PNSG 2255 Maternity Clinical
COURSE SYLLABUS
Spring Semester 2022

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

COURSE INFORMATION

Credit Hours/Minutes: 2/2250
Class Location: East Georgia Regional Medical Center, ATI online, Gillis Building
Class Meets: March 21, 2022 through March 28, 2022 intertwined with PNSG 2310 and PNSG 2415. See clinical schedule for details.
Course Reference Number (CRN): 40152 – Vidalia; 40163 - Swainsboro
EHR Enrollment Key: 3U2EZVH

INSTRUCTOR CONTACT INFORMATION

Instructor Name: Sheila Van Dyke, BSN, RN
Office Location: Vidalia Campus, Gillis Building, Room 706
Office Hours: Please schedule an appointment during clinical
Email Address: svandyke@southeasterntech.edu
Phone: 912-538-3105
Fax: 912-538-3106
Tutoring Hours: Please schedule an appointment.
Preferred Method of Contact: EMAIL

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

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

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

Students are responsible for all policies and procedures and all other information included in Southeastern Technical College's Catalog and Student Handbook (http://www.southeasterntech.edu/student-

affairs/catalog-handbook.php).

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, 2nd edition, 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

Laptop/personal computer is required.

Suggested specifications include:

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

Required:

- Webcam with microphone
- A minimum internet speed of 5 Mbps. (10 Mbps or more is recommended). Test your internet speed using www.speedtest.net.

Google chrome and Firefox are the recommended browsers to use for blackboard collaborate.

Students should not share login credentials with others and should change passwords periodically to maintain security.

COURSE DESCRIPTION

At completion of this maternity course, students will have completed a minimum of 38 clock hours of maternity related clinical experience. This course focuses on clinical health management and maintenance and

the prevention of illness, care of the individual as a whole, and deviations from the normal state of health. The definition of client care includes using the nursing process, performing assessments, using critical thinking, providing client education, displaying cultural competence across the life span and with attention to special populations. Topics include: health management and maintenance and prevention of illness, care of the individual as a whole, pathological and non-pathological concerns in obstetric clients and the newborn; client care, treatments, pharmacology, and diet therapy related to obstetric clients and the newborn; and standard precautions.

MAJOR COURSE COMPETENCIES

1. Overall
2. Clinically-based Nursing Care Associated with Obstetric and Newborn Clients

PREREQUISITE(S)

Program admission

COURSE OUTLINE

CLINICALLY-BASED NURSING CARE ASSOCIATED WITH OBSTETRIC AND NEWBORN CLIENTS

ORDER	DESCRIPTION	LEARNING DOMAIN	LEVEL OF LEARNING
1	Integrate techniques to promote health management and maintenance and prevention of illness related to the obstetric and newborn client.	Psychomotor	Complex Response
2	Use approaches for caring for the individual as a whole with respect to the obstetric and newborn client.	Psychomotor	Mechanism
3	Demonstrate competence in caring for individuals with pathological disorders that affect the obstetric and newborn client.	Psychomotor	Guided Response
4	Use nursing observations and interventions related to each diagnostic study and procedure related to the obstetric and newborn client.	Psychomotor	Mechanism
5	Apply the nursing process with emphasis on assessment and client education related to the obstetric and newborn client.	Psychomotor	Mechanism
6	Demonstrate an understanding of and ability to perform treatments related to the obstetric and newborn client.	Psychomotor	Guided Response
7	Perform administration of prescribed medications related to the obstetric and newborn client.	Psychomotor	Guided Response
8	Perform administration of prescribed diet related to obstetric and newborn clients.	Psychomotor	Guided Response
9	Implement standard precautions related to the obstetric and newborn client.	Psychomotor	Mechanism
10	Display cultural competence as applicable to obstetric and newborn clients.	Affective	Responding

ORDER	DESCRIPTION	LEARNING DOMAIN	LEVEL OF LEARNING
11	Demonstrate clinically relevant care for individuals related to obstetric and newborn clients 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, students are highly encouraged to wear masks or face coverings while in a classroom or lab at Southeastern Technical College. Masking may be implemented in some program areas (i.e. Health Sciences and Cosmetology) where students, faculty, and clients are in close proximity and social distancing cannot be maintained. 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).
Students participating in clinical learning experiences are required to follow the specific screening and PPE protocols of the clinical facility.

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)

COVID-19 Key Symptoms
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
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, 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

These requirements should be kept neat and orderly by the student. The student will turn in completed timesheets, preceptor evaluations, and student evaluations at the end of the clinical day. 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.

EHR DOCUMENTATION

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

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

Students will have the clinical instructor 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.

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.

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 38 clinical hours 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: Macy Gay mgay@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: Macy Gay mgay@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.

ACADEMIC DISHONESTY POLICY

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

PROCEDURE FOR ACADEMIC MISCONDUCT

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

1. **First Offense**
   Student will be assigned a grade of "0" for the test or assignment. Instructor keeps a record in

course/program files and notes as first offense. The instructor will notify the student's program advisor, academic dean, and the Registrar at the student's home campus. The Registrar will input the incident into Banner for tracking purposes.

2. **Second Offense**
   Student is given a grade of "WF" (Withdrawn Failing) for the course in which offense occurs. The instructor will notify the student's program advisor, academic dean, and the Registrar at the student's home campus indicating a "WF" has been issued as a result of second offense. The Registrar will input the incident into Banner for tracking purposes.
3. **Third Offense**
   Student is given a grade of "WF" for the course in which the offense occurs. The instructor will notify the student's program advisor, academic dean, and the Registrar at the student's home campus indicating a "WF" has been issued as a result of third offense. The Vice President for Student Affairs, or designee, will notify the student of suspension from college for a specified period of time. The Registrar will input the incident into Banner for tracking purposes.

STATEMENT OF NON-DISCRIMINATION

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

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

American With Disabilities Act (ADA)/Section 504 - Equity- Title IX (Students) – Office of Civil Rights (OCR) Compliance Officer	**Title VI - Title IX (Employees) – Equal Employment Opportunity Commission (EEOC) Officer**
Helen Thomas, Special Needs Specialist Vidalia Campus 3001 East 1st Street, Vidalia Office 165 Phone: 912-538-3126 Email: Helen Thomas hthomas@southeasterntech.edu	Lanie Jonas, Director of Human Resources Vidalia Campus 3001 East 1st Street, Vidalia Office 138B Phone: 912-538-3147 Email: Lanie Jonas mailto: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:

ASSIGNMENT	GRADE PERCENTAGE
ATI Clinical Online Day	20
EGRMC Clinical Rotation Day 1	30
EGRMC Clinical Rotation Day 2	30
Laboring Patient Simulation	10
Reflection	10

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

PNSG 2255 Maternity Clinical
Spring Semester 2022
Lesson Plan

DATE/TIME LOCATION INSTRUCTOR	CONTENT	HOURS	DOCUMENTATION Due Date/Time:	COMPETENCY AREA
3/16/2022 0900	EGRMC Online Orientation: respective campuses	2		Course 1-3 Core: a, b, c
03/21/2022: EGRMC 06:45-19:15 Van Dyke/Guin	***follow clinical rotation schedule*** EGRMC	 EGRMC -12	 3/21/22 2359	Course 1-3 Core: a, b, c
3/22/22: EGRMC 06:45-19:15 Van Dyke/Guin 3/22/22: Online 0800-2000 Van Dyke/Guin	***follow clinical rotation schedule*** EGRMC ONLINE CLINICAL: ATI Module	 EGRMC -12 Online-10	 3/22/22 2359 As per module	Course 1-3 Core: a, b, c
3/23/22: EGRMC 06:45-19:15 Van Dyke 3/23/22: Online 0800-2000 Guin	***follow clinical rotation schedule*** EGRMC ONLINE CLINICAL: ATI Module	 EGRMC -12 Online-10	 3/23/22 2359 As per module	Course 1-3 Core: a, b, c
3/24/22: EGRMC 06:45-19:15 Guin	***follow clinical rotation schedule*** EGRMC	 EGRMC -12	 3/24/22 2359	Course 1-3 Core: a, b, c
3/28/2022 Vidalia Campus: Gillis Building	***See schedule for assigned time*** Laboring Patient Simulation	4	3/28/2022 2359	Course 1-3 Core: a, b, c

MAJOR COURSE COMPETENCIES:

1. Overall
2. Nursing Care of the Obstetric Client
3. Nursing Care of the Newborn Client

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.

DISCLAIMER STATEMENT

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 the semester. The syllabus displayed in advance of the semester in a location other than the course you are enrolled in is for planning purposes only.

Documentation Requirements for Maternity Nursing

Required Documents/Forms for each clinical day:

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

These requirements should be kept neat and orderly by the student. The instructor will pick up completed time sheets at the end of the day. Failure to complete the forms as outlined above may result in the student's inability to attend clinical until the assignment/requirement is completed and/or points deducted from the clinical grade.

Required EHR documentation for each Clinical Day:

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

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

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

Once the student is enrolled in the course, the student will see the list of activities for the clinical course. The

student will choose the activity and create a patient. Enter the patient's age. In the comment section, enter the name of the clinical facility. Please remember, Protected Health Information (PHI) for a real client should never be entered into an academic EHR.

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

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

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

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

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

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

Weekly Reflections:

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

- Do not use any client names or identifying information in this reflection
- At least 1 page typed 12 Calibri font doubled spaced
- Place in Blackboard drop box by due date on syllabus

Reflection (Due _____ in Blackboard dropbox)

1. **Nursing Judgement:**
    a. Nursing judgement involves the use of critical thinking and decision-making skills when making clinical judgments that promote safe, quality patient care. Describe situations where nursing judgment was used to improve and promote quality of care. What was the outcome? How could the outcome been different had the nurse not used appropriate nursing judgement?

Practical Nursing Clinical Course Evaluation Form

Name: _____ Course: _PNSG 2255___ Semester: _Spring 2022___ Total hours: _____

	Documentation	Care Plan	Preceptor Evaluation	Daily Average
EGRMC Clinical Day 1				
EGRMC Clinical Day 2				
Laboring Patient Simulation Day			Not applicable	
ATI online Day		Not applicable	Not applicable	

Assessment	Percentage	Points Earned
EGRMC Day 1	**30%**	
EGRMC Day 2	**30%**	
ATI Clinical Online Day	**20%**	
Laboring Patient Simulation	**10%**	
Reflection	**10%**	
Clinical Grade		
Clinical Occurrence		
Final Clinical Grade		

Comments_____

_____

_____

Student Signature_____ Date_____

Instructor Signature_____ Date_____

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

Performance Criteria	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F (0 points)
1. Assessment Narrative Complete on one (1) client in EHR as the History and physical note	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
2. Nurse's notes Nurse's notes completed on one (1) client in EHR detailing care, complaints, and tasks completed throughout the shift. Nurse's notes should include start of care and end of care note.	The charting format is used correctly. The nurse's notes uses correct grammar, spelling, and abbreviations. Charts descriptively using appropriated medical terminology. Charts client's response, abnormal findings or changes in	1-3 grammatical, spelling, or abbreviation errors noted. 1-3 unapproved terms used. Includes majority of pertinent data related to client's condition, abnormal findings, or changes in condition, but	4-6 grammatical, spelling, or abbreviation errors noted. 4-6 unapproved terms used. Includes minimal pertinent data related to client's condition, abnormal findings, or changes in condition.	7-10 grammatical, spelling, or abbreviation errors noted. 7-10 unapproved terms used. Does not include pertinent data related to client's condition, abnormal findings, or	Not Done

	condition. Follow up to pain, prn meds, and urgent situations.	also includes non-related data. Follow up to pain, prn meds, urgent situations documented most of the time.	May also include non-related data. Follow up to pain, prn meds, urgent situations documented some of the time.	changes in condition. May also include non-related data. Follow up to pain, prn meds, urgent situations not documented.	
3. Assessment Flowsheet Complete on one (1) client in EHR	Assessment flow sheet is completed in its entirety. The charting format is used correctly. Client's abnormal findings are charted.	Assessment flowsheet is nearly complete with the exception of one system.	Assessment flowsheet is partially complete with the exception of two systems.	Assessment flowsheet is barely complete with the exception of three or more systems.	Not Done
4. Admission Complete on one (1) client in EHR • History of present illness/injury • Allergies • Home medication list • Past medical history • Past surgical 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
5. Medication Administration Medications administered by the student during the clinical day are placed in EHR as an order then documented on the MAR. For each medication, student must document: Medication classification, indication, and nursing considerations.	Medication administration is completed in its entirety. The charting format is used correctly.	Medication administration is nearly complete with the exception of one-two areas.	Medication administration is Partially complete with the exception of three-four areas.	Medication administration is barely complete with the exception of five or more areas.	Not Done

***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.					

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 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	Interventions are not appropriate to meet patient health needs. 1 of the 4 required interventions are	Not Done

	A (20 Points)	B (15 Points)	C (10 Points)	D (5 Points)	F
	interventions identified.		required interventions are listed.	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 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

PN CLINICAL WEEKLY TIME SHEET

(Complete Time Sheet Using Blue or Black Ink)

Student Name: _____

Day	Date	Clinical Site	In	Out	In	Out	Total Hours Worked	Preceptor Signature
Make-up								
Post Conference								

Student Signature: _____ Date: _____

Labor & Delivery Worksheet

LABOR & DELIVERY (L&D) WORKSHEET **STUDENTS NAME:**	**THIS IS FOR YOUR PERSONAL USE TO ASSIST WITH EHR DOCUMENTATION WHILE AT CLINICAL.**
Patient History:	
Patient's Age/ Date of Birth: _____ Pre-pregnancy Weight: _____ Gestational Weight: _____	Gravida _____ Para _____ Term _____ Abortion _____ (Note: This includes elective and spontaneous) Living _____
Estimated Date of Delivery (EDD) _____ Last Menstrual Period (LMP) _____	ALLERGIES:
PRENATAL CARE When did prenatal care begin?	YES _____ NO_____ _____
REASON FOR ADMISSION	LABOR _____Spontaneous Rupture of Membranes (SROM) _____INDUCTION_____OBS_____ OB / MEDICAL COMPLICATION_____
ONSET OF LABOR:	NOT IN LABOR: Yes _____ No _____
Risk Assessment:	
SIGNIFICANT PREGNANCY RELATED PROBLEMS AND TREATMENT	
SIGNIFICANT NON-PREGNANCY HEALTH PROBLEMS	
MEDICATIONS (MEDS) – (INCLUDING PAIN MEDS), DOSAGE, FREQUENCY AND INDICATIONS	

LABOR & DELIVERY (L&D) WORKSHEET **STUDENTS NAME:**	**THIS IS FOR YOUR PERSONAL USE TO ASSIST WITH EHR DOCUMENTATION WHILE AT CLINICAL.**
PREVIOUS OB HISTORY	Multiple Gestation Yes _____No_____ Previous Cesarean Section Yes _____No _____ Pregnancy Induced Hypertension (PIH) Yes _____No_____ Chronic Hypertension (HTN) Yes _____ No _____ Neonatal Death Yes _____No _____ ANOMALIES Yes _____ No _____ PRECIPITOUS LABOR (<3HRS) Yes _____ No _____ History of Post-Partum Hemorrhage Yes _____ No ____ TRANSFUSION REACTION Yes _____ No _____
Current Labs	
Blood type /Rh factor	Type _____Date Rhogam
Antibody Screen	Negative _____Positive _____
Rubella	Non immune _____Immune_____
Diabetic Screen	Normal _____Abnormal_____
Hepatitis B	Positive _____Negative _____Tested
Human Immunodeficiency Virus (HIV)	Positive _____Negative _____Tested
Group Beta Strep (GBS)	Positive _____Negative _____Tested
Sexually Transmitted Infection (STI)	Positive _____ Negative __ Tested___
Assessment	
CERVICAL DILATION EFFACEMENT STATION	_____centimeters _____percent _____
In which stage and or phase of labor is your client?	
Newborn Assessment	
Fetal Heart Rate (FHR) _____	
FHR variability	a. Decreased _____ b. Average _____ c. Increase _____
Periodic changes in FHR	a. Accelerations _____ b. Early decelerations _____ c. Variable decelerations _____ d. Late decelerations _____
Gestational weight _____	a. Small for gestation age _____ SGA b. Large for gestational age _____LGA c. Appropriate for gestational age ____ AGA
Uterine Activity Evaluation	
External monitor in place (circle one) Yes or No	Internal Monitor-Intrauterine Pressure Catheter (IUPC) Yes or No (circle one)

LABOR & DELIVERY (L&D) WORKSHEET **STUDENTS NAME:**	**THIS IS FOR YOUR PERSONAL USE TO ASSIST WITH EHR DOCUMENTATION WHILE AT CLINICAL.**
Describe uterine contraction pattern.	Frequency: Duration: Intensity: Is contraction pattern within normal limits? _____
Nursing Conventions and Evaluation	
Tasks to assist with during the L & D clinical rotation. Place a check beside tasks you get to assist with:	
Antepartum assessment: _____ Intrapartum care – process and coaching: _____ Auscultation of fetal heart tones: _____ Preoperative preparation and care: _____ Female catheterization: _____ Application of external fetal monitor & Toco transducer: _____ Epidural/spinal anesthesia: _____	Local anesthesia: _____ Identify obstetric complications: _____ a. Pregnancy induced hypertension b. Preterm labor (PTL) c. Gestation Diabetes d. Other

STUDENT EVALUATION OF CLINICAL EXPERIENCE
Practical Nursing

Semester_____
Year_____
Clinical site (NO abbreviations) _____
Preceptor's Name _____

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: _____
_____
_____

Student: _____
Clinical Site: _____ __

PRECEPTOR/INSTRUCTOR EVALUATION
PNSG 2255, 2310, 2320

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

Please provide comments for any scores less than 2.

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

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

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

_____ _____

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

Southeastern Technical College Practical Nursing
Online Clinical Simulation Student Agreement and Instructions

PURPOSE:

- To afford education that stimulates clinical reasoning, critical thinking skills, and time management strategies in an innovative setting.
- To provide a dedicated environment for students to learn strategies that will enhance client safety and the quality of health care via simulation technology. This environment provides the learner opportunities to participate in clinical experiences in a safe, non-threatening, and structured environment.
- To increase the safety and effectiveness of client care through inventive, interdisciplinary training.
- To build confidence in clinical performance, including clinical reasoning and psychomotor skills.
- To increase exposure to critical, yet low-frequency client encounters in order to minimize the risk to clients.
- To increase effective communication among all members of the health care team.
- To use simulation as a tool for the assessment of clinical skills.

GUIDELINES:

- Throughout your time during the simulation experience, you will interact with several different simulation-based learning experiences. This includes screen-based simulation and/or client actors depending on the specific scenario. You must act as you would in an actual clinical setting.
- Simulation fosters active engagement in a safe learning environment. Your role is to enter into the spirit of the simulation while engaging with the client, family, and other members of your healthcare team. This will provide you with the best active learning opportunity possible.
- Remember confidentiality: what happens in simulation stays in simulation. You should participate in simulation with a non-judgmental attitude and be open to learning from your clients, peers and faculty.
- Students should abide by the clinical rules and regulations in the student handbook. This includes, but is not limited to:
    - Attendance/tardiness
    - Clinical preparedness (supplies and equipment)
    - Confidentiality/HIPPA
    - Professional conduct and standards

STUDENT BEHAVIOR IN SIMULATION:

- Professional attitudes at all times.
- You must act as you would in an actual clinical setting.
- No using excuses. Please refrain from saying "this does not look/feel real", " I would not do this in real life", or anything of the sort. Remember this **IS** real.
- Adhere to your assigned role and practice within your scope of practice.

- Treat your team members, clients, and instructors with respect and dignity.
- Disciplinary action for professional misconduct will be followed based on the standards in the PN student handbook.

TIME FRAME:

- **0800** Clinical day starts with pre-briefing session in WebEx.
- Mid-day meeting; see module lesson plan for specific time.
- Lunch break varies dependent upon the specific clinical day. See module lesson plan for specific lunch time.
- Debriefing session in WebEx. Time varies dependent upon the specific clinical day. See module lesson plan for specific debriefing time.
- Students should complete Activities within the learning Module in the sequence that the activities are numbered. Activities are placed in a specific sequence to enhance the clinical simulation experience.
- See learning modules for the specific times that the activities are due.

GENERAL INSTRUCTIONS FOR ACTIVITIES:

- ATI assignments or activities that have been completed previously in another course must be completed again when assigned in a clinical module. Please be aware that ATI activities/assignments have the date and time attached when completed by the student.
- The student should use the allotted time for the activity/assignment as outlined in the clinical module.
- ATI templates can be found on the ATI website and can be downloaded/edited by the student. The student may complete the template by typing or writing the information as long as the template is completed in its entirety.
- Students should have ATI books. The ATI books can also be found on the ATI website.
- Assignments/activities will either be completed from the ATI website or by the student and placed into Blackboard. See modules for specific activity locations.

CLINICAL GRADE FOR ONLINE CLINICAL MODULES:

- The instructor will view the ATI reports to ensure the student has completed the activity with the appropriate time and score.
- Each activity within a module will receive a grade based on ATI score or points for completion. The activity grades will be averaged and the student will receive a final grade for the entire module. See clinical rubric for further details.

Common Questions/Answers about Online/Clinical Simulation

1. I completed my assignment, but my submission time (Dropbox items and lessons/modules within ATI) reflects it is late according to my daily student schedule. Do I still get credit? **Answer: No**. A grade of zero (0) will be recorded. Student receives an email confirmation of assignments submitted into a Dropbox. The email confirmation will state, "Your work was received! You successfully submitted your coursework." The email will also have the date and time received. Further submission details include name of course, name of dropbox, and size of submitted work.

2. Can I login to ATI and minimize my upcoming lesson/assignment during pre or post briefing, as long as I do not go into lesson, send emails, or submit assignments? **Answer: No**. ATI, Blackboard, and emails maintain a record of time. Instructors should have full, undivided attention of the student during these sessions. Under no circumstances should students be engaged in other activities. Please refer to Level III Behaviors in the Student Handbook.

3. I continue to have internet problems, but will this be counted against me? **Answer: Yes.** Please refer to Student Handbook in reference to excessive tardies, early departures, and absences. It is the student's responsibility to secure a place with adequate service. Habitual tardiness is unacceptable. Time missed must be made up at the discretion of the instructor. Remember, this is clinical time.

4. At the end of my day, I discovered that I needed to spend 60 minutes in an ATI module that was scheduled to start at 10:00AM, but I only spent 35 minutes. Can I log back into ATI module for 25 more minutes so that I can capture my clinical time? **Answer: No.** Students are informed to pull their own reports after the completion of an ATI assignment. Once it is discovered (which should be immediately after leaving the session), the student may login back into lesson to complete their time to total 60 minutes. **Once the student starts on the next activity on the daily student schedule, the student has forfeited the opportunity to "add time" to a lesson, quiz, test, posttest.** This applies to ALL activities. Time missed must be made up at the discretion of the instructor. Remember, this is clinical time.

5. I took my Gerontology Practice Quiz in ATI, but I failed to "submit" at the end of the quiz. Can I submit now, and receive credit? **Answer: No.**

6. I submitted my assignment to the WRONG Dropbox by the deadline. Do I receive credit for my work? **Answer: No.**

7. I completed all of my EHR documentation, but I completed it in the WRONG course. Do I receive credit for my work? **Answer: No.**

8. Is my instructor being unfair by counting off points for spelling and grammar, even though I excelled in critical thinking as well as grasped the objective? **Answer: No.** Grammar and spelling matter. Appropriate grammar and spelling reflect professionalism and is critical in the nursing world. Simply, it matters!

9. I forgot to tell my instructor that I would be late joining the prebriefing/postbriefing session. Will this be counted against me? **Answer: Yes.** This is clinical. Refer to Student Handbook.

What is meant by “what happens in simulation, stays in simulation? **Answer:** Look in Student Handbook: Unprofessional behaviors: Level 1 (One) behaviors

Virtual Clinical Module Grading Rubric

- ATI activities will receive numeric grade/score.
- Activities such as completion of templates, case study response, and reflection questions will receive points for completion.
    - See Blackboard activities grading rubric.
- The activity grades will be averaged together to form one final grade for each clinical module

EXAMPLE:

ACTIVITY	POINTS POSSIBLE	GRADE/POINTS EARNED
Activity 1	10	90% ATI grade = 9 points
Activity 2	10	10 points for complete templates
Activity 3	10	9 points for one area incomplete on medication cards
Activity 4	10	70% ATI grade= 7 points
Activity 5	10	100% ATI grade= 10 points
Activity 6	10	Case study and response complete= 10 points
Activity 7	10	88% ATI grade = 8.8 points
Activity 8	10	60% ATI grade = 6 points
Activity 9	10	Reflection questions answered= 10 points
Activity 10	10	100% ATI grade = 10 points
		Final grade for clinical module: 89.8

MODULE 1

ACTIVITY	POINTS POSSIBLE	GRADE/POINTS EARNED
Activity 1	10	
Activity 2	10	
Activity 3	10	
Activity 4	10	
Activity 5	10	
Activity 6	10	
Activity 7	10	
Activity 8	10	
Activity 9	10	
Activity 10	10	
		Final grade for clinical module:

Blackboard Activities Grading Rubric

Grade	
100	Assignment is completed in its entirety. Does not contain any inaccurate information and is not lacking any clinically important information.
90	Assignment is nearly complete with the exception of one area - inaccurate information or lacking clinically important information in one area.
80	Assignment is nearly complete with the exception of two areas - inaccurate information and/or lacking clinically important information in two areas.
70	Assignment is nearly complete with the exception of three areas – inaccurate information and/or lacking clinically important information in three areas.
60	Assignment is nearly complete with the exception of four areas – inaccurate information and/or lacking clinically important information in four areas.
50	Assignment is nearly complete with the exception of five or more areas – inaccurate information and or lacking clinically important information in five or more areas.
0	Assignment not done or submitted late.

_____ Preliminary Activity Grade

Points deducted from preliminary activity grade for spelling / grammar errors:

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

_____ Final Activity Grade

Example:
Preliminary Grade = 80 (two areas incomplete)
2 points deducted for 5 spelling errors
Final Activity Grade = 78

ONLINE VIRTUAL ATI CLINICAL DAY:

Real Life Clinical Reasoning Instructions and Grading

Real Life Clinical Reasoning Scenarios encourage critical thinking, clinical decision making, and clinical judgment by presenting students with a realistic clinical scenario which takes on a unique path based on students' decisions. Students are challenged to make important healthcare decisions that significantly impact client outcomes.

When students complete a scenario, an Individual Report is automatically generated. The report provides an overall reasoning score, performance related to outcomes (QSEN, NCLEX Client Need Category, and Body Function), and feedback on questions answered. The question, selected option, and rationale for the option are provided for the student to review.

The score for the scenario will be the average of the individual outcome scores as noted on the Individual Performance Profile for that scenario. The student will receive their grade on the first attempt at the scenario. If during the scenario attempt, a decision or series of decisions are made that could result in harm to the client or impact the client negatively the scenario will end prematurely. At this point, the student will be able to see their individual scores and rationales. If the student has not utilized all of their time, they should retake the scenario utilizing the optimal decisions. This will ensure they get credit for the entire duration of the assigned time. If the student has exhausted their time they must move on to the next activity as outlined in the schedule.

Students are encouraged to keep a copy of their individual performance profile for their records.

ATI Clinical Online Module

Activity	Time	Resource Location	Complete
0800-0830 Prebriefing Session • Review instructions and grading for online Real Life Scenarios • Consider your clinical rotation, what potential or actual safety risks did you observe? How could they have been avoided? • During your clinical rotation what type of cultural issues did you observe? • Describe moral distress and burnout. Did you observe any burnout on your assigned unit? What made you suspect burnout? What do you feel was a factor in the situation? Explore resources that you can use for resolution.	30 min	WebEx	
Activity 1 (0830-0915) • Complete assigned reading on gestational diabetes (p. 55, 56) in ATI Maternal Newborn book. Review and reread content on Gestational Diabetes in your FA Davis book • Fill out System Disorder form as a reference for Gestational Diabetes	45 min	MY ATI > Active Learning Templates, Blackboard	
Activity 2 –(0915-1015) Real Life Maternal Newborn 3.0 Complete the scenario for: Gestational Diabetes	60 min	MY ATI > APPLY	
Activity 3: (1015-1100) • Complete assigned reading on uterine atony (p. 110) and postpartum hemorrhage (pg 109) in ATI Maternal Newborn book. Review and reread content on Postpartum hemorrhage and uterine atony in your FA Davis book • Fill out the System Disorder form as a reference for Uterine Atony.	45 min	MY ATI > Active Learning Templates, Blackboard	
Activity 4 – (1100-1200) Real Life Maternal Newborn 3.0 Complete the scenario for: Postpartum Hemorrhage	60 min	MY ATI > APPLY	
1200-1215 Mid-Day Meeting **1215-1315 LUNCH** ***Activities 1 – 4 must be completed by 1300.**			

Activity 5 – (1315-1400) Real Life Maternal Newborn 3.0 Complete the scenario for: Preterm Labor	60 min	MY ATI > APPLY	
Activity 6 (1400-1445) • Complete assigned reading on gestational hypertension (p. 56-57) in ATI Maternal Newborn book. • Fill out the System Disorder form as a reference for Gestational Hypertension. Review and reread content on Gestational Hypertension in your FA Davis book	45 min	MY ATI > Active Learning Templates, Blackboard	
Activity 7 – (1445-1545) Real Life Maternal Newborn 3.0 Complete the scenario for: • Preeclampsia	60 min	MY ATI > APPLY	
Activity 8– (1545-1645) Real Life Maternal Newborn Complete scenario for: • Teaching Prenatal Care and Newborn Care	60 min	MY ATI > APPLY	
***ACTIVITIES 5 – 8 MUST BE COMPLETED BY 1645**			
1645-1715 Debriefing Session After completion of the above scenarios, engage in facilitated group debriefing. • Reactions (Emotions) ▪ How did these scenarios go? ▪ How do you feel about the scenarios? • Analysis ▪ What were individual scenarios about? ▪ What happened to this clients? ▪ Why did it happen this way? ▪ How could this have been prevented? • Summary ▪ What worked well in these scenarios? ▪ What can we learn from these cases? ▪ What could have been performed in a better way? If you happen to deal with a similar cases in the clinical setting in the future, what learning point will you particularly consider?	30 min	Webex	
Activity 9 –(1715-1815) Learning System PN 3.0 Complete the quiz for Nursing Care of Children Final	60 min	MY ATI > TEST	

Activity 10 – (1815-1930) Reflection Reflect on how you performed on the activities in this module. Complete a Blackboard entry (at least 1 page, 12 Calibri font, double-spaced) on the following questions: 1. Share outcomes from similar simulation or real-life experiences that demonstrated professionalism. 2. Compare and contrast observations of actual and ideal practice as it relates to client, visitor and/or staff member safety. 3. Reflect on safety risks or errors while watching the scenario or during debriefing. 4. Describe strategies you employ to support resilience and mitigate burnout in your nursing practice. 5. Describe and "Aha" moment you experienced during the simulation and how you will apply this to your work as a member of a team in the future.	75 min		

*** ACTIVITIES 9 - 10 MUST BE COMPLETED BY 2000.**

A Note to the Student

Simulation

Simulation training allows you to learn and practice how to act and react in a real-life patient encounter. Simulation in teams provides a safe environment to learn from mistakes, improve communication, and develop critical thinking skills.

It is important to understand that to maximize the benefits of the simulation for you and your fellow students, you must enter into the spirit of the story and act as if the simulator is a real patient. Believing the simulation and trying not to break the illusion will make it a much better learning experience.

The Simulator/Patient

The patient you encounter will have a name, age, weight, and unique medical and social history. The patient simulator features, controlled by the instructor, allow you to assess and reassess relevant baseline vital signs, symptoms, and feedback from your patient, and to perform multiple procedures. The features include:

- Speaking/voice response
- Spontaneous breathing with variable respiratory rate, visible chest rise and fall, and 4 anterior auscultation sites
- BP measured manually by auscultation of Korotkoff sounds
- Independent right and left lung sounds synchronized with breathing
- Heart sounds synchronized with ECG
- Bilateral carotid and brachial pulse, radial pulses (right side only), variable with blood pressure
- Multiple birthing positions
- Discharge of blood and amniotic fluid
- Urinary function – catheterization possible
- IV access/IV fluid connection in both arms
- Subcutaneous and intramuscular injection sites (deltoid and lateral thigh)
- Fetal heart sound/bowel sounds
- Vaginal delivery of infant
- Variable uterine tonus, which can be felt by palpation

During the simulation an interactive patient monitor will be available. On the monitor, measurement of fetal heart rate/pattern, uterine contraction pattern, blood pressure, pulses, temperature, and other vital signs can be read.

Participants in simulation often feel some degree of stress from the experience. This is due to a variety of factors. For example, practicing in an unfamiliar setting, the uncertainty of the experience itself, and watching oneself on videotape, either alone or with colleagues, can produce some degree of anxiety in most people. Generally, this type of stress is benign and actually may contribute to the learning experience.

Debriefing

When the actual simulation is finished, a debriefing/guided reflection session can be a valuable learning experience. During debriefing, you can receive feedback on your performance from your fellow students and the instructor. The debriefing also should be a time for you to get answers to your questions and to any uncertainties that may have come up during simulation.

Report to Students

Name: Amelia Sung

Age: 36 years

Gender: Female

Time: 0700 h

Report:

Amelia Sung is a 36-year-old Filipino woman, G2P1 (L1) at 39 weeks gestation, who was admitted 6 hours ago in active labor. At admission she was 4 cm dilated, 100% effaced, -1 station, and fetus in vertex position. Epidural anesthesia was initiated at 0230 h. At 0330 h her membrane ruptured; fluid was clear; dilation was 6 cm and the fetus still at-1 station in vertex position. Two hours ago she was fully dilated and started pushing. The fetal heart rate has been stable with a baseline of 120-130/min, moderate variability, and variable decelerations since she started pushing. She is getting tired from pushing, and the descent of the fetal head has been slow. In the past few contractions the fetus has started to crown. She is given O_2 at 10 L/min per non-rebreather mask for decelerations, and an IV with lactated Ringer's is running at 125 mL/h. Her last delivery ended with shoulder dystocia because the baby was large. The provider has been called and will arrive soon, so Amelia may continue pushing.

Obstetric Admission Card

Patient Name: Amelia Sung		**Allergies:** Penicillin	
Demographics:			
Gender: Female	**Age:** 36 years	**Height:** 157 cm (62 in)	**Weight:** 73 kg (160 lbs)
MR#: 057631	**Gestation week:** 39	**Gravida:** 2	**Para:** 1 (L1)
Marital status: Married		**Race:** Filipino	
Next of kin: Husband		**Religion:** Catholic	
Physician: Dr. Jeff Smith		**Language:** English	

History:

Medical:
Previous shoulder dystocia. No surgical history.

Pregnancy:
- Registered for prenatal care at 6 weeks, dates confirmed by 1st trimester ultrasound
- Declined genetic screening or testing
- Total pregnancy weight gain 18 kg (40 lbs)
- 1-hour glucose screen at 26 weeks 145 mg/dL, and 3-hour glucose tolerance test (within normal limits)
- Blood type: O positive
- Group B Strep at 36 weeks: Negative
- Estimated fetal weight at 38 weeks by ultrasound: 3600 g (7 lbs 15 oz)

First born male delivered vaginally 3 years and 3 months ago. Weight: 3912 grams (8 lbs 10 oz). Length: 55 cm (22 in). Delivery complicated by shoulder dystocia.

Social:
Works as bank clerk, lives with husband and 3-year-old child. Emigrated from the Philippines at age 5 with her family.

Indication for Admission:

☐ Scheduled augmentation	☐ Labor assessment	☐ Scheduled C-section
☐ Preterm labor	☐ Severe preeclampsia	☐ Diabetes type 1
☐ Rupture of membranes	☐ Premature rupture of membranes	☐ Placenta previa
☑ Other: In active labor		

Admission Status:

☑ Inpatient	☐ Observation	☐ Outpatient in a bed

Admit to: Labor and Delivery Unit

Additional Clinical Signs

Fetal head is crowning

Laboratory Data

Blood type, screen, and serology from prenatal record

Medical History

Patient Data

Gender: Female
Age: 36
Weight: 73 kg (160 lbs.)
Height: 157 cm (62 in)
Gravida: 2 Para: 1 (L1)
Gestation week: 39
Allergies: Penicillin
Religion: Catholic

Examinations:

- Admission at 0100 h: dilation 4 cm, 100% effaced, fetus in vertex position at -1 station
- 0330 h: dilation 6 cm, 100% effaced, fetus in vertex position at -1 station
- 0500 h: dilation 10 cm, 100% effaced, fetus in vertex position at 0 station

Past Medical History

Allergic to Penicillin (hives). Previous shoulder dystocia. No surgical history

Pregnancy History

Registered for prenatal care at 6 weeks, dates confirmed by 1st trimester ultrasound. Declined genetic screening or testing. Total pregnancy weight gain 18 kg (40 lbs.).Taking prenatal vitamins daily.

1-hour glucose screen at 26 weeks 145 mg/dL, and 3-hour glucose tolerance test (within normal limits). Estimated fetal weight at 38 weeks by ultrasound: 3600 g (7 lbs 15 oz)

Blood type: O positive. Group B Strep at 36 weeks: negative.

First born male delivered vaginally 3 years and 3 months ago. Weight: 3912 grams (8 lbs 10 oz). Length: 55 cm (22 in).

Physician Orders

Immediately available:
See admission card

Obstetric Admission Card — Continued

Date	Time	Physician Orders
		Call Orders: ☑ Systolic BP greater than 140 mm Hg or less than 90 mm Hg ☑ Diastolic BP greater than 90 mm Hg ☑ Pulse rate greater than 100 bpm or less than 50 bpm ☑ Oral temperature greater than 38° C (100.4° F) ☑ SpO_2 less than 94% ☑ Meconium stained fluid ☑ Non-reassuring fetal HR ☑ Rupture of membranes greater than 12 hours ☑ Positive HIV rapid test results ☑ Other: rupture of membranes, vaginal bleeding, abdominal or epigastric pain, call provider with significant changes
		Activity: ☐ Bed rest ☐ Bedside commode ☑ Bathroom privileges ☑ Up ad lib ☐ May shower for pain relief and/or comfort ☑ May use labor tub for pain relief and/or comfort if fetal HR is reassuring
		Assessments **Maternal:** ☑ BP Q 1 hour x 2 then Q 4 hours ☑ Temp, HR, RR Q 1 hour ☑ Temp Q 2 hours after rupture of membranes intrapartum or if temp greater than 38° C (100.4° F) orally ☐ System assessment ☐ Q 8 hours ☑ Q 4 hours ☐ Deep tendon reflexes ☑ Q 4 hours ☐ Q 2 hours ☐ Q 1 hour ☑ Continuous pulse oximetry ☑ Breath sounds Q 4 hours ☑ Obtain baseline maternal weight, then daily weights ☐ Other: **Fetal:** ☑ Continuous external monitoring (fetal HR and uterine activity) ☐ Auscultate fetal HR per doptone per: ☐ Low risk guidelines ☐ High risk guidelines ☐ Non-stress test ☐ One hour monitoring ___ times daily ☐ Continuous uterine monitoring only ☐ Other: **Labor:** ☐ No vaginal exams ☑ Vaginal exams by: ☑ Physician ☑ Certified Nurse-Midwife ☐ RN
		Intake and Output: ☐ Strict I&O ☐ Every shift ☐ Every hour ☑ In and out catheterize Q 4 hours PRN with epidural ☐ Anchor Foley catheter ☐ Foley with urometer

Obstetric Admission Card – Continued 2

Date	Time	Physician Orders
		Precautions: ☐ Initiate/maintain seizure precautions ☐ Minimize outside stimuli (light, noise, visitors)
		Venous Thromboembolism (VTE) Prophylaxis: ☑ VTE pharmacological prophylaxis NOT indicated: ☑ Low Risk ☐ Patient fully anticoagulated ☐ Encourage ambulation
		Nutrition: ☐ NPO ☐ Ice Chips ☐ Carb control 4 carb choices ☐ With _____ snacks ☑ Regular as tolerated ☐ Clear liquid ☐ Carb control 5 carb choices ☐ Soft diet
		Continuous Infusions: ☐ None ☑ Initiate IV care protocols as appropriate, including: • Central venous catheter care protocols • Peripheral venous catheter care protocol • Peripherally inserted central catheter care protocol ☐ Peripheral lock ☐ Other:_____
		Medications: For non-reassuring fetal heart pattern ☑ Lactated Ringer's 500 mL IV bolus
		Routine Tests: ☑ Complete blood count, STAT ☑ Blood type and screening ☐ Syphilis Treponemal IgG (if not documented x 2 on prenatal record), STAT ☐ HIV–1/2, POC (tuberculosis)
		No Prenatal Care Tests: ☐ Complete Blood Count, Syphilis Treponemal IgG, Type and screen, Rubella IgG, Urine drug screen, Hepatitis B Antigen, STAT <u>Indication: No prenatal care</u> ☐ Sickle Cell Screen, STAT ☐ HIV–1/2, POC (tuberculosis) Cultures: ☐ Vagino-rectal Group B Strep GBBS ☐ Gonorrhea/Chlamydia/DNA probe - Source: ☐ Urine ☐ Vaginal ☐ Cervical

Obstetric Admission Card – Continued 3

Date	Time	Physician Orders
		No Prenatal Care Tests - Continued: ☐ Bedside ultrasound per OB Resident/Certified Nurse-Midwife. Indication: Estimated fetal weight and gestational age assessment ☐ Platelets, STAT ☐ Coagulation screen, STAT ☐ Basic metabolic panel, STAT ☐ Comprehensive metabolic panel, STAT ☐ Fasting blood sugar, STAT ☐ K and glucose STAT and then Q 6 hours ☐ Hepatic function panel, STAT ☐ SGOT (AST) (liver function test), STAT ☐ LDH (tissue damage), STAT ☐ Uric acid, STAT ☐ Kleihauer Betke, STAT ☐ Fetal fibronectin (fFN), STAT ☐ Other:_____
		Urinalysis: ☐ UA Child Care Management System/Catheter, STAT ☐ Urine culture, STAT ☐ 24-hour urine for total protein and creatinine clearance ☐ Urine drug screen Indication:_____
		Bedside Testing: ☐ Blood glucose meter: ☐ AC (before meal) and 3 hours after meal ☐ Fasting ☐ 2 hours post prandial ☐ Other: ☐ Tuberculosis skin test (PPD) ☐ Bedside ultrasound per OB Resident/Certified Nurse-Midwife. Indication:_____
		Cultures: ☐ Vagino-rectal Group B Strep – obtain if results not on prenatal record ☐ Gonorrhea/Chlamydia/DNA probe - Source: ☐ Urine ☐ Vaginal ☐ Cervical
		Radiology: ☐ OB ultrasound per radiology. Indication:_____ ☐ Do not do a transvaginal ultrasound ☐ In radiology ☑ At bedside
		Respiratory Care: ☑ Oxygen 10 L/min per rebreather mask for non-reassuring (Category II or III) fetal heart rate ☑ May discontinue oxygen when fetal heart returns to reassuring (Category I)

Obstetric Admission Card – Continued 4

Date	Time	Physician Orders
		Consults: ☑ Anesthesia Indication: ☑ Epidural ☐ PRN ☑ After 5 cm cervical dilatation ☑ Other: Obtain BP and HR Q 5 minutes for 20 minutes after epidural initiated or until patient is stable. Then Q 15 minutes until delivery ☐ Maternal-Fetal Medicine Indication: ☐ Care Coordinator Indication: ☐ OB Attending Staff Indication: ☐ Neonatology Indication: ☐ Social Service Indication: ☐ Other:_____ Indication:_____ ☐ Chemical Dependency/Chronic Pain consult Indication: ☐ Illicit drugs and prescribed medications ☐ Chronic pain drugs *(cross of one or both)*
		Others:

Medication Administration Record

Patient Name: Amelia Sung		**Allergies:** Penicillin	
Demographics:			
Gender: Female	**Age:** 36 years	**Height:** 157 cm (62 in)	**Weight:** 73 kg (160 lbs)
MR#: 057631	**Gestation week:** 39	**Gravida:** 2	**Para:** 1 (L1)
Marital status: Married		**Race:** Filipino	
Next of kin: Husband		**Religion:** Catholic	
Physician: Dr. Jeff Smith		**Language:** English	

Medication	Schedule	Day 1	Day 2	Day 3	Day 4
Lactated Ringer's 1000 mL IV 125 mL/hr	Now	0130 NN			
Epidural anesthesia initiated	Discontinue when delivery complete	0230 NN			

PRN Medication	Schedule	Day 1	Day 2	Day 3	Day 4

INITIALS	PRINT NAME	SIGNATURE
NN	Nina Nilsson	Nina Nilsson

Labor Data Collection Form

Patient Name: Amelia Sung	**Allergies:** Penicillin

Demographics:

Gender: Female	**Age:** 36 years	**Height:** 157 cm (62 in)	**Weight:** 73 kg (160 lbs)
MR#: 057631	**Gestation week:** 39	**Gravida:** 2	**Para:** 1 (L1)
Marital status: Married		**Race:** Filipino	
Next of kin: Husband		**Religion:** Catholic	
Physician: Dr. Jeff Smith		**Language:** English	

	Maternal vital signs					Fetal		Contrac-tions		Vaginal exam				
Time	Temp/Site	Heart rate	Blood pressure	Respiratory rate	SpO_2	Fetal heart rate baseline	Electronic fetal monitoring (Y/N)	Frequency	Duration	Effacement	Dilatation	Station	**Observations** (bleeding, ROM, color, fetal position, etc.) **Procedures** (amniotomy, block, etc.)	Initials
0100	37	82	126/78	20	99	120		4	70	100%	4	-1		
0230	37.2	86	128/80	20	98	125		4	70				Epidural initiated	
0330	36.9	88	134/80	22	97	125		3	70	100%	6	-1	Membranes ruptured. Clear fluid	
0500	37	86	138/78	20	98	130		3	60	100%	10	0	Pushing started	

Assessment findings:

Labor Data Collection Form – Continued

I&O

Time	IV Infusions				Intake				Total IN	Output				Total OUT	Initials
				Total IV intake	PO	Enteral (meds, flushes, irrigations)	Tube feeding (Type: _____)	Total PO/Enteral intake		NG/OG (Clamped/LIS/LCS)	Emesis	Urine	Stool (size, color, character)		
0630												350 mL			

Plan of care:

Notes:

Lab Data

Patient Name: Amelia Sung		**Diagnosis:**	
Allergies: Penicillin			
DOB:	**MR#:** 057631	**Date:**	**Time:**

Test	Result	Reference range
Transferred from prenatal record		
Blood type		
Blood type	O+	
Serology		
HIV- ½ antibody screen	Nonreactive	
Group B Streptococcus	Negative	
Gonorrhea/Chlamydia GC/CT	Negative	
Syphilis Treponemal IGA	Nonreactive	
Hepatitis B	Negative	
Rubella	Immune	