required assignments.

POST CONFERENCE

Any scheduled pre or post-conference meetings whether in person or via WebEx will be scheduled on the Lesson Plan and included in the clinical schedule. Meetings are mandatory. Students who are tardy/absent may receive an occurrence.

DAILY REQUIREMENTS
These requirements for PNSG 2035 should be kept neat and orderly by the student. The instructor will collect completed time sheets, preceptor evaluations, and student evaluations daily. 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.

Students will refer to Documentation Requirements for PNSG 2035.

EHR DOCUMENTATION

Documentation in EHR, is due by **2359 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 will remain at the clinical facility to complete documentation requirements for the last two (2) hours of the shift (1515-1715). The student must go to the cafeteria (or other designated area) of the hospital with their laptop, connect to the Wi-Fi and complete documentation requirements.

Student should have clinical folders available for instructor pick up at the start of clinical the following day.

No printed material may be removed from any clinical site. This is a possible HIPPA violation. See Department of Nursing Program Student Handbook.

Students should have the instructor sign the clinical time sheet following completion of the shift. This will be completed during post-conference on a daily basis each clinical day.

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.

PRECEPTOR/INSTRUCTOR EVALUATIONS:

Only approved nursing preceptors may be used at STC clinical sites. The absence of an approved nursing preceptor may result in the inability to complete the clinical day. 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 REQUIREMENTS

All students are required to meet Health Documentation Requirements.
Refer to STC Department of Nursing Student Handbook Fall 2023 for additional details.

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

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.

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.

In the case of tardiness or absence of a clinical day, students should contact the instructor and the clinical facility

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: Emily Jarrell (ejarrell@southeasterntech.edu) , 478-289-2259, Building 1, Room 1210
Vidalia Campus: Helen Thomas hthomas@southeasterntech.edu , 912-538-3126, Building A, Room 108

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: Emily Jarrell (ejarrell@southeasterntech.edu), 478-289-2259, Building 1, Room 1210
Vidalia Campus: Helen Thomas (hthomas@southeasterntech.edu), 912-538-3126, Building A, Room 108

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

Refer to STC Department of Nursing Student Handbook Fall 2023 for additional details.

65% point 11/06/2023

ACADEMIC DISHONESTY POLICY

Refer to STC Department of Nursing Student Handbook Fall 2023 for additional details.

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 108 Phone: 912-538-3126 Email: Helen Thomas hthomas@southeasterntech.edu	Melanie Walker, Director of Human Resources Vidalia Campus 3001 East 1st Street, Vidalia Office 138B Phone: 912-538-3230 Email: Melanie Walker mwalker@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 my STC 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.

Assessment/Assignment	Percentage
Daily Average (8 clinical days)	100 %

GRADING SCALE

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

PNSG 2035 Nursing Fundamentals Clinical
Fall Semester 2023 Lesson Plan

Date/Week	Chapter/Lesson	Content	Assignments & Tests Due Dates	Competency Area
Thursday 10/26/2023 **Clinical Day 1**	Clinical Experience	**Facility:** See Schedule **Clinical Instructor:** See Schedule	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Document top 3 priority nursing diagnostic statements designated as **1.**, **2.**, **3.*** Add under "Assessment" portion of Care Plan Template in EHR Tutor ➢ **Prioritizing 3 Nursing Diagnostic Statements**	Course 1-13 Core A-C
Monday 10/30/2023 **Clinical Day 2**	Clinical Experience	**Facility:** See Schedule **Clinical Instructor:** See Schedule	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment	Course 1-13 Core A-C

Date/Week	Chapter/Lesson	Content	Assignments & Tests Due Dates	Competency Area
			• **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Care Plan on priority diagnosis for client* Add under Care Plan Template in EHR Tutor ➢ **Care Plan**	
Tuesday 10/31/2023 **Clinical Day 3**	Clinical Experience	**Facility:** See Schedule **Clinical Instructor:** See Schedule	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) **EHR Tutor:** *Document top 3 priority nursing diagnostic statements designated as* ***1.**, **2.**, **3.*** Add under “Assessment” portion of Care Plan Template in EHR Tutor ➢ **Prioritizing 3 Nursing Diagnostic Statements**	Course 1-13 Core A-C
Wednesday 11/01/2023 **Clinical Day 4**	Clinical Experience	**Facility:** Appling Nursing and Rehabilitation Pavilion – Baxley, Ga **Clinical Instructor:** Sheila Van Dyke	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe	Course 1-13 Core A-C

Date/Week	Chapter/Lesson	Content	Assignments & Tests Due Dates	Competency Area
			Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Care Plan on priority diagnosis for client* Add under Care Plan Template in EHR Tutor ➢ **Care Plan**	
Thursday 11/02/2023 **Clinical Day 5**	Clinical Experience	**Facility:** Appling Nursing and Rehabilitation Pavilion – Baxley, Ga **Clinical Instructor:** Megan Guin	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Document top 3 priority nursing diagnostic statements designated as **1.**, **2.**, **3.*** Add under "Assessment" portion of Care Plan Template in EHR Tutor ➢ **Prioritizing 3 Nursing Diagnostic Statements**	Course 1-13 Core A-C

Date/Week	Chapter/Lesson	Content	Assignments & Tests Due Dates	Competency Area
Monday 11/06/2023 **Clinical Day 6** ***65% point***	Clinical Experience	**Facility:** Appling Nursing and Rehabilitation Pavilion – Baxley, Ga **Clinical Instructor:** Sheila Van Dyke	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Care Plan on priority diagnosis for client* Add under Care Plan Template in EHR Tutor ➢ **Care Plan**	Course 1-13 Core A-C
Tuesday 11/07/2023 **Clinical Day 7**	Clinical Experience	**Facility:** Appling Nursing and Rehabilitation Pavilion – Baxley, Ga **Clinical Instructor:** Megan Guin	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Document top 3 priority nursing diagnostic statements designated as **1.**, **2.**, **3.***	Course 1-13 Core A-C

Date/Week	Chapter/Lesson	Content	Assignments & Tests Due Dates	Competency Area
			Add under "Assessment" portion of Care Plan Template in EHR Tutor ➢ **Prioritizing 3 Nursing Diagnostic Statements**	
Wednesday 11/08/2023 **Clinical Day 8**	Clinical Experience	**Facility:** Appling Nursing and Rehabilitation Pavilion – Baxley, Ga **Clinical Instructor:** Sheila Van Dyke	• **EHR Tutor**: Personal History • **EHR Tutor**: Allergies and Home Medication List • **EHR Tutor:** Vital Signs (One set of manual vital signs with Head to Toe Assessment and two (2) additional sets of manual vital signs on two different clients.) • **EHR Tutor**: Flowsheet Assessment • **EHR Tutor:** Head to Toe Narrative Assessment (Choose History and Physical Note) • **EHR Tutor:** *Care Plan on priority diagnosis for client* Add under Care Plan Template in EHR Tutor ➢ **Care Plan**	Course 1-13 Core A-C

COMPETENCY AREAS:

Clinically- based Experience

1. Perform history-taking skills.
2. Perform patient assessments.
3. Implement the nursing process.
4. Implement critical thinking.
5. Demonstrate techniques to promote health management and maintenance and prevention of illness.
6. Perform nursing care with respect to activities of daily living.
7. Demonstrate appropriate documentation.
8. Implement client education.
9. Develop approaches for caring for the individual as a whole.
10. Demonstrate the nursing process with emphasis on assessment and client education.
11. Perform standard precautions.

12. Relate clinically relevant care for individuals with respect to the life span.
13. Display cultural competence and maintain patient confidentiality.

GENERAL CORE EDUCATIONAL COMPETENCIES:

a) The ability to utilize standard written English.
b) The ability to solve practical mathematical problems.
c) The ability to read, analyze, and interpret information.

Documentation Requirements for PNSG 2035:
Fundamentals of Nursing Clinical

REQUIRED DOCUMENTS/FORMS FOR EACH PNSG 2035 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 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). Forms not signed by the student will result in a 10-point deduction from the daily clinical grade, and the student will be required to come in and sign at the time determined by the instructor. Time should be measured in 15-minute increments. Timesheets will be completed on a weekly basis. Each week starts on Sunday and ends on Saturday.

- **Preceptor Evaluation Forms** are completed and signed by the instructor for each day during the Fundamentals of Nursing clinical experience. 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 instructor. Incomplete/incorrect preceptor forms may result in a ten (10) point deduction from the daily clinical grade. It is the student's responsibility to provide the instructor with an evaluation form by the end of the clinical day.

- After each clinical day, the student will complete the **Southeastern Technical College Student Evaluation of Clinical Experience form.** The student will complete 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 2035 should be kept neat and orderly by the student. The instructor will pick up completed time sheets and student evaluations of the clinical facility on the last day of each week. 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.

Documentation in EHR is due 2359 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.

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.

REQUIRED EHR (ELECTRONIC HEALTH RECORD) DOCUMENTATION

- The student must log into ATI, access EHR, and enroll in the course using the course enrollment key provided by the instructor. The course enrollment key and the name of the course can be found in the Lesson Plan.
- 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.

Choose **ONE** client for the day to complete the required documentation in EHR: (See Southeastern Technical College Practical Nursing Daily Clinical Rubric for details)

ACTIVITY 1 IN EHR:

- Go to EHR: **>** Provider **>** History **>** Personal History
- Complete Past Medical History
- Complete Past Surgical History/Procedures
- Pregnancy History: **(Not Required for Fundamentals Clinical)**
    - **G** (Gravida) Total Pregnancies
    - **T** (Term Births) Born at 38 weeks or more
    - **P** (Preterm Births)
    - **A** (Abortions/miscarriages)
    - **L** (Living Children)
- Family History: **(Not Required for Fundamentals Clinical)**
- Complete Social and Safety Screening **(Not Required for Fundamentals Clinical)**

- **Allergies:**
    - NKDA (No Known Drug Allergies) **OR**
    - Medication with allergic reaction documented
- **Home Medication List:**
    - Five current medications client is prescribed/ordered
    - If the client has less than five medications ordered, student will consult with instructor/nurse to document the most commonly administered medications of the facility

ACTIVITY 2:

- **Vital Signs:**

- Go to EHR: Flowsheet **>** Vital Signs
- Three (3) manual sets of Vital Signs **(B/P, Pulse, Respirations, and Temperature)**
- **Client vital signs are documented at the beginning of Narrative Assessment**
- Other two sets are documented under Vital Signs Flowsheet in EHR Tutor
- This allows instructor/student to relate physical assessment with vital signs

- **Assessment Flowsheet:**
  - EHR: Choose Flowsheets **>** Choose Assessment

ACTIVITY 3:

- Head to Toe Physical Assessment
  - EHR: Choose Notes > Choose NEW NOTE **>** Choose Note Type: Choose *History and Physical Note*
  - Narrative Format: Head to Toe Physical Assessment

ACTIVITY 4:

- Care Plans **OR** Prioritizing three (3) prioritized diagnostic statements (Designated on the Lesson Plan)
  - **Day 1**: Prioritizing three (3) prioritized diagnostic statements
  - **Day 2**: Care Plan
  - **Day 3**: Prioritizing three (3) prioritized diagnostic statements
  - **Day 4**: Care Plan
  - **Day 5**: Prioritizing three (3) prioritized diagnostic statements
  - **Day 6**: Care Plan
  - **Day 7**: Prioritizing three (3) prioritized diagnostic statements
  - **Day 8**: Care Plan
- Care Plan is written based on the ONE chosen client for the day for documentation requirements
- Choose Care Plan > New Problem Need in EHR Tutor
- *Document top 3 priority nursing diagnostic statements designated as 1., 2., 3.* Add under "Assessment" portion of Care Plan Template in EHR Tutor
- Reference documentation goes under "Comment" section at the bottom of the Care Plan

ACTIVITY 5:

- Instructor will complete **Preceptor/Instructor Evaluation PNSG 2035** on each student daily. Student evaluations are based on QSEN standards in the delivery of nursing care.

Fundamentals of Nursing Clinical Daily Grade Rubric

ACTIVITY	POINTS POSSIBLE	GRADE/POINTS EARNED
Activity 1	_____ /20 Points	**A.)** Personal History (5 Required Areas) (10 Points) **B.)** Allergies (5 Points) and Home Medication List (5 Meds Required) (5 Points)
Activity 2	_____/20 Points	**A.)** Vital Signs (3 sets) (10 Points) **B.)** Flowsheet (10 Points)
Activity 3	_____/20 Points	Narrative Format: Head to Toe Physical Assessment (***Rubric)***
Activity 4	_____/20 Points (Care Plan) ***OR*** _____/20 Points (Prioritizing 3 Nursing Diagnoses)	Care Plan on Priority Nursing Diagnosis **(*Care Plan Rubric)*** Care Plans will be graded using Practical Nursing Care Plan Rubric and converted to a 20-point scale. Example: Student makes an "85" on Care Plan. To convert: 85/100=**X**/20, **X**=17/20 Points ***OR*** Prioritizing Diagnostic Statements: (6.66 points each) Student correctly prioritizes all three complete diagnostic statements (2-part or 3-part) in correct order receives 20 points.
Activity 5	_____/20 Points	**Preceptor/Instructor Evaluation specific for PNSG 2035** Preceptor/Instructor Evaluations are converted to a 20-point scale. Example: Student makes a "90" on the Daily Preceptor/Instructor Evaluation. To convert: 90/100=**X**/20, **X**= 18
		Daily Clinical Grade:

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

PRECEPTOR/INSTRUCTOR EVALUATION

PNSG 2035

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.		
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**	
Recognize role and scope of practice of practical nurse. (perform nursing care with respect to activities of daily living)		
List multidisciplinary team members within the health care settings. (understand different roles of healthcare team with emphasis on client centered care)		
QSEN Concept: Evidence Based Practice **Utilize evidence-based rationales and resources when providing safe, quality client-centered care.**	**X**	
Define evidence-based practice. (demonstrates techniques to promote health management, maintenance, and prevention of illness)		
Recognize the nurse’s role in evidence-based practice. (demonstrates the nursing process with emphasis on assessment and education)		
Use evidence-based practice to reduce variations in nursing care.		

QSEN Concept: Safety: **Apply strategies that minimize risk and provide a safe environment for clients, self, and others.**	**X**	
Recognize hazards of the client's environment.		
Identify actions to reduce risk of injury to self and others. (implements standard precautions, uses proper body mechanics)		
QSEN Concept: Informatics: **Utilize client care technology in the provision of safe, quality client-centered care.**	**X**	
Demonstrate the proper use of electronic health record systems according to HIPPA regulations in all health care settings.		
Concept: Professionalism **Practice in a professional manner while providing client-centered nursing care.**	**X**	
Demonstrate principles of work ethics. (Punctual, professional, appropriate dress, behavior, and appearance in clinical setting. Shows initiative)		

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

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

____

Preceptor Printed Name

HEAD TO TOE NARRATIVE PHYSICAL EXAM RUBRIC

Assessment Narrative	**A (20 Points)**	**B (15 Points)**	**C (10 Points)**	**D (5 Points)**	**F (0 points)**
Complete on **one** (1) client in EHR as the History and Physical Note to include a full set of vital signs. (BP, Pulse, Respirations, Temperature)	Assessment narrative is completed in its entirety including a full set of vital signs. 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 appropriate 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

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

FLOWSHEET ASSESSMENT RUBRIC

Assessment Flowsheet	**(10 Points)**	**(8 Points)**	**(5 Points)**	**(2 Points)**	**(0 Points)**
	Assessment Flow Sheet is completed in its entirety. Client's abnormal findings are charted. There are no blank spaces. If there are blank spaces, an explanation is documented in the comment section at the bottom textbox related to the system.	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.	

Systems:

1. Head, Face, Anterior Fontanel, Neck
2. Eyes, Ears, Nose, Throat
3. Neurological Group
    - Deep Tendon Reflexes should be N/E. Documented in the Neurological Comments text box.
4. Glasgow Coma Scale
5. Respiratory
    - Notice that Breath Sounds and Comments share a text box. Breath Sounds should never be blank.
6. Cardiac
7. Peripheral Vascular
8. Integumentary
    - Braden Scale
9. Musculoskeletal
    - Morse Fall Scale
10. Gastrointestinal
11. Genitourinary
12. Pain Assessment

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

CARE PLAN TEMPLATE

Use this Care Plan Template as a reference. Care Plan documentation is entered in EHR.

<table>
<tr><td rowspan="2">A
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T</td><td colspan="3">Subjective Data</td></tr>
<tr><td colspan="3">Objective Data</td></tr>
<tr><td>D
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S</td><td>Diagnostic Statement</td><td colspan="2">Nursing Diagnosis:

Related to:

As evidenced by:</td></tr>
<tr><td>P
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Goal must Be Measurable</td><td colspan="2">Client Will:</td></tr>
<tr><td>I
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I</td><td colspan="2">Nursing Interventions</td><td>Rationale</td></tr>
</table>

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N</td><td>Subjective Data</td><td>Objective Data</td></tr>
<tr><td colspan="2">Was the desired outcome achieved? ☐ Yes ☐ No
If no, what revisions to the interventions will you make?</td></tr>
</table>

Instructor's Comments:

____

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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	Interventions pertain to patient situation or nursing diagnosis statement and meets patient health needs but lack some specificity. 3 of the 4 required	Interventions pertain to nursing diagnosis statement in an indirect way; does not completely meet patient health	Interventions are not appropriate to meet patient health needs. 1 of the 4 required	Not Done

	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F
	of patient specific nursing interventions identified.	interventions are listed.	needs; 2 of the 4 required interventions are listed.	interventions are listed.	
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

STC STUDENT EVALUATION OF CLINICAL EXPERIENCE

Practical Nursing
Semester_________________
Course___________________
Year_____________________
Clinical site (NO abbreviations) ____
Preceptor's Name ____________________________
Date: _________________________

INSTRUCTIONS: Please evaluate your clinical site. Answer each statement by circling the number that most accurately reflects your evaluation of the site. Please use the scale below:
1=Strongly Disagree
2=Disagree
3=No opinion/Not applicable
4=Agree
5=Strongly Agree

CLINICAL EXPERIENCE:
1. The clinical site provided adequate practice opportunities for my growth as a student nurse.
5 4 3 2 1
2. The clinical site was receptive of me as a student nurse.
5 4 3 2 1
3. The clinical site had resources to support my learning experience.
5 4 3 2 1
4. The clinical site provided an atmosphere where I could integrate class with clinical experience.
5 4 3 2 1
5. I would recommend this clinical site to other nursing students.
5 4 3 2 1

EXPERIENCE WITH PRECEPTOR/STAFF:
6. The clinical preceptor was knowledgeable and helpful to my clinical experience.
5 4 3 2 1
7. The clinical preceptor was willing to facilitate my learning needs.
5 4 3 2 1
8. The clinical preceptor demonstrated a positive attitude for teaching me.
5 4 3 2 1
9. The clinical staff members were positive role models for me.
5 4 3 2 1
10. I would recommend this preceptor to other nursing students.
5 4 3 2 1

Additional Comments: ____
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____
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PN CLINICAL WEEKLY TIME SHEET

(Complete Time Sheet Using Blue or Black Ink)

Student Name: _________________________ **Total hours for Week: ____________**

Course: ________________________________

Day	Date	Clinical Site	In	Out	In	Out	Total Hours Worked	Preceptor Signature
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Make-up								
Post Conference								

Student Signature: ________________________________ Date: _________________
Instructor Signature: _______________________________ Date: __________________