Kingdom of Saudi Arabia
Ministry of Higher Education
University of Tabuk
Faculty of Nursing

المملكة العربية السعودية
وزارة التعليم العالي
جامعة تبوك
كلية التمريض

Faculty of Applied Medical Science
Department of Nursing

Clinical Training Manual
2022-2023

Approved by department Council reference #13404

Date of Approval: 15-9-2022

Prepared by: Clinical Training Committee

Course Title

Semester /Year

Course/Clinical Faculty

Dr.	**Ms.**
Course Coordinator	Title/Assignment:
Office location:	Office location:
Office Phone:	Office Phone:
Email:	Email:
Office Hours:	Office Hours:
Dr.	Ms.

CLINICAL TRAINING:

Clinical Training is provided for students simultaneously with the theory part of the course Nursing Care of the (Course Title). Students are scheduled in the Clinical simulation Center, Nursing Skills Laboratory, and Training Hospitals to develop their competencies in the management of (according to course Title) Competencies include the knowledge, skills, and attitudes appropriate in the care and management of (adults or according to course Title).

Clinical Training provides the opportunity for the students to develop their skills initially in the laboratories and eventually manage an actual patient in the hospital settings under the supervision of Clinical Instructors. Clinical training will enable the students to apply concepts/ theories learned in the classroom. The Clinical instructors are responsible in bridging these concepts into the clinical setting. Learning experiences are processed considering gaps between theory and practice.

CLINICAL OUTCOMES:

Throughout this clinical rotation, students are expected to:

1.
2.
3.

CLINICAL PLACEMENT:

Students are randomly assigned to clinical placements at either:

1.
2.
3.
4.

CLINICAL SCHEDULE:

Each student trains ------ day per week throughout the semester. The Duration of the training is ----- hours.
Duty days for different groups are the following:
Day1: name of the clinical area

Day2: name of the clinical area
Day3: name of the clinical area
Day4: name of the clinical area

CLINICAL EVALUATION:

Clinical performance will be evaluated utilizing the clinical performance evaluation form, worksheets, Nursing Care Plans and the clinical skills Audit. Each objective is critical and must be successfully met by the end of the rotation. Students will receive formative and summative evaluation of their clinical performance. Each student will receive a mid-semester and final evaluation by the clinical instructor.

CLINICAL POLICIES

Attendance Policy

Late attendance: A student is considered late if she/he arrives within 15 minutes for a one-hour session and 30 minutes for more than one-hour session from the start of the scheduled time.

Absences:

- A student who has been late thrice (3 times) shall be considered to have incurred one (1) day absence.
- A student is considered absent if she/he arrives more than 30 minutes after the scheduled time. The student is allowed to attend the class but will not be allowed to take the quiz if there is any.
- Students who incur accumulated absences (excused and unexcused) of more than twenty-five (25) percent of the prescribed number of Class hours in each semester shall be considered DROPPED.

Faculty contact information is provided and should be used to **contact the instructor** in advance of a clinical absence. No third-party messages (i.e., from friend or classmate) will be accepted.

Dress Code

1. Nursing students will dress according to nursing department and/or agency policy and demonstrate good personal hygiene**.**
2. Uniforms (navy blue scrub suit and white lab coat) should be clean and neat.
3. Students must wear their identification card at all times while inside the agencies during clinical training.
4. White leather nursing or tennis shoes (no cloth shoes, open toe shoes, or clogs) with minimal colored trim should be worn.
5. Fingernails must be short and clean. Nail polish and artificial nails should not be worn.
6. Jewelry is limited to wedding rings only.

Required Clinical Supplies

1. Watch with second hand.
2. Stethoscope
3. Penlight

Students who do not adhere to the clinical dress code will have this documented on the clinical evaluation tool as an unsatisfactory mark.

Clinical Skills:

Students are to seek help from the nurse preceptor and/or clinical instructor when they are unsure of anything relating to the assignment and to ask for assistance with new or unfamiliar activities. A student who is told to wait for assistance is expected to do so. Students are expected to work within their assignments, level of skills, and with appropriate supervision.

Students are expected to demonstrate selected psychomotor skills competently in lab prior to attending clinical in a hospital. The number and type of skills that are available in the clinical facility are based on the type of unit. For any clinical nursing skill, the student must have direct supervision by the clinical faculty or nursing staff when performing these skills, with the exception of personal care or taking vital signs. Students are not permitted to perform any nursing skills without prior approval from the instructor and direct supervision by a licensed professional. There may be an occasion that a nurse will offer an opportunity for a student to complete a skill. In this circumstance, the student must seek approval from the clinical faculty prior to the initiation of these skills. The student may not perform any clinical nursing skills without the express consent of the clinical faculty. In

other words, the clinical faculty must be apprised of all clinical activities at all times. Failure to follow these guidelines will result in immediate clinical failure.
You will be afforded the opportunity to do most nursing skill that presents itself, if you have previously demonstrated the skill, and as your instructor believes you are capable and competent to perform. There are certain functions you are never allowed to perform or perform without supervision. They are as follows:

1. You cannot take phone orders (only licensed personnel are allowed this privilege).
2. You cannot hang blood or blood products (but may assist with initiating blood).
3. You cannot sign out narcotics.
4. You cannot administer chemotherapy.
5. You cannot administer ANY IV push drug, IV antibiotic, or IVF with additives without the **direct supervision** of a licensed professional.

WRITTEN CLINICAL ASSIGNMENTS:

A late assignment will not be accepted unless prior arrangements have been made with the respective faculty member. The grade for a late assignment may be adjusted downward by 5 percent per day the assignment is late. Make up assignments for missed class/clinical days are at the discretion of the faculty. Excessive late assignments will result in clinical failure.

Students who are unclear about assignments, expectations or any aspect of the course are responsible for making an appointment with an instructor to receive clarification in sufficient time to successfully complete the assignment.

1. **Case Presentation (5% of clinical grade)**

Students will work on a case presentation with their clinical group. Details for division into groups will be provided by the clinical faculty. The presentation will focus on the completing of a holistic, patient-centered care plan that addresses actual or potential alternations in each body system. The group will use data gathered during clinical sessions to construct a case scenario. Based upon the scenario assessment data, students will create a nursing plan of care documented on clinical forms used throughout the clinical experience. Each group will present the case scenario and plan of care during the final class period. Guidelines/rubric for the presentation will be posted on Blackboard or students emails no later than midterm.

2. **Clinical Worksheets & Care Plan Packet (30% of clinical grade)**

Students are required to complete a clinical worksheet packet for one assigned patient (one clinical work sheet per Hospital, each clinical worksheet worth10 points)). This form should be completed with hospital rotation. The clinical packet is available on Blackboard or will be sent through email to students. **There is no worksheet due to the simulation experience.**

Students are required to submit a care plan for a patient they have been assigned (two care plans in each hospital), using the approved care plan format. The guidelines and template for care plan are available on Blackboard or will be sent via email. **Students will have a total of 4 care plans due during their clinical training, each worth 10 points.**

3. **Clinical Skills audit (5%):**

This form is designed to provide a guideline for the students during the training period in the assigned hospital. The form includes a list of major skills/procedures to ensure the achievement of clinical objectives of each specific unit. The form is kept by the Nurse student. After completion of task, it is the responsibility of the student to check and to take the signature from immediate staff nurse trainer (preceptor) and submit to the clinical instructor at the end of the clinical training.

4. Clinical Simulation Activities

Details regarding Clinical Simulation Activities will be provided by the clinical faculty. These simulation learning activities are non-graded and will be completed during clinical time.

The outcomes of these activities are as follows:

Scenario #1: (Title of The Scenario)

Upon completion of this clinical scenario activity, the student will be able to:

1.
2.
3.
4.
5.

Scenario #2: (Title of The Scenario

Upon completion of this clinical scenario activity, the student will be able to:

1.
2.
3.
4.
5.
6.

Summary of Clinical Grade: (Clinical grade is 100% of the course grade)

OSCE 1	10%
Worksheets & Nursing Care Plans	30%
Case presentation	5%
Clinical Performance Evaluation	10%
Clinical Skills audit	5%
OSCE 2	15%
Final written exam	25%
Total	100

Briefing and Debriefing:

The clinical instructor about the clinical objectives, guidelines, requirements, evaluation, schedule, and hospital policies gives orientation. Each student is required to have this orientation. Briefing about the clinical focus is done each week. The clinical instructor before the end of the duty conducts a debriefing each week. Clinical instructors will provide feedback regarding requirements submitted and the weekly performance of the student.

GUIDELINES FOR THE CLINICAL ASSIGNMENTS

OVERVIEW

- Clinical documents should be typewritten and submitted per the clinical assignment schedule on the approved forms.
- The clinical worksheet should be completed in its entirety for one (1) assigned patient. Unknown, unavailable, or not applicable information should be indicated using the abbreviations UNK = unknown, UNA = unavailable, or N/A = not applicable.

CARE PLAN INFORMATION

ASSESSMENT DATA

In the **Subjective Data** list, relevant data includes (examples):

- client complaints
- description of the client's support system
- client awareness of her/his own abilities/disabilities disease process
- client's stated health care needs

In the **Objective Data** list, relevant data includes:

- physical assessment data such as vital signs, skin condition, range of mobility, indicators of nutritional status, etc.
- chart information including lab and test results
- objective assessments of mental state as well as physical findings, including such information as facial expressions (e.g., grimaces when family is discussed; stares at floor and makes no eye contact while speaking), body movements (clenches fists throughout day; rocks back and forth in chair throughout group therapy sessions); general behaviors (e.g., stayed in room until 11:00AM on this shift; when out of room, stood in a corner of hallway furthest away from people)
- observations of support systems in action
- information on the client's readiness for learning and learning potential

NURSING DIAGNOSES

The nursing diagnosis should be written for the **top priority** identified for the client. The nursing diagnosis must be an approved NANDA nursing diagnosis.

When creating the care plan; write the diagnosis with the highest priority first. There should be 1 diagnosis for each care plan.

Select only diagnoses that are amenable to resolution by nursing actions (no collaborative problems).

Write out the three parts of the Nursing Diagnosis:

1. **Statement of the actual or potential problem**: this is a nursing diagnosis; not a medical diagnosis;
2. **Related to**: the etiology must be amenable to nursing interventions. As most human responses are related to several factors, each factor must be listed, e.g.

   Acute pain related to:

I. Fracture of the left femur secondary to automobile accident (unrestrained passenger)
II. Non-displaced fracture of the 9th rib secondary to automobile accident (unrestrained passenger)
III. Avulsion wound of the left lower leg secondary to automobile accident (unrestrained passenger)

3. **As evidenced by (AEB)**: the subjective and objective data that supports the diagnosis.
BE SPECIFIC, e.g. patient actual statements, B/P 142/70, guarding behavior when nurse approaches bed, etc.

CLIENT GOALS

Number each goal.

As with nursing diagnoses, goals include three parts:

1. Statement of client-centered goal, stated in terms of client achievement, e.g.
"The client will maintain minimum pain level.
2. As measured by each goal must be measurable, with clear indication of how it will be measured, e.g.
"As measured by description of pain level at 3 or less on a pain scale of 1-10".
3. To be evaluated by each goal must state a target date and hour for evaluation, e.g.
"By 3p.m. March 12, 2006 (specify date, hour)."

There are two levels of goals: long-term and short-term.

- Long-term goals (LTGs): LTGs are directed toward:
  1. Promoting wellness
  2. Preventing disease
  3. Promoting recovery
  4. Facilitating coping
     - The time frame for evaluation of LTGs will likely extend beyond the due date for the Care Plan.
     - The long-term goals should focus on the identified PROBLEM.
- Short-term goals (STGs): STGs often denote immediate steps that lead toward fulfillment of LTGs.
     - Time set for evaluation should be within relatively short.
     - The short-term goals should focus on the etiology (r/t factors)/influencing factors.

Develop at least **one STG and one LTG** for each nursing diagnosis with follow-through for evaluation when you are on the unit, i.e. (will demonstrate effective use of splinting techniques using a pillow by 2pm on January 22, 2022)

NURSING INTERVENTIONS WITH SCIENTIFIC RATIONALE

After writing each goal, determine appropriate nursing interventions needed to achieve the goal. A few points to remember:

- Interventions are nursing actions that are specific, not global. For example, "administer pain medications" is too broad. A more specific alternative is:
  - Assess pain response using a scale of 1-10 every two hours and as needed.
  - For pain on a scale of 4-6, administer Tylox 1-2 tabs every 4 hours as ordered.
  - For breakthrough pain and pain greater than 6, administer morphine sulfate 2 mg IVP q 1-2 hours.

    - Demonstrate use of pillow as an agent to splint the ribs when coughing or turning.
- In most cases, several nursing interventions are needed to achieve any one goal.
- There should be interventions to meet the LTG & the STG. The interventions for the LTG should be focused on the problem, whereas the interventions for the STG should focus on etiology/influencing factors.
- After each nursing action give the scientific rationale for selecting the action. Cite your source for this rationale using APA format. Sources might include the medical-surgical textbook, the pathophysiology textbook, research article, or discussion with an experienced health care professional (see APA on how to cite personal communication).
- Rationale must be logical and relevant.
- Rationale must be in your own words using professional language or properly cited according to APA methods.

EVALUATION OF THE PLAN

For STGs:

State when goal is evaluated and be sure evaluation is congruent with time designated in the statement of the goal. Also be sure to use the measures designated for goal achievement to state client's degree of success, e.g,

"Client has experienced a decrease in level of pain as verified by self-evaluation of anxiety as 4 on the 10-point pain scale when re-administered at 1:00 p.m. on 1/22/15."

- (If the goal is not accomplished, alternative is: "2 tablets of tylox were insufficient to maintain pain at less than 6. Administered 2 mg of IV morphine sulfate and will monitor response at 1:30 p.m.")

Determine the effect of nursing interventions in accord with goal outcome, e.g.

"Client stated that being able to splint her ribs when she coughed significantly helped to decrease pain.'"

- (If goal is not accomplished, alternative is: "Client had difficulty using the pillow to splint her ribs due to her anxiety about the pain. Will assist family member to splint using the pillow.")

Note what changes or continuations with nursing interventions are needed to achieve goal, e.g.

"Continue to monitor pain level and use morphine for breakthrough pain; Begin instruction of relaxation techniques including deep breathing to assist with anxiety created by pain.

- (If goal was not accomplished, alternative is: contact the orthopedic surgeon to discuss alternative pain medications that may better manage pain. Explore with client additional comfort measures that have worked in the past.)

For LTGs:

Although LTGs will probably not be achieved before the Care Plan is submitted, they should be evaluated as follows:

"Evaluation of this goal is set for (state the date & time). The client has made (no) (some) (significant) progress toward this goal: (describe any movement toward the goal)."

NUR 332M Care Plan Grading Rubric

	Exceeds Standard	Meets Standard	Below Standard
Assessment 2pts	1.86-2 points Includes relevant subjective and objective data. Data supports nursing diagnosis.	1.5-1.85 points Limited data to support nursing diagnosis.	1.49-0 points Data is incomplete and/or does not support nursing diagnosis.
Diagnosis 2 pts	1.86-2 points Diagnosis identifies key problem from presented assessment data. Diagnosis is clearly structured and includes relevant etiology and contributing factors.	1.5-1.85 points Diagnosis stated without etiology or contributing factors thoroughly identified.	1.49-0 points Diagnosis fails to identify key problem. Diagnosis not clearly stated with irrelevant etiology and/or contributing factors.
Goals 2pts	1.86-2 points Goals are realistic, precise, and measurable. Includes STG and LTG for each diagnosis with stated time frame.	1.5-1.85 points STG and LTG are realistic and precise. Unspecific time frame or method to measure outcome.	1.49-0 points Goals are unrealistic and/or ambiguous. Missing STG and/or LTG.
Interventions 2pts	1.86-2 points Interventions support goals and are comprehensive and precise. Each intervention includes scientific rationale. Clearly related to intervention	1.5-1.85 points Interventions support goals but are limited and/or non-specific. Rationales included for each intervention with limited support.	1.49-0 points Interventions are unclear and do not support goal(s). Scientific rationale incomplete and does not support intervention.
Evaluation 2pts	1.86-2 points Clearly evaluates each intervention and goal, with client response to goal. Includes necessary revisions to plan of care.	1.5-1.85 points Limited evaluation of interventions and/or goals.	1.49-0 points Goal and/or intervention evaluation is incomplete.

University of Tabuk
Faculty of medical Applied sciences
Nursing Department
Care Plan

Client Initials: Student name:_____ ID:_____ Date:_____

<table>
<tr><th>Assessment</th><th>Nursing DX/Clinical Problem</th><th>Client Goals/Desired Outcomes/Objectives (with time scale)</th><th>Nursing Interventions/Actions/Orders and Rationale</th><th>Evaluation</th></tr>
<tr><td rowspan="3">Subjective (1p)

Objective (1p)</td><td>Problem(1p)</td><td>Long Term: (1p)</td><td>(1p)</td><td rowspan="3">(1p)

(1p)</td></tr>
<tr><td>R/T(0.5p)</td><td rowspan="2">Short Term: (1p)</td><td rowspan="2">(1p)</td></tr>
<tr><td>AEB(0.5p)</td></tr>
</table>

University of Tabuk
Faculty of medical Applied sciences
Nursing Department
Care Plan
Clinical Worksheet

Client Initials: _____ **Student: _____** **Date of Care: _____**

Demographic Information	Health History	Care Prescriptions
Age: ____ Gender: ____ **Nationality: ____**	**Chronic conditions & previous health problems:**	**Nutrition** Type of diet: _____ ☐ NPO ☐ Tube Feeds: Type _____ Rate _____ ☐ G tube ☐ NG tube ☐ Aspiration risk ☐ Thickened liquids: Type _____
Code Status: _____		
Weight: ____ Height: ____ **BMI: ____: the patient is _____**		
Reason for Admission [patient's own words]**:**	**Unexpected events/complications during hospitalization:**	**Activity:** ☐ Independent ☐ Assist ☐ Dependent ☐ Ad lib ☐ BR only ☐ Chair ☐ Ambulate ☐ Bed Rest ☐ Assistance of ___ (# of people) Assistive devices: ☐ Gait belt ☐ mechanical lift ☐ walker ☐ cane ☐ Other : _____
	Previous surgeries: [type/year]	
Medical Diagnosis [medical terms]:	**Nursing Diagnoses** (5, prioritized, with related factors)**:**	**Elimination:** ☐ Continent ☐ Incontinent ☐ Voiding ☐ Foley catheter ☐ I & O ☐ Enema ☐ Colostomy ☐ Other: _____
		Skin Care: ☐ Intact skin ☐ Pressure ulcer stage: _____ ☐ Other: _____ ☐ Turn & position w/ skin care q. 2 hrs **Wound Care:** ☐ Dressing/drain ☐ Drsg. Change/treatment Location & Type_____ **IV Site:** Location _____ Size: _____ ☐ Saline Lock ☐ IV Fluids: _____ Rate: _____
Date of admission:		
Allergies:		**Pulmonary care:**
Other notes:		☐ O2 ___ L/min via ☐ N/C ☐ mask ☐ on room air
		☐ Incentive Spirometer q ___ hrs. ☐ MDI inhaler Mini-neb Med. ☐ albuterol ☐ atrovent

		□ Other **Glucometer:** □ ac & hs □ other _____ □ sliding scale insulin, every_____ hours

Discharge Plan/Long Term Needs:

Teaching Needs:

Medications (scheduled & prn)

Name/Dose/Route	Class & Action	Major Side Effects	Nursing Implications	Patient Education

Lab Values & Diagnostic Test Results

a. Important lab tests to monitor **Why? (Consider diagnosis, pre-existing conditions, medications, complications, etc.)**

b. Hematology **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

		Date	*Date*	*Date*	
WBC					
Plt					
Hgb					
Hct					
RBC					

c. Chemistry **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

K+					
Na+					
Cl-					
CO2					
BUN					
Cr					
Glucose					
Albumin					

d. Coagulation **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

PT					
INR					
PTT					

e. Urine **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

Color					
Appearance					
Spec. gravity					
PH					
Glucose					
Ketones					

Nitrates					
RBCs					
WBCs					
Casts					
Protein					

f.

ABGs	**Normal values**	**Patient's Values (include serial labs)**			**Significance for this patient**
pH					
$PaCO_2$					
HCO_3					
PaO_2					
SaO_2					

g.

Other	**Normal values**	**Patient's Values (include serial labs)**			**Significance for this patient**

h. <u>Pertinent radiological studies:</u>

i. <u>Other diagnostics</u> (e.g. ECG, EEG, echo):

Patient Assessment & Nurses Notes

VS: (P,T,RR,BP,PO2,Pain)

Neuro: (GCS, Pupil size,….)

Musculoskeletal: (Strength, movement, coordination,….)

Skin: (Color, warmth, texture, abnormalities,…)

Cardiac: (Cardiac & peripheral pulses for rhythm, sounds, strength,…)

Pulmonary: (auscultation, airway clearance, breathing pattern, respiratory therapy,…etc)

GI/Nutritional Status: (appetite, food consumption, bowel sound, bowel motion, NPO status, type of diet, disorders,..)

GU/Reproductive: (Continence, abnormalities,…)

Psychosocial: (anxiety level, social interaction, family support, body image, psychological disorders,…)

Date/Time	**Nurses Notes**

Note: Nurses Notes are for additional information not included in the assessment or worksheet, such as events or procedures done during the shift. Do not just repeat assessment information or list routine care included in the worksheet or that would be charted on flow-sheets.

Faculty of medical Applied sciences
Nursing Department
Care Plan
Clinical Worksheet Grading Rubric

Client Initials: _____ **Student: _____** **Date of Care: _____**

<table>
<tr><th>Demographic Information</th><th>Health History 1 pt</th><th>Care Prescriptions</th></tr>
<tr><td>Age: ____ Gender: ____
Race: ____</td><td rowspan="2">Chronic conditions & previous health problems:</td><td rowspan="2">Nutrition:
Type of diet: _____
☐ NPO
☐ Tube Feeds: Type _____ Rate _____
☐ G tube ☐ NG tube
☐ Aspiration risk ☐ Thickened liquids: Type _____</td></tr>
<tr><td>Code Status: _____</td></tr>
<tr><td>Weight: ____ Height: ____
BMI: ____</td><td></td><td></td></tr>
<tr><td rowspan="2">Reason for Admission [patient's own words]:</td><td>Unexpected events/complications during hospitalization:</td><td rowspan="2">Activity: ☐ Independent ☐ Assist ☐ Dependent
☐ Ad lib ☐ BR only ☐ Chair ☐ Ambulate ☐ Bed Rest
☐ Assistance of ___ (# of people)
Assistive devices:
☐ Gait belt ☐ mechanical lift ☐ walker ☐ cane
☐ Other : _____</td></tr>
<tr><td>Previous surgeries: [type/year]</td></tr>
<tr><td>Medical Diagnosis [medical terms]:</td><td rowspan="4">Nursing Diagnoses (5, prioritized, with related factors and supporting evidence): 2 pts</td><td>Elimination: ☐ Continent ☐ Incontinent
☐ Voiding ☐ Foley catheter ☐ I & O
☐ Enema ☐ Colostomy ☐ Other: _____</td></tr>
<tr><td>Date of admission:</td><td rowspan="2">Skin Care:
☐ Intact skin ☐ Moisture barrier: _____
☐ Other: _____ ☐ Turn & position w/ skin care q. 2 hrs
Wound Care: ☐ Dressing/drain ☐ Drsg. Change/treatment
Location & Type_____
IV Site: Location _____ Size: _____
☐ Saline Lock
☐ IV Fluids: _____ Rate: _____</td></tr>
<tr><td>Allergies:</td></tr>
<tr><td>Other notes:</td><td>Pulmonary care:</td></tr>
<tr><td></td><td></td><td>☐ O2 ___ L/min via ☐ N/C ☐ mask ☐ O_2 Sat</td></tr>
<tr><td></td><td></td><td>☐ Incentive Spirometer q ___ hrs.
☐ MDI inhaler Mini-neb Med. ☐ albuterol ☐ atrovent</td></tr>
<tr><td></td><td></td><td>☐ Other</td></tr>
</table>

		Glucometer: □ ac & hs □ other _____ □ sliding scale insulin

Discharge Plan/Long Term Needs: 0.5 point

Teaching Needs: 0.5 points

Medications (scheduled & prn) 1.5 pts

Name/Dose/Route	Class & Action	Major Side Effects	Nursing Implications	Patient Education

Lab Values & Diagnostic Test Results 1.5 pt

a. Important lab tests to monitor **Why? (Consider diagnosis, pre-existing conditions, medications, complications, etc.)**

b. Hematology **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

		Date	*Date*	*Date*	
WBC					
Plt					
Hgb					
Hct					
RBC					

c. Chemistry **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

K+					
Na+					
Cl-					
CO2					
BUN					
Cr					
Glucose					
Albumin					

d. Coagulation **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

PT					
INR					
PTT					

e. Urine **Normal values** **Patient's Values (include serial labs)** **Significance for this patient**

Color					
Appearance					
Spec. gravity					
PH					
Glucose					
Ketones					

Nitrates					
RBCs					
WBCs					
Casts					
Protein					

f.

ABGs	**Normal values**	**Patient's Values (include serial labs)**			**Significance for this patient**
pH					
$PaCO_2$					
HCO_3					
PaO_2					
SaO_2					

g.

Other	**Normal values**	**Patient's Values (include serial labs)**			**Significance for this patient**

h. Pertinent x-rays or radiological studies:

i. Other Diagnostics (e.g. EKG, EGD, echo):

Patient Assessment & Nurses Notes 2pts

VS:

Neuro:

Musculoskeletal:

Skin:

Cardiac

Pulmonary:

GI / Nutritional Status

GU/Reproductive

Psychosocial:

Date/Time	**Nurses Notes 1 point**

Note: Nurses Notes are for additional information not included in the assessment or worksheet, such as events or procedures done during the shift. Do not just repeat assessment information or list routine care included in the worksheet or that would be charted on flow-sheets

CLINICAL SKILLS AUDIT

Name of Student: _____ Student No._____

Clinical Institution: _____

Rating Scale:

1- Needs improvement, performs poorly
2- Performs satisfactorily with minimal assistance
3- Performs very satisfactorily
4- Able to perform procedure excellently

PROCEDURE	DATE	OBSERVED	ASSISTED				DONE				SUPERVISOR	REMARKS
			1	2	3	4	1	2	3	4		
ASSESSMENT												
1. history taking												
2. vital signs												
3.physical assessment												
3. Assessment of patient with integumentary disorders												
4. Assessment of patients with renal disorders												
5. Assessment of patients with musculoskeletal disorders												
6. Assessment of patients with neurological disorders												
7. Assessment of patients with oncology disorders												
8. Assessment of patients with endocrine disorders												
9. Use of the Glasgow coma scale												
10. Pressure Ulcer Risk assessment (Braden Risk Assessment chart)												
11. Fall assessment (Morse Fall Scale)												
Diagnostic Examinations:												

12. Health teaching before diagnostic procedure												
13. Collection of specimen for diagnostic/laboratory procedures												
14. Interpretation of laboratory findings												
Nursing Diagnosis												
15. Identification of appropriate nursing diagnosis												
16. Prioritization of nursing diagnoses												
Planning:												
17. Writes appropriate objectives												
Interventions:												
18. Measuring urine output for a patient with Indwelling folley catheter												
19. Urinary catheterization												
20. Removal of urinary catheter												
21. Bladder irrigation												
22. Skin care												
23. Measuring capillary blood glucose (CBG)												
24. Insulin injection												
25. Assisting in hemodialysis												
26. Cast care												
27. Traction care												
28. Tracheostomy care												
29. Assisting in preparation of chemotherapy												
Assisting in ADLS												
30. Bed making												
31. Hygiene												
Medication												
32. Drug calculation												

33. Intradermal injection												
34. Subcutaneous injection												
35. Intramuscular injections												
36. Removal of IV lines												
37. Assisting in preparation and administration of IV lines												
38. Handover using SBAR												
39. Care of the dying												
40. Health teaching re Discharge plan												
Documentation												
41. Flow sheets: - Vital signs - I/O - Weight monitoring - NVS monitoring												
42. Nurses' notes												
43. Other skills												

clinical Evaluation Form

S = Satisfactory (1)
U = Unsatisfactory (0)
NO = Not Observed

Students name: ----------
Clinical area: ----------
Final Grade: ----------

	Midterms			Finals		
	S	**U**	**NO**	**S**	**U**	**NO**
1. Communication: Facilitates continuity of care through oral, written and computer mediated communication.						
• Establishes therapeutic relationships with clients						
• Utilizes non-verbal communication appropriately to convey meaning						
• Verifies the meaning of non-verbal communication cues.						
• Focuses on patient-centered communication, goals and concerns.						
• Uses language consistent with the patient's level of understanding						
• Explains nursing actions to be taken						
• Relates in a manner that respects the values, dignity, and culture of others						
• Reports pertinent data to staff and instructor in a timely manner						
• Documentation is accurate, complete, current, concise, and organized						
• Utilizes appropriate medical terminology in oral and written communication						
• Analyzes the intersubjective experience of the nurse/client relationship						
• Verbal shift report is complete, appropriate and accurate.						
• Asks pertinent questions related to patient condition and care						
• Demonstrates cultural sensitivity and knowledge of cultural differences in client interactions.						
2. Safety: Delivers safe care						
• Protects the patient from physical injury by implementing appropriate safety measures						
• Uses appropriate ambulation and transfer techniques						
• Performs psychomotor skills safely and according to skills guidelines and hospital protocols						
• Complies with all precautionary measures (i.e. Fall prevention, skin integrity, aspiration prevention, seizure precautions)						
• Handwashing						
• Medical asepsis						
• Surgical asepsis						
• Uses gloves and masks and other barriers appropriately						
• Disposes of wastes appropriately						
• Disposes of sharps and used equipment appropriately						

	Midterm			Final		
	S	**U**	**NO**	**S**	**U**	**NO**
***2. Safety**: Delivers safe care*						
• Protects the patient from physical injury by implementing appropriate safety measures						
• Uses appropriate ambulation and transfer techniques						
• Performs psychomotor skills safely and according to skills guidelines and hospital protocols						
• Complies with all precautionary measures (i.e. Fall prevention, skin integrity, aspiration prevention, seizure precautions)						
• Complies with standard precautions and all infection control standards						
Handwashing						
Medical asepsis						
Surgical asepsis						
Uses gloves and masks and other barriers appropriately						
Disposes of wastes appropriately						
Disposes of sharps and used equipment appropriately						
• Prevents emotional jeopardy by avoiding any action or inaction which threatens the emotional well-being of the patient or significant other						
• Identifies patient prior to interventions						
• Protects self from injury through effective use of body mechanics						
• Maintains patient privacy and confidentiality in compliance with HIPPA regulations						
• Uses patient care equipment appropriately and safely						

	Midterm			Final		
	S	**U**	**NO**	**S**	**U**	**NO**
3. Nursing Process:						
• Collects data that is relevant to the client's condition and presenting problems						
• Assesses appropriate labs and diagnostic data						
• Assesses teaching/learning needs						
• Identifies nursing diagnoses based on appropriate database						
• Utilizes critical thinking in applying the nursing process						
• Performs physical and health assessment of clients utilizing proper techniques of examination and focusing on conditions of the:						
Skin						
Neurological system						
Gastrointestinal system						
Peripheral vascular system						
Cardiovascular						
Respiratory						
Musculo-skeletal						
Mental status						
Psycho-social and emotional						
• Prioritizes a focused assessment based on client condition						
• Documents findings using appropriate terminology						
• Differentiates between normal and abnormal findings						
• Identifies strengths and limitations of the clients						
• Develops a plan of care that demonstrates understanding of client needs						
• Performs interventions according to hospital policies and procedures						

3. Nursing Process (Continued)

• Verbalizes the scientific rationale for nursing interventions							
• Provides age appropriate and culturally competent care							
• Develops goals in collaboration with client/significant other							
Prioritizes goals							
Realizes goals in a timely fashion							
• Identifies significant changes in database and/or patient condition							
• Develops teaching plan appropriate to patients' needs and level of understanding							
• Involves the interdisciplinary team in D/C planning							
• Asks appropriate questions to determine patient's response to nursing care							
• Evaluates patient outcomes in relation to established goals							
• Reviews pertinent literature related to presenting health problems							
• Participates with peers and other professionals in evaluating the quality of the nursing care provided for clients							

	Midterm			Final		
	S	**U**	**No**	**S**	**U**	**No**
4. **Demonstrates competency in drug computations and drug administration**						
• Validates the accuracy of the medication order						
• Calculates drug dosage correctly						
• Identifies indications, actions and side effects of client's medications						
• States the nursing implications of the drugs						
• Safely administers medications:						
Oral						
SQ						
IM						
IV– Central, Peripheral						
IVPB						
• Calculates IV flow rate accurately and monitors infusion rate correctly						
• Promptly and correctly documents administration of medications						
• Evaluates outcomes/effectiveness of medications						

5. Leadership						
• Shows initiative in seeking out learning experiences						
• Serves as a resource to peers						
• Advocates on behalf of patient						
• Acts effectively in role of team leader to peers						
• Demonstrates leadership in group process •						
• Contributes to the learning of peers •						

	Midterm			Final		
6. Professional Accountability	**S**	**U**	**NO**	**S**	**U**	**N O**
• Seeks assistance appropriately from instructor, peers, and other professionals.						
• Acts on constructive feedback to improve clinical performance.						
• States the clinical expectations of the course.						
• Plans clinical time to ensure meeting clinical objectives.						
• Manages time effectively to complete clinical assignments.						
• Keeps a daily journal of clinical learning goals and experiences which foster self-awareness.						
• Appears on time and prepared to practice for all clinical activities.						
• Notifies the instructor in advance of lateness or absence.						
• Reports on and off the clinical unit.						
• Participates in group process. Is a team player.						
• Is prepared for pre-conference						
• Identifies legal and ethical issues that relate to patient care.						
• Complies with standards of professional ethics						
• Complies with dress code and grooming standards for clinical practice						
• Demonstrates professional demeanor in interactions with client, family, peers and staff.						
• Utilizes appropriate resources as sources of information.						

Strengt
Areas of

Midterm grade:

_____

Instructor Signature…….

Student Signature…….

Date…….

Final: grade

_____

Instructor Signature…….

Student Signature…….

Date…….

Student Comments

Students name: ----------
Clinical area: ----------
Final Grade: ----------

CASE STUDY (ORAL) PRESENTATION RUBRIC

CRITERIA	4 Excellent	3 Good	2 Fair	1 Poor							
Content	In-depth and thorough discussion of assigned topics spontaneously without referring to notes or slides	Majority of the topics are thoroughly discussed and given in-depth discussion while occasionally refers to notes and slides	Only some topics are thoroughly discussed and given in-depth discussion while constantly referring to slides	Limited analysis of data, interpretation, and correlation							
	Student demonstrates full knowledge (more than required) by answering all class questions with explanation.	Student is at ease with expected answers to all questions but fails to elaborate.	Student is uncomfortable with information & can answer only rudimentary questions.	Student does not have grasp of information: student cannot answer questions about subject.							
	Student presents information in logical, interesting sequence which audience can follow.	Student presents information in logical, sequence which audience can follow.	Audience has difficulty following presentation because student jumps around.	Audience cannot understand presentation because there is no sequence of information.							
Delivery	Relaxed, self-confident.	Demonstrates quick recovery from minor mistakes	Difficult to recover from minor mistakes	Nervous							
	Shows natural body movements that develop enthusiasm and affects audience positively	Possesses body movements that enhance presentation	Body movements and gestures enhance presentation to a limited extent	Self-conscious							
	Voice projection fluctuates in volume and inflection and sustains interest	Voice projection is satisfactorily varied in volume and inflection	Voice projection is fairly varied in volume and inflection	Voice projection is monotonous							
	Very good articulation and communicative	Good articulation and communicative	Grasps for words sometimes	Inarticulate most of the time							
Presentation Aids	AV materials are well done and are used to make the presentation more interesting and meaningful	Makes use of AV materials that enhances the presentation to a good extent	Makes use of some AV materials that enhances the presentation to a limited extent	Makes use of AV materials but does not enhance the presentation							
Time Management	Finishes within the prescribed time with appropriate pacing	Finishes within the time frame but failed to give emphasis on some topics	Hurriedly finished on time	Did not finish on time							

Faculty Name & Signature: _____

CASE STUDY RUBRIC (WRITTEN)

	Exceptional 4	Satisfactory 3	Unacceptable 2	Consider Remediation 1	
1. Patient's Past Medical History a. History	History is complete and is appropriate with the age, gender and chief complaint. It is written in logical format.	History is age/gender appropriate and contains pertinent information. However, it is missing some vital points relating to the chief complaint.	History is scant. The majority of vital information is missing relating to the chief complaint.	The work in this category is far below what is expected to be presented.	
2. Assessment and Plan a. Anatomy and Physiology	Pathophysiology is presented based on the signs and symptoms and risk factors presented by the patient.	Pathophysiology is presented utilizing the risk factors of the patient towards the disease process.	The majority of the risk factors presented in the pathophysiology is missing relating to the identified problem	The work in this category is far below what is expected to be presented.	
b. Physical Assessment	Physical exam has been completed as instructed, is age/gender appropriate, relates to the chief complaint, and pertinent findings.	Physical exam is appropriate for the chief complaint but there are pertinent systems or special tests missing.	Appropriate physical examination is incomplete. The information obtained would not be sufficient to support the diagnosis.	The work in this category is far below what is expected to be presented.	
c. Plan of Care	Student outlines a complete and effective plan of care for selected patient	Student outlines an effective care plan for selected patient, with one or two missing components	Plan of care is incomplete, with several components that are missing or not relative to the selected patient's condition.	The work in this category is far below what is expected to be presented.	
c. Laboratory Diagnostic tests	All appropriate labs and diagnostic tests are recorded and rationalized	The majority of the appropriate tests have been ordered. There are one or more missing.	The majority of the appropriate tests are missing.	The work in this category is far below what is expected to be presented.	
3. Treatment overview	There is a complete discussion of the actual treatment including rationale for each aspect of treatment.	The summary of treatment is adequate with some facts omitted.	The summary of treatment is poor and many facts are omitted.	The work in this category is far below what is expected to be presented	
4. Organization	The paper is well-written in a logical, organized manner	The paper relays information but is slightly disorganized	The paper does not relay adequate information on the subject, is disorganized and difficult to follow.	The work in this category is far below what is expected to be presented.	
5. Content	The length of the paper is appropriate to communicate the ideas presented professionally.	There are topics throughout the paper which should have been explained more thoroughly.	The paper is poorly written with incomplete data and communication of thought.	The work in this category is far below what is expected to be presented	
				TOTAL	

Name of Rater: _____ Signature: ----------

Date: _____

Case Title: _____ **Date Presented: _____**