ARKANSAS TECH UNIVERSITY

DEPARTMENT OF NURSING

NUR 4405

PRACTICUM IN NURSING III

NURSING CLIENTS IN CRISIS

Spring 2012
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Course: NUR 4405 (01)

Course Title: Practicum in Nursing III - Nursing Clients in Crisis

Credit Hours: Five (5) Hours

Contact Hours: Five (5) Hours

Placement: Senior Year

Instructors:

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Catalogue Description:

This is a clinical nursing course that provides the opportunity for the integration of concepts and theories taught in NUR 4206. Expected nursing behaviors include promotive, supportive and restorative behaviors. The nursing process is applied in a caring way to the care of clients undergoing major psychosocial and/or physiological maladaptations. The nursing roles utilized in the delivery of care are those of communicator, care giver, collaborator, researcher, teacher, and advocator. The quality of care is measured according to the criteria of professional nursing standards. The practicum is conducted in hospitals, outpatient treatment programs and other community settings.

Required Textbooks:

Retain texts from previous nursing courses.

Additional Texts:


Optional Text:

Nursing Diagnosis Text

Auto-tutorial materials are available in the Student Learning Laboratory for student use.

Bibliography

Use the required and suggested readings in this syllabus and in the Nursing Theories and Concepts syllabus, readings at end of chapters in texts and the computerized nursing indexes as bibliography.

Justification/Rationale for the Course

By the completion of this course the student will progress toward program goals/outcomes 1, 2, 3, and 4.

This upper division professional nursing practicum course provides opportunities for the student to apply knowledge and skills from the general education component and from nursing courses to the care of individuals, families and groups.
C. Course Objectives:
On completion of the course, the student should be able to:

1. Utilize the nursing process to provide care for individuals, families, and groups who are experiencing physical and/or psychological mal-adaptation.

2. Incorporate promotive, supportive, and restorative concepts in the application of nursing care to individuals, families, and groups in crises.

3. Incorporate roles of care giver, communicator, researcher, teacher, collaborator, and advocator in delivery of nursing care.

4. Apply nursing theories and concepts in the care of individuals, families, and groups experiencing crises.

5. Integrate professional nursing standards into nursing practice.

6. Recognize legal and ethical issues related to the delivery of professional nursing care for clients in crises.

7. Demonstrate scientifically based psychomotor and psychosocial skills.

8. Value the bio-psycho-social, spiritual, and cultural aspects of man in the delivery of caring, holistic nursing care.

9. Apply clinical research findings as they relate to the care of individuals, families, and groups who are experiencing physical and/or psychological crises.

Assessment (Evaluation) Methods

1. Grading Scale

   A = 90-100
   B = 80-89
   C = 75-79
   D = 68-74
   F = 67 and below

2. A grade of “C” or above must be achieved in every nursing course in order to progress in the nursing program.

3. A semester grade of "I" or "Incomplete" maybe recorded for a student who has not completed all the requirements of a course because of illness or other circumstances beyond the student’s control, provided work already completed is of passing quality. Before a grade of “I” may be recorded, the student and instructor must determine course requirements to be completed and the completion date. (See Student Handbook)
4. Course Grade

Clinical Performance.................................................80%
(Includes Daily Care Plans and other written work)
Case Presentation.......................................................20%

100%

5. All paperwork is due on the date assigned. Failure to meet the deadline may result in a lower grade on paperwork.

Clinical performance must be at least 75% before case presentation will be averaged with that grade.

A grade of 75% or above must be achieved in each clinical area before a passing grade is earned for the course. If a clinical grade falls below a 75%, the student will not be successful in passing Practicum III.

Professional Points: Maximum of two points may be designated for this course.

Communication

A great deal of communication between faculty and students will take place through Blackboard. It is the student’s responsibility to regularly check for email messages on their ate.edu e-mail and Blackboard announcements.

Policies

Practicum Attendance:

1. The student must attend, on a regular basis, all nursing experiences as attendance is an indicator of professionalism. Absences will be reflected in the evaluation of the student's ability to meet course objectives and may seriously jeopardize the student's grade. For clinical rotations, an absence will result in a make-up assignment. Make-up assignments will equal the number of clinical hours missed. Assignments may vary with instructor. Failure to make up clinical assignments will result in failure of the course. The student is responsible for contacting the instructor regarding make-up assignments within one week of absence. If a student is absent for more than 2 clinical days, the student may be dropped from the course.

2. The student is responsible for being prepared and on time for all clinical experiences. The student shall review pertinent content and objectives from Nursing 4206 and pertinent objectives and content from this syllabus prior to arrival at the clinical setting.

3. In the rare event of a necessary absence, personal notification must be made to the proper agency as well as to the clinical instructor prior to the absence.

4. Planned learning experiences outside the classrooms are an integral part of the nursing course. These experiences will be announced at least three (3) weeks in advance and all students are expected to participate.

5. The student is responsible for verbally notifying the instructor if he/she will be late to clinicals. Tardiness reflects a lack of professionalism and excessive tardiness will be reflected on students evaluations.

Background Checks:

Students will be required to complete a criminal background check per departmental policy.

Insurance:

All students must show evidence of having liability insurance prior to starting clinical experience.

C.P.R. Certification/TB Skin Test/Hepatitis B Vaccination

All students must present evidence of American Heart Association certification for cardiopulmonary resuscitation, negative TB skin test, and completion of the Hepatitis B vaccinations, as required by the Department of Nursing.

Transportation:

Students are responsible for having transportation to clinical sites. Students may be required to attend clinical in cities such as Fort Smith, Morrilton, or Conway.

Dress and Behavior:

1. The student must wear the standard school uniform while attending any clinical experience. Appropriate street clothes will be worn in psychiatric care settings. Students are expected to be neat and clean in appearance. When obtaining clinical data for the client assignments, students must wear a laboratory coat with an ATU name badge over their appropriate street clothes (see Dress Code, Student Handbook).

2. The students will be expected to maintain a professional attitude at all times while in the clinical area. Client confidentiality must be maintained. Students will abide by the agency’s regulating policies.

3. Students are expected to:
   a. Present written work that is theirs alone.
   b. Correctly document any materials from a textbook, pamphlet, journal, etc. that is used for an assignment.
   c. Only use authorized devices or materials for an examination and no copying from other students’ papers.

4. Plagiarism is defined as stealing and presenting as one’s own ideas or words of another, or not documenting material correctly. Any identified plagiarism will be automatic failure and dismissal from the program.

5. All resources must be documented on clinical paperwork.

Clinical Facility Policies

All students will adhere to each clinical facility’s policies regarding time spent in the facility, i.e., background check, drug screening, HIPPA training, orientation, etc.
Medication Calculation Exam:

1. The student must pass the Level III medication calculation exam before administering medications in the clinical setting.

2. Passing score is considered to be 100%.

3. The student may have three attempts to pass the exam.

4. If the student does not pass the exam after the third attempt, the student will be withdrawn from the course.

COURSE OUTLINE

PRACTICUM IN NURSING III:

I. Orientation

II. Psychosocial related foci

III. Physiological related foci

IV. Tri Chapter Research Day

Teacher Role:

Demonstrator, Evaluator, Facilitator, Resource Person, Role Model, Communicator, and Supporter

Student Role:

Learner, Teacher, Advocate, Care Giver, Collaborator, Communicator, and Researcher

Teacher-Learning Strategies:

A variety of critical thinking activities, including:

Pre and post care conferences, actual and simulated demonstrations, use of resource persons, charts, diagrams, anatomical models, selected observational experiences, nursing interventions for selected groups and selected clients, role play and role modeling, nursing rounds, process recordings, nursing care plans, auto-tutorial materials, and milieu and mental status assessments.
### Clinical Performance Evaluation Tool (CPET)

**Student:** ____________________________  **Clinical Area:**  __________________________

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Faculty Signature: __________________ Student Signature: __________________

Date:________

COMMENTS:
# Clinical Performance Evaluation Key

1. **Patient Centered**
   - **a.** Understands the patient values, preferences, and their expressed needs as part of clinical interview. Implements the place of care as incorporated in the nursing process, including the evaluation of care.
   - **b.** Communicates the patient values, preferences, and their expressed needs to other members of the health care team.
   - **c.** Uses the situational context, with background, assessment, and recommendations (SBAR) to structure care for the patients with other members of the health care team.
   - **d.** Assesses the presence and extent of pain and suffering and makes recommendations to help improve such.
   - **e.** Assesses levels of physical and emotional comfort and makes recommendations to help improve such.

2. **Teamwork & Collaboration**
   - **a.** Demonstrates awareness of own strengths and limitations as a team member.
   - **b.** Functions competently within own scope of practice as a member of the health care team.
   - **c.** Initiates requests for help when appropriate to the situation.
   - **d.** Communicates with team members, adapting own style of communicating to needs of the team and situation.

3. **Evidence Based**
   - **a.** Demonstrates knowledge of basic scientific methods and processes.
   - **b.** Differentiates clinical opinion from research and evidence summaries.
   - **c.** Bases individualized care plan on patient values, clinical expertise, and evidence.
   - **d.** Reads original research and evidence based reports related to area of practice.

4. **Quality Improvement**
   - **a.** Describes strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice.
   - **b.** Recognizes that nursing and other health professions students are parts of systems of care and processes that affect outcomes for patients and families.
   - **c.** Gives examples of the tension between professional autonomy and system functioning.
   - **d.** Explains the importance of variation and measurement in assessing quality of care.
   - **e.** Describes approaches for changing processes of care.

5. **Safety**
   - **a.** Demonstrates effective use of technology and standardized practices that support safety and quality (medication administration).
   - **b.** Demonstrates effective use of strategies to reduce risk of harm to self or others.
   - **c.** Uses appropriate strategies to reduce reliance on memory (e.g., forcing functions, checklists).
   - **d.** Communicates observations or concerns related to hazards and errors to patients, families, and health care team.

6. **Informatics**
   - **a.** Explains why information and technology skills are essential for safe patient care.
   - **b.** Navigates the electronic health record.
   - **c.** Documents and plans patient care in an electronic health record.
   - **d.** Recognizes the time, effort, and skill required for computers, databases, and other technologies to become reliable and effective tools for patient care.

Clinical Performance Evaluation Tool Guidelines

- Each student will self-evaluate at the end of each rotation by completing a CPET.
- Each faculty member will complete a CPET for each student at the end of each clinical rotation.
- Each row item must be evaluated by the final evaluation.
- The clinical score will be determined by clinical faculty placing an “S, NI, N/A, N/O, or U.”
- The score for clinical evaluation will be either “passing” or “failing.”
- A passing grade will only be assigned IF all items are checked “S” at the end of the final evaluation.

Core Competencies Key
- Each core competency has a template or key, which specifies individual guidelines and examples for each.
- The keys are based on level of matriculation in each clinical course.

Grading Guidelines, Entire Course
- The score for each student in the course will be the numeric grade received for the course based on all of the didactic work required in the clinical syllabus.
- Clinical performance will be evaluated with the Clinical Performance Evaluation Tool (CPET), and will be scored either “pass” or “fail.”
- Every student must receive a score of “pass” on the CPET to pass the course.
- If a student receives a “fail” on the CPET, the student will receive an “F” for the course.


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<tr>
<th>Grade calculation:</th>
<th>Clinical Coursework</th>
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<tr>
<td>20% Intensive Care</td>
<td>2 clinical quizzes</td>
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<td>2 articles</td>
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<td>20% Medical-Surgical</td>
<td>2 clinical quizzes</td>
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<td>20% Psychiatry</td>
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<td>15% Professionalism</td>
<td>Professionalism evaluated on five behaviors (5pt each clinical):</td>
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<tr>
<td>5% ICU</td>
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<td>5% Med.-Surg.</td>
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<td>D. Notifies clinical faculty of absence or tardiness</td>
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<td>E. Follows policy and procedure of clinical facility</td>
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<tr>
<td>15% Case Presentation</td>
<td>Guidelines in syllabus</td>
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<tr>
<td>10% Paperwork</td>
<td>Consult clinical faculty and syllabus for requirements</td>
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Faculty and students are also referred to the QSEN pre-licensure competencies @ http://www.qsen.org/ksas_prelicensure.php

S = Satisfactory
NI = Needs Improvement
U = Unsatisfactory
N/A = Not Applicable
# ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 4405 – Practicum in Nursing III
**Final** CPET Scoring

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Faculty Signature: __________________  Student Signature: __________________
Date: __________

Faculty Signature: ________________
Faculty Signature: ________________
Faculty Signature: ________________

**COMMENTS:**
Guidelines for Case Presentation

Each student will present a patient case study. You will be required to present a PowerPoint presentation to your selected group members and instructor(s). Groups will be formed at the beginning of the semester and will be posted in Blackboard. Each instructor will facilitate the group assigned to them and may require group discussions prior to presenting your case presentation. Below are the requirements for your presentation. Please use the headings below for your PowerPoint slides.

1. **Introduction**
   - Give an introduction to your patient (age, gender, etc.)
   - Discuss the medical diagnosis (diagnosis, what happened, etc.)
   - Discuss the priority nursing problem (What should you as a nurse focus on or do?)

2. **History**
   - Identify past medical history
   - Identify past treatments received up to the time of admission (medications, treatments, surgeries, lab tests, etc.)

3. **Pathophysiology/Psychopathology**
   - Fully explain their disease process

4. **Nursing Physical Assessment/Mental status Assessment**
   - Write out a complete Head to Toe assessment or Mental Assessment, including: vital signs, intake and outputs, diet therapy, intravenous therapy (Be specific)

5. **Related treatments**
   - Discuss medical and/or environmental treatments your patient is receiving at the time of care, addressing patient’s present diagnosis.

6. **Nursing care plan**
   - Identify at least 3 nursing diagnosis and nursing goals
     - Priority nursing diagnosis written in Nanda format written in specific, measurable terms
   - Nursing Interventions
     - Interventions specific to the goals and nursing diagnosis
     - Supported by evidenced based on rationales with sources listed
     - Individualized to this patient’s case
   - Evaluation
     - Identify patient responses to these interventions
     - Determine if goals were met
   - Modifications
     - Modify plan of care base on care plan evaluations
     - Recommend what patient/nurse should do in future to continue recovery/improvement
7. Legal/Ethical Issues
   Identify a legal or ethical issue
   Discuss your actions or actions that should have been done
   Discuss how you applied the ANA Code of Ethics

8. Teaching
   Discuss the patient/family’s educational needs
   Discuss how you determined these needs
   Discuss your interventions to meet these educational needs
   Discuss the continued educational support needed for your patient/family

9. Critical Thinking Questions
   Each group member will present a critical thinking question to the presenter at the end of the presentation. The presenter will answer the question based on their current knowledge of their patient. The presenter and the audience will be graded on how well they articulate these questions.

10. PowerPoint
    No more than 15 slides
    Reference slide with correct APA format
    Grammatically correct
    Provide 2 copies of PowerPoint to the instructor at the time of presentation

11. Attendance
    Each student is required to attend all group members’ presentations or a score of zero will be earned

12. Discussion
    Each student will be graded on their discussion with the presenter, demonstrating critical thinking and posing a critical thinking question for the presenter to answer. You will be scored with each group member and the total score will be averaged on this section.

13. Related Nursing Research
    At least one research article related to the care of the patient.
Theories and Concepts III: Guidelines for Case Presentation

Student Name: ___________________________ Date: ____________________

Group Members: ____________________________________ ___________________________

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<tr>
<th>Topics</th>
<th>4=A Above average knowledge of topic of quality of discussion/presentation</th>
<th>3=B Average knowledge of topic of quality of discussion/presentation</th>
<th>2=C Below average knowledge of topic of quality of discussion/presentation</th>
<th>1=D Insufficient knowledge of topic of quality of discussion/presentation</th>
<th>0=F Failed knowledge of topic of quality of discussion/presentation</th>
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<tr>
<td>1. Introduction</td>
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<td>2. Pathophysiology</td>
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<td>4. Assessment</td>
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<td>5. Related Treatment</td>
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<td>6. Nursing Care Plan</td>
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<td>7. Legal/Ethical</td>
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<td>8. Teaching</td>
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<td>9. Critical Thinking (as presenter)</td>
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<td>10. Powerpoint</td>
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<td>11. Attendance</td>
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<td>12. Related Research</td>
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<tr>
<td>13. Discussion with other group members (score will be determined by an overall average)</td>
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Add each topic score to find the total points earned __________/(divide it by) 52 (total points possible) x 100 = __________ percentage earned

Faculty comments and signature:
Use complete sentences with reflective thought. If you are unable to define critical thinking you must look up the definition prior to answering question 5. **Due each week of clinical.**

1. What did you learn today that was the most beneficial?

2. What would you like to learn more about or what did you not fully understand?

3. What will you do to accomplish this?

4. If you could live today over, what would you do differently?

5. How do you feel about your experience today?

6. Give an example of how you used the critical thinking process today?
INTERPERSONAL PROCESS RECORDING

Focus:

To assist the student to develop skill in observation, in communicating and in gaining the ability to apply theories and concepts to nursing situations.

Objectives:

1. To apply psychiatric/mental health concepts to a nurse-client interaction.
2. To develop the ability to identify his/her thoughts and feelings in relation to self and others.
3. To increase ability to identify client's needs and skill in meeting these needs.
4. To plan, structure and evaluate nursing action on a conscious level.
5. To analyze client behavior based on psychiatric/mental health concepts.

The process recording is a systematic method of collecting data prior to interpreting, analyzing, and synthesizing the data obtained. It is a verbatim report of the verbal and non-verbal communication between two people for the purpose of assessing their interaction.

Procedure:

Select a client in the clinical setting for participation in a one-to-one relationship. You are required to turn in two interpersonal process recordings with clients, including thoughts and feelings as soon after the interactions as possible. The recordings should be a full account of the interactions.

Confidentiality:

All client records contain privileged information and are to be carefully guarded. Process records should be read only by the appropriately designated persons. Do not use the client's name but substitute initials for the name. The client as a human being, has the right to know with whom you are sharing the information about him. The process recording will be shared with your instructor, classmates, and appropriate clinical staff.
Interpersonal Process Recording - Continued

**Items To Be Included**

I. Introductory Material

   A. Description of the client
      Chief complaint, age, marital status, predisposing causes of illness, etc.
   B. Description of setting (lighting, noise, temperature, etc.)
      Where interaction took place
      What client was doing when approached, etc.
   C. Description of your thoughts and feelings prior to the interaction.
   D. Therapeutic objectives/goals of the interaction (patient centered)

II. Recording of Interaction (use 3 columns)

   A. Describe how interaction was initiated
   B. Client communication:
      verbal, non-verbal, silence, etc.
   C. Nurse communication: verbal, thoughts, feelings, hypotheses, and validation with client
   D. Applicable behavioral concepts/principles and meaning of the communications/behaviors
   E. Describe termination of the interaction
   F. Analysis: communication techniques, why are they used, what are you hoping to accomplish?

III. Evaluation for Nursing Intervention

   A. Description of your thoughts after the interaction.
   B. Goals for future interactions.
   C. Describe areas for improvement related to therapeutic communication.
   D. Evaluate planned objective/goals of the interaction.

Review communication techniques, and process recording, prior to communicating with clients.
Interpersonal Process Recording Example

<table>
<thead>
<tr>
<th>NURSE: VERBAL AND NONVERBAL</th>
<th>PATIENT: VERBAL AND NONVERBAL</th>
<th>PRINCIPLES THAT EXPLAIN BEHAVIOR AND INTERVENTION, FEELINGS AND OBSERVATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Interaction Number 12</td>
<td>*Goal: Patient will identify situations arousing discomfort and how he handles them.</td>
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</table>

Mr. E. had just returned from a home visit. He came over to me and said he had to check his clothes and would be right back. I said I would wait for him in the usual place. He returned ten minutes later at 8:10 a.m.

How was your weekend?

Fine, and yours?

Well, I was out on pass. I had a good time. I spent a lot of time straightening things up - putting summer clothes away and sorting out things. I could only work a few hours and then had to take a snooze.

We had company too. My sister had just told people that I wasn't feeling well. She didn't tell them what was wrong and they expected to see me with casts or something. She left it to me to tell them what was wrong.

How did you feel about telling them?

Oh, I had no feelings about it at all. They're friends and they understand. They've seen me upset and angry. They understand.

What do you do when you get angry?

Well, I count to ten. Mostly I keep it in. My friends realize that. I don't get violent like some people.

I was a little irritated that Mr. E. would be late; even though I knew it was ward policy that his clothes be checked at once. However, I waited in the usual place. Reinforcing trust by being on time and remaining there for patient. Maintaining terms of contract.

Focus conversation back to patient.

Fatigue may be emotional as well as physical. Sleep can be a defense against a trying situation.

Patient's anxiety rose here, shown by much moving around in his chair, embarrassed laughter, and lack of eye contact. Sister probably gave responsibility to patient because of her own feelings.

Focusing to get pt to express feeling.

Denial of feelings as a protective mechanism. Hopes friends understand but not sure.

Exploring pt.'s usual coping strategies and helping patient to be aware of his behavior in reaction to stress.

− Continue −

* This is an example only. Your IPR should be longer than this example.
I. ASSESSMENT

A. BIO-PSYCHO-SOCIAL: Include initials of client, age, sex, religion, description of family structure, financial status, occupation and other psycho-social-cultural info. Identify stage and what development task client is dealing with according to Erickson. Include a brief history of patients' illness, treatment, medication regimen, etc. List current medications and other treatment ordered.

B. MENTAL STATUS ASSESSMENT - Complete this assessment during your time with client, focusing on current status. Include other mental status information from chart, but **identify it as such**.

C. PHYSICAL ASSESSMENT - Do as much physical assessment of client as is appropriate; remembering that much will be from direct observation.

II. PLAN OF CARE

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<tr>
<th>NURSING DIAGNOSIS</th>
<th>EXPECTED OUTCOME</th>
<th>IMPLEMENTATION</th>
<th>RATIONALE</th>
<th>EVALUATION</th>
<th>MODIFICATIONS</th>
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ARKANSAS TECH UNIVERSITY
Department of Nursing

PSYCHIATRIC CARE PLAN
GUIDE
ARKANSAS TECH UNIVERSITY
Department of Nursing

MILIEU ASSESSMENT

Setting _____________ Date _____ Name __________________________

Evaluate the milieu in terms of the following characteristics:

1. Provision for physical safety and security

2. Provision for validation of humanity (include family, cultural, religious and other affiliations)

3. Provision for structured interaction

4. Provision for open communication with client by nursing staff and other members of the health care team.

Summary of the strengths and weakness of this milieu:

Suggestions for change:
MENTAL STATUS EXAM

Student_________________________ Client Initials_____ Date_________

1. General appearance: motor activity, interaction during interview, grooming and dress, facial expression, level of consciousness.

2. Emotional state (mood and affect): If potential for suicide, suicidal or homicidal thoughts? If so, assess further.

3. Thought content and perceptions (delusions, illusions, hallucinations, depersonalization, obsessions or compulsions, phobias, fantasies, daydreams, etc.).

4. Flow of thought and speech.

5. Sensorium and cognition:
   a. Orientation
   b. Memory (remote, recent, immediate)
   c. Intellectual Functioning
      1) Concentration and calculation
      2) General information and intelligence
      3) Abstract thinking
      4) Judgement

6. Insight

Impressions: Nursing diagnoses (prioritized):
MINI-MENTAL STATUS ASSESSMENT

STUDENT’S NAME ___________________     Setting ______________________
CLIENT INITIALS _____                               Date __________

Maximum      Score

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<th>ORIENTATION</th>
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<td>5</td>
<td>What is the (year) (season) (date) (day) (month)? (1 point for each)</td>
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<tr>
<td>5</td>
<td>Where are we (state) (county) (town) (hospital) (floor) (1 point for each)</td>
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REGISTRATION

3     | Name three objects: Give one second to say each. Then ask the patient to repeat all three after you have said them. (1 point for each item) Give one point for each correct answer. Then repeat them until the patient learns all three. Count trials and record. |

ATTENTION AND CALCULATION

5     | Serial sevens. Give one point for each correct. Stop after five answers. Alternatively, spell “world” backwards. |

RECALL

3     | Ask for three objects repeated above. Give one point for each correct. |

LANGUAGE

9     | Name a pencil and watch when pointed to (2 points) Repeat the following, “No ifs, ands, or buts.” (1 point) Follow a three-stage command: “Take a paper in your right hand, fold it in half, and put it on the floor.” (3 points) Read and obey the following: “Close your eyes.” (1 point) Write a sentence. (1 point) Copy design. (1 point) |

Total Score _____ What does this score mean?

Nursing Diagnoses based on your exam:

Practicum Guide
Group Observation/Participation Paperwork

Use ONE group you attended to complete the following:

Type of Group________________________________

Describe:
Seating:

Size:

Membership:

Which of the curative factors were observed? How were these evident?

Describe the leadership style. Was it effective for this type of group? How is this leadership style similar to and different from other leadership styles observed this week?

Which of the member roles did you observe in this group? How were the roles recognized?

Use an extra sheet of paper and draw a pictorial of the group process. Include thoughts related to patterns of interaction during the group.
Practicum Guide

Vista Psychiatric Hospital, Fort Smith

The student will upon completion of this practicum experience:

1. Recognize problems associated with a diagnosis of a psychiatric disorder for the:
   a. individual
   b. family
   c. community

2. Recognize own feelings concerning acute psychiatric clients.

3. Describe activities/services provided by the agency that improve mental functioning.

4. Evaluate the nurslings’ role in the institution, utilizing the ANA Scope and Standards of Psychiatric-Mental Health Nursing Practice as well as the roles of the baccalaureate prepared nurse.

5. Correlate nursing research to practicum experiences.

6. Evaluate group process based on the group process observation form found in your syllabus and the presence of Yalom’s curative factors.

7. Read Townsend chapters 9, 10, 20 and 24

8. Select a patient in the unit to which you are assigned and develop a plan of care for this patient for each practicum day. (This will include a Mental Status Exam [at least one during this practicum experience] or a Mini Mental Status Assessment.)

9. Complete a psychopharmacologic profile of current psychopharmacologic interventions being utilized and you will select one drug and contact a local pharmacy for the cost for a months supply. This will be presented in post conference.

10. Complete a milieu assessment and at least one IPR during this practicum experience.

11. Submit a log answering the above objectives and documenting learning experiences in conferences during a practicum period.
Prior to experience, read Townsend, Chapter 10 and 27. Pay special attention to the 12 steps of Alcoholics Anonymous.

1. Describe the type of treatment program provided clients in this setting.

2. Outline the behaviors and roles of the nurse as a member of the team, including the performance of independent and dependent nursing functions. If a nurse is not a member of the team, identify roles the nurse could assume in this setting. How could a professional nurse be beneficial in this setting? Use course objective #3.

3. Describe the model(s) of psychiatric care you saw utilized on the unit: medical model, behavior modification model, psychoanalytic model, social-interpersonal model or other.

4. Describe the behaviors exhibited by patients. Compare these behaviors with S/S of substance abuse as discussed in Townsend, Chapter 27.

5. Establish a beginning nurse-client relationship in a caring manner with at least one client/family and complete IPR (if allowed by agency).

6. Submit a research article and discuss how this information was or could be applied to patient care at this agency

7. Submit a log answering the above objectives and documenting learning experiences.
Objectives:

1. Recognize own feelings about both the aging process and clients with organic mental disorders.

2. Recognize the problems associated with an organically impaired client for the:
   a. Individual
   b. Family, particularly caregivers
   c. Community

3. Describe the services provided by agency for this population.

4. Identify criteria used for accepting clients into the gero-psychiatric center or unit.

5. Identify various behavioral manifestations of dementia.

6. Identify possible nursing diagnoses for clients and their caregivers with organic mental disorders using latest ND list.

7. Describe characteristics of aging that you observed in clients at the center.

8. Describe how this center is involved with:
   a. Promotive behaviors
   b. Supportive behaviors and/or
   c. Restorative behaviors

9. Discuss how a nurse might contribute to the center (include concept of roles of baccalaureate nursing using course objective # three – page five).

10. Perform a mini-mental status exam on at least one client (page 23).

11. Identify support groups that are helpful for families of clients with organic mental disorders.

12. Complete a nursing plan of care for at least one client.

Prior to experience, review: Townsend, Chapters 26 and 35
ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405
Transitional Unit Day Treatment/Inspiration

Objectives:

1. Recognize own feelings concerning chronic psychiatric clients.

2. Participate in client group activities and describe the group process. Use pages 24-25 and complete a group process of one observed group. This can be completed at either Transitional Unit Day Treatment or Inspirations.

3. Describe activities/services provided by the agencies. How do these services improve mental functioning? How do these services benefit the community?

4. Describe how the agencies promote client independence.

5. Describe how the nurse might make a greater contribution to the group process (include roles of baccalaureate nursing using course objective #3, page 5).

6. Assess the community for services for clients with psychiatric problems.
Clinical Objectives for Practicum in Intensive Care Unit

The nursing student is expected to:

1. Locate the crash cart and all emergency equipment/supplies in the unit.

2. Observe use of special equipment used in the ICU (e.g. ventilator) and demonstrate proper use of such equipment after receiving instructions on use.

3. Identify priority physiological and psychological nursing diagnosis and appropriate interventions for selected clients.

4. Utilize the nursing process to care for clients and families in the critical care setting.

5. Incorporate physical examination into assessment of clients.

6. Analyze the ICU milieu and its effects on clients and caregivers.

7. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.

8. Compare normal laboratory values with those of clients in the ICU setting.

9. Evaluate effects of nursing interventions and revise interventions as necessary.

10. Seek assistance from instructor when unfamiliar with any aspect of client care.

11. Discuss ethical-legal issues in the ICU environment.

12. Be prepared to present verbal care plan to clinical instructor.
ICU Verbal Care Plan

The student will be prepared to answer the following questions at the beginning of the clinical day. The instructor may choose a time later in the day to discuss the care plan with the student; however, the student should always be prepared at the beginning of the clinical shift. This information is presented to the clinical instructor without the use of notes, with the exception of lab values and medications. The instructor may ask the student to update this information during the course of the day.

1. What acute disease does your client have?
   Explain the basic pathophysiology

2. What chronic diseases does your client have?
   Explain the basic pathophysiology of each and how they may relate to the acute disease.

3. Explain lab and radiology data (may use notes).

4. Tell about your client’s medications (may use notes).
   Discuss purpose, common side effects, and priority nursing implications.

5. Describe the client’s social, spiritual, and personal status.
   How does this impact care? Who lives with the client? Describe client’s relationships. Does the client have any spiritual needs or concerns?

6. Identify two to three nursing diagnoses for this client in order of priority.
   Which nursing diagnosis is first in priority? Explain rational for the order of priority of these diagnoses.

7. Describe your plan of care today.
   List one goal for each nursing diagnosis. Explain interventions. What teaching will be planned for client and/or family?

8. At the end of your clinical day, evaluate your plan of care.
   What changed during the course of the shift? Was it necessary to revise the plan of care based on changes in the client’s condition or diagnosis? Was it necessary to revise priorities of diagnosis? Was nursing care holistic?
NURSING CARE PLAN GUIDE: INTENSIVE CARE

Student Name _________________________                                              Date __________

Patient Initials __________ Age __________                                              Short-term GOALS:

Medical Diagnoses: ________________________                                         #1

                            ____________________ ______                                         #2

Priority    #1    #2    #3

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<th>NURSING DIAGNOSES</th>
<th>INTERVENTIONS</th>
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<th>EVALUATION</th>
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NUR 4405_Spring 2012.doc
Clinical Objectives for the Practicum in Emergency Department (ED)

The nursing student is expected to:

1. Locate the crash cart and make medication cards on at least five major drugs used in emergency situations.

2. Familiarize self with the special equipment used in the Emergency Department and demonstrate appropriate interventions in the use of that equipment.

3. Write an abbreviated care plan on three selected clients in the ED setting, which should include: one priority nursing diagnosis, one short-term goal, nursing assessment (vital signs, observations), nursing interventions, and evaluation.

4. Utilize the nursing process to provide care for a variety of clients, comparing normal and abnormal values of lab and x-ray exams.

5. Complete admission and referral procedures on selected clients.

6. Incorporate physical examination into the assessment procedure of such clients.

7. Compare coping patterns of at least three clients in crisis because of an emergency medical or surgical problem.

8. Make a judgment as to the adequacy of these coping patterns and document any interventions that were affected by the nurse in helping these clients cope.

9. Document the adequacy of support systems of selected clients in crisis because of an emergency medical or surgical problem.

10. Document the triaging of clients. Identify principles being used.

11. Discuss ethical-legal issues in the ED environment.

12. Analyze the ED milieu and its effects on clients, care givers and staff.
Addendum to NUR4405 Practicum in Nursing III (Spring 2009)

Clinical objectives for practicum in cardiac/medical-surgical unit

The nursing student is expected to:

1. Locate the crash cart and all emergency/supplies in the unit.
2. Observe use of special equipment used in the cardiac/medical-surgical unit and demonstrate proper use of such equipment after receiving instructions on use.
3. Identify priority physiological and psychological nursing diagnosis and appropriate interventions for selected clients.
4. Utilize the nursing process to care for clients and families in the cardiac/medical-surgical unit.
5. Incorporate and demonstrate physical examination into assessment of clients.
6. Analyze and interpret cardiac rhythm strips for selected clients.
7. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.
8. Compare normal laboratory values with those clients in the cardiac/medical-surgical unit.
9. Evaluate effects of nursing interventions and revise interventions as necessary.
10. Seek assistance from instructor when unfamiliar with any aspect of client care.
11. Discuss ethical-legal issues in the cardiac/medical-surgical unit.
12. Be prepared to present verbal care plan to clinical instructor.
1. Locate equipment and supplies used on the orthopedic and rehabilitation units.

2. Utilize the nursing process to provide care to clients with orthopedic or neurological dysfunction.

3. Identify therapies unique to these units.

4. Identify the diversity of health care team members giving care to ortho/neuro clients.

5. Explain the impact of various medical conditions on clients with orthopedic dysfunction.

6. Describe protocol that determines a client's eligibility and potential for rehabilitation.

7. Write an abbreviated care plan (5 x 8 index card) on one client each week. Include vital information, medical diagnosis, nursing diagnoses, etc.

8. Complete log documenting each objective and how it was met.
ARKANSAS TECH UNIVERSITY
Department of Nursing

NUR 4405 Practicum in Nursing III

Objectives for PACU Experience

The nursing student is expected to:

1. Locate the crash cart and all emergency/supplies in the unit.

2. Observe use of special equipment used in the PACU and demonstrate proper use of such equipment after receiving instructions on use.

3. Identify priority physiological and psychological nursing diagnoses and appropriate interventions for selected clients.

4. Utilize the nursing process to care for clients and families in the PACU.

5. Incorporate and demonstrate physical examination into assessment of clients.

6. Recognize therapeutic effects and potential side effects of prescribed medications for selected clients.

7. Identify and discuss criteria for admission to and discharge from the PACU.

8. Identify immediate, potential post-operative complications and discuss the role of the PACU nurse in preventing those complications.

9. Seek assistance from instructor when unfamiliar with any aspect of client care.

10. Discuss ethical-legal issues in the PACU.

11. Be prepared to present verbal care plan to clinical instructor.
CARDIAC MONITOR, EKG AND HEMODYNAMIC STRIP

CARDIAC MONITOR:
RATE: PRI: QT:
INTERPRETATION:

___________________________________________________

STRIP

___________________________________________________

EKG:
INTERPRETATION:

HEMODYNAMIC STRIP:
RAP: PAP: DIASTOLIC
SYSTOLIC
MEAN
PAWP: SVR: C.O. C.I.
SVO2: CVP:

INTERPRETATION:
# ARTERIAL BLOOD GASES

**CLIENT INITIALS**________________**STUDENT**__________________________________

VENT SETTINGS/OXYGEN ORDERS_____________________________________________________

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<th>TIME</th>
<th>INTERPRETATION</th>
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VENT SETTINGS/OXYGEN ORDERS_____________________________________________________

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<tr>
<td>AST (SGOT)</td>
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<tr>
<td>Cholesterol</td>
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</tr>
<tr>
<td>LDH</td>
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</tr>
<tr>
<td>CPK</td>
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<td></td>
</tr>
<tr>
<td>CPK Isoenzymes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MM, MB, BB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troponin Levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRUG BLOOD LEVELS</td>
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</tr>
<tr>
<td>DIGOXIN</td>
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<tr>
<td>THEOPHYLLINE</td>
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</tr>
<tr>
<td>DILANTIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentamicin, Tobra</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BNP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEST</td>
<td>NORMAL</td>
<td>RESULTS</td>
</tr>
<tr>
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<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>BLOOD STUDIES</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>RBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCV</td>
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</tr>
<tr>
<td>MCH</td>
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<tr>
<td>MCHC</td>
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<tr>
<td>Hgb</td>
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<tr>
<td>Hct</td>
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<tr>
<td>Platelets</td>
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</tr>
<tr>
<td>WBC</td>
<td></td>
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<tr>
<td>Bands</td>
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</tr>
<tr>
<td>Neutrophils</td>
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</tr>
<tr>
<td>Eosinophils</td>
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<tr>
<td>Lymphocytes</td>
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</tr>
<tr>
<td>Basophils</td>
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<tr>
<td>Monocytes</td>
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<td></td>
</tr>
<tr>
<td>PT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INR/TI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTT</td>
<td></td>
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</tr>
</tbody>
</table>

**URINALYSIS (U/A):**

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Color</th>
<th>Urobilirubin</th>
<th>Bilirubin</th>
<th>Ketones</th>
<th>Glucose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein</td>
<td>WBC</td>
<td>Blood</td>
<td>pH</td>
<td>S.G.</td>
<td></td>
</tr>
</tbody>
</table>

U/A Interpretation:

Latest Chest X Ray Results

EKG Interpretation

Other X-ray, Ultrasound, Nuclear Medicine, Endoscopic Studies, ECHO
**PRIMARY INTRAVENOUS THERAPY:** (List type of IV - peripheral IV's; central lines - single/double/triple lumen)

Primary IV Site(s):

Primary IV Fluids

---

**LIST ALL ANTIBIOTICS**

<table>
<thead>
<tr>
<th>IV antibiotic</th>
<th>mg</th>
<th>ml</th>
<th>Rate: cc/hr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

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**LIST ALL INFUSION DRIPS** [i.e., antiarrhythmics, low dose dopamine & ect]

<table>
<thead>
<tr>
<th>DRIPS [concentration]</th>
<th>Rate: cc/hr</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCG/KG/MIN</td>
<td></td>
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</tr>
</tbody>
</table>

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**IV SEDATION AND CONTINUOUS DRIPS**

<table>
<thead>
<tr>
<th>Diprivan</th>
<th>Ativan</th>
<th>Morphine</th>
<th>Demerol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Heparin** (list the concentration)

Show med math: Rate: cc/hr _____ Units/hour: _____ Last PTT/Pts INR

---

**Parenteral TPN/Lipids**

<table>
<thead>
<tr>
<th>ML/HR</th>
<th>TYPE: ML/HR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

24 Hour Calorie intake: Relevant Lab Results: Last Albumin: WT: DIET:

---

**Nutritional Assessment:**

Journal Assignment Name: __________________________ Date: _____________
PATIENT ALLERGIES:

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Classification</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency (list times)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peak</td>
<td>For IV meds – list compatibility with other IV meds/solutions ordered for patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Therapeutic effect (why med ordered for THIS patient)  
Contraindications (for THIS patient)

Common side effects

Interactions with other patient drugs or herbal medicines
Lab value alterations caused by medication:

Be sure to teach patient the following about this medications:

Would hold (NOT GIVE) this medication if:  
Check **before** giving:  
Check after giving:

Dose Calculation:

How is mixture prepared:
Patient’s Initials:________  Room:_______ Age:______  Gender:______  
Admission Date: __________  Code Status: Full Dnr Dni  
Height (Inches):_____ft. _____inches  Weight _____lbs _____Kg  
Allergies:________________________

**Chief complaint/Chief concern:** (What brought the patient to seek medical care?)

**Admitting Diagnosis**

**Situation:** (What is happening at the present time?)

**Background:** (What are the circumstances leading up to this situation?)

**Assessment:** (What do you think the problem is?)

**Recommendation:** (What should be done to correct the problems identified?)
Pathophysiology of admission diagnoses and past medical condition affecting the admission diagnosis:

Surgery or procedure patient has undergone:

Description of surgery/procedure:
Objectives:
At the end of the Tri Chapter Research Day, the student will be able to:

1. Discuss at least two poster presentations the student found interesting.
2. Summarize at least two presentations made by speakers. Discuss application of research to nursing practice.
3. Discuss the importance of nursing research to the advancement of the profession.
4. Identify the role of the BSN, RN in the research process.
5. Evaluate attendance to the conference.