HOUSTON COMMUNITY COLLEGE SYSTEM JOHN B.

COLEMAN HEALTH SCIENCE CENTER

RNSG- 1160

Level 2

Nursing Care of the Childbearing and Childrearing Family

CRNs # 40176, 40184, 40187,40200

CLINICAL-NURSING

SYLLABUS

FALL -2017

INSTRUCTOR'S CONTACT INFORMATION:

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Please feel free to contact us at any time concerning any problems that you are experiencing in this course. You do not need to wait until you have received a poor grade before asking for my assistance. Your performance in this class is very important to us. We are available to hear your concerns and discuss course topics. Feel free to contact us by phone or email.

You will be communicated in this course through Canvas. Please regularly check the Announcement Section in the Canvas.

COURSE DESCRIPTION

A health-related work-based learning experience that enables the student to apply specialized occupational theory, skills and concepts. Direct supervision is provided by the clinical professional. On-site clinical instruction, supervision, evaluation, and placement are the responsibility of the college faculty. Clinical experiences are unpaid external learning experiences. Course may be repeated if topics and learning outcomes vary.

II. PRE-REQUISITES: ENGL 1301, ENGL 1302, BIOL 1406, BIOL 2401, BIOL 2402, BIOL 2420, PSYC 2301, PSYC 2314, RNSG1301, RNSG 1115, RNSG 1360, RNSG 1513, RNSG 1441, RNSG 1105, RNSG 2360.

III. CO-REQUISITE: RNSG 1251, RNSG 2160, RNSG 2213

IV. COURSE LEARNING OUTCOMES

As outlined in the learning plan, the student will apply the theory, concepts, and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with the particular occupation and the business/industry; demonstrate legal and ethical behavior, safety practices, interpersonal and teamwork skills, communicating in the applicable language of the occupation and the business or industry

CHILDBEARING MODULE

At the completion of the course, the student will have been provided with opportunities and resources to:

1. Assess the health status and health needs of childbearing and childrearing clients and their families in health and illness. (DEC-IIA, IIB)
2. Communicate effectively with childbearing and childrearing clients and their families, significant others, and members of the multidisciplinary team.
3. Apply principles of the teaching/learning process in promoting, maintaining, and/or restoring health to childbearing and childrearing clients and their families.
4. Use clinical data and current literature as a basis for decision-making in nursing practice for childbearing and childrearing clients and their families. (DEC-IIC)
5. Collaborate with clients, their families, and other health care professionals to provide care for childbearing and childrearing clients and their families.
6. Safely administer nursing care to childbearing and childrearing clients and their families. (DEC-IID)
7. Apply legal and ethical standards of nursing practice to childbearing and childrearing clients and their families. (DEC-IIE)
8. Evaluate childbearing and childrearing clients' and their families' responses to therapeutic interventions.
9. Participate in activities that promote the development and practice of nursing care for childbearing and childrearing clients and their families.
10. Exhibit accountability and responsibility for the quality of nursing care provided to the childbearing and childrearing clients and their families.

V. METHODS OF ACCOMPLISHING LEARNING OUTCOMES

1. Multimedia - Computer Aided Instruction and Video use*
2. Nursing Skills Lab*
3. Client care*
4. Nursing care plan.
5. Health teaching

VI. EVALUATION

1. <u>Clinical Preparation</u> – 20%

Students must be adequately prepared for the clinical practicum each clinical day. The student must demonstrate orally and/or in writing evidence of preparation for clinical/client care.

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OB rotation: Review instructions for clinical preparation in the OB course materials. A current (within 2 years of publication) evidence-based practice Nursing Journal article review must be submitted as assigned by clinical instructor. Refer to OB clinical course material for grading criteria. Students will be assigned an OB topic related to antepartum obstetric complications to present during post-clinical conference.
All the grades will be averaged at the end of the semester.

2. <u>Nursing Care Plan/Data Collection and Analysis – 50% (TWO CARE PLANS AND TWO DATA ANALYSIS)</u>

Care Plans: One satisfactory (75% or higher) Standard Care Plan is required for OB clinical, with a minimum of three (3) nursing diagnoses worked through completely (see standard care plan form). Once a satisfactory standard care is met, then students can complete Data collection analysis for subsequent clinical weeks. When the student submits each care plan, a grading form for the care plan (Criteria for Grading Nursing Care Plans) must be included. Failure to include a grading form will result in 10 points being deducted from care plan grade. The grades for t**nursing care plan and the data collection analysis** will be averaged at the end of the course. Care plans handed in after the due date and/or time will result in 10 points being deducted from care plan grade each day the care plan is late. A care plan handed in more than 2 days late will result in a grade of "0".

Selection of Clinical Experiences:

a) Students are required to participate in the selection of clients in clinical practice, as applicable.

b) Children are **NOT** allowed on clinical units. Please make appropriate child care arrangements for pre-clinical clinical activities.

<u>Health Teaching</u>: The student will implement one (1) health teaching in one clinical area (antepartum, L&D, postpartum, & nursery) and will submit documentation of the teaching encounter, along with data collection & analysis or nursing care plan.
Students are expected to participate in group conferences with staff, peers, and faculty to coordinate client care management and to share information regarding clients' progress, clients' need for teaching, and discharge planning. ***These activities will serve to demonstrate student competency in the following SCANS competency requirements: Display creative thinking, exhibit decision-making skill, use problem-solving skill, and visualize eye concepts.** The student will receive a grade for each clinical day, according to designated criteria.

3. **Client Care Performance Evaluation- 30%**

Weekly clinical performance will be assessed and students will receive a weekly grade, which will be averaged for the evaluation grades.

Clinical Math Testing:

Math Policy: Safe administration of medications is a cornerstone of safe patient care. In an effort to assure students are prepared to calculate medication dosages, there will be a math test prior to each clinical rotation.

Procedure: Each student will be given a math packet to review prior to the new semester Foundation students will be given the packet during orientation. On the first day of theory for the designated term (Foundations, Transition, Medical/Surgical Nursing, Pediatrics, and Obstetrics), the instructor for the theory class will present an overview of the math for the upcoming clinical.

The math test will be given by the theory instructors. Students will be required to pass the exam with 90% or better. The

student who is not able to successfully pass the math test with 90% or better on the first will have the weekly formative grade reduced by 30 points. **An unexcused absence for the Drug Calculations Exam is considered an attempt. No makeup exam will be administered.**

Any student unable to pass the exam by the third attempt will not be allowed to continue in the clinical and therefore will be counted as failing the clinical rotation.

VII. CLINICAL PERFORMANCE/PREPARATION

The student must demonstrate orally and in writing evidence of thorough and accurate assessment of client (s). Failure to complete the care plan components will result in an unsatisfactory grade for that day and this student will not be allowed to do client care**. The student must** submit a care plan for clients including drug cards. The care plan must be submitted within the stated deadline. The student will select their clients as per clinical instructor's guidance. Students are required to collaborate with faculty and the staff of the institution so that the rules or guidelines regarding student's clinical practice are adhered to and clients' safety is not compromised. **NOTE: Students who demonstrate behaviors endangering the clients, other people or self will be removed from the clinical facility**.

*These activities will serve to demonstrate student competency in the SCANS competency requirements. Students are expected to monitor client's responses to nursing care and treatment and report these responses to the appropriate member of the health team. All data reported and documented must be accurate and complete. Students are expected to participate in-group conferences with staff, peers, and faculty to coordinate client care management and to share information regarding clients' progress and the need for client teaching and discharge planning.

Facility requirements and guidelines:

Students are required to complete all orientation for the clinical facility, per facility requirements. Students must maintain updated immunization, CPR, TB, and all required health records on Certified Background. A student who does not attend clinical orientation and/or does not have updated records on certified background, will be not be allowed to attend clinical, per ADN program and clinical facility policies. Students are required to work with the faculty and the staff of the institution so that the rules and/or guidelines regarding students' clinical practice are adhered to and clients' safety is not compromised. **Note: Students who demonstrate behaviors endangering the clients, other people, or self will be removed from the clinical facility**.

VIII. ATTENDANCE AND TARDINESS

Strict attendance is required for all clinical experiences and clinical facility orientation. For RNSG 1160, student must complete 96 hours for obstetric clinical rotation per BON requirements. Failure to complete the required hours may result in the student receiving an incomplete for the clinical course and may not progress in the program. Students are responsible for notifying faculty and/or the clinical agency of absences from required clinical experiences prior to the scheduled time for the experience. Students are expected to follow guidelines provided by individual courses or levels. Discussion with your clinical faculty member should occur prior to any anticipated absence such as illness or crisis in the family or death of a close family member. Students who are either pregnant or have become pregnant during their clinical rotation must submit documentation from their physician to assume full duty in clinical. If you attend clinical but is ill or have other issues that require you not to continue in clinical, it will be considered an absence and you will need to complete the missed clinical hours upon documentation provided.

The stated numbers of absence may vary by course and the student should refer to the syllabi for specifics. For the OB module, this number is 12.5% or 1 day (12 hours) of scheduled clinical time. *Absences will result in a deduction of **10% per occurrence** to the final grade*.

A student who does not arrive at the assigned clinical facility and designated place at the appointed time will be

considered tardy. After two clinical "tardiness", the student will be counseled for unprofessional conduct. **A student who is thirty or more minutes late will be marked absent for the clinical day, and it is the faculty's discretion and clinical facility requirements that will determine if student is allowed to stay for clinical day.**

Any absence must be accompanied by valid documentation. Students who fail to notify their clinical instructor of a clinical absence will receive a zero (0) for this behavior on the weekly performance evaluation. **A student who has excessive absences may be administratively dropped from the course.**

IX. REQUIRED TEXTBOOKS:

Perry, S. E., Hockenberry, M. J, Lowdermilk, D. L., Wilson, D., (2015). Maternal Child Nursing Care, 5th ed. St. Louis: Elsevier/Mosby Co.
ISBN 978-0-323-09610-2

Crum, K. A. & Wilson, D. (2014). Virtual Clinical Excursion, 5th ed. Maryland Heights, Missouri: Elsevier/Mosby Co. ISBN 978-0-323-22187-0

RECOMMENDED RESOURCES:

Gray-Morris, Debra, (2006) Calculate with Confidence, 4th ed. St. Louis: C.V. Mosby.
ISBN0-323-01349-X.

XI. POLICIES:

All students will adhere to HCCS policies as delineated in the HCCS and ADN handbooks. Students who repeat a course three or more times will face significant tuition/fee increases at HCC and other Texas public colleges and universities. Please ask your instructor/counselor about opportunities for tutoring/other assistance prior to considering course withdrawal, or if you are not receiving a passing grade.

XII. SPECIAL NEEDS

Any student with a documented disability (e.g. physical, learning, psychiatric, vision, hearing, etc.) who needs to arrange reasonable accommodations must contact the Disability Services Office of their respective college* at the beginning of each semester. Faculty is authorized to provide only the accommodations requested by the Disability Support Services Office.
For questions, contact the Disability Counselor at your college. To visit the ADA Web site, log on to www.hccs.edu, click Future Students, scroll down the page and click on the words Disability Information.

EARLY ALERT PROGRAM:

The Houston Community College Early Alert program has been established to assist in the overall effort to retain students who are at risk of failing, withdrawing, or dropping a course. This process requires instructional faculty and student support staff to identify students who are performing poorly as early as possible and provide relevant support services to help students overcome their deficiencies. A student is identified when an instructor notices academic or personal difficulties that affect student's academic performance. The possible problem(s) could be tardiness, missed/failed test scores, excessive absences, or a number of other circumstances. Once a referral is made counselors will then contact students to discuss t issues and possible solutions to their academic difficulties.

EGLS3 – Evaluation for Greater Learning Student Survey System:

At Houston Community College, professors believe that thoughtful student feedback is necessary to improve teaching and learning. During a designated time, you will be asked to answer a short online survey of research-based questions related to instruction. The anonymous results of the survey will be made available to your professors and division chairs for continual improvement of instruction. Look for the EGLS3 as part of the Houston Community College Student System online near the end of the term.

XIII. MEETING DATES/TIMES AND LOCATION

Dates/Time Susan Thomas - Tuesdays 7am -7pm Sugarland Methodist hospital.
Lilian Ofoegbu Wednesdays 7am-7am – Sugarland Methodist Hospital
We will meet at the SIM LAB and OB simulation scenarios will be used cover the clinical objectives until we start the clinical rotations at the clinical sites.

XIV. LEARNING ACTIVITIES

A. Contemporary Technology

1. Computer Assisted Instruction (explanatory and interactive)
2. Internet access
3. Medline access

B. Clinical / Laboratory Activities

1. Learning through simulation
2. Psychomotor skill development
3. Client care management
4. Clinical conferences

XV. METHODS OF EVALUATION

Pre-Clinical Preparation, (article review)	20%
Data Collection Analysis/Nursing Care Plan (Simulation scenarios can be replaced for care plans and data collection)	50%
Weekly Performance Evaluation	30%

HCC ADN Grading Scale

A = 100 – 90…….……4 points per semester hour

B = 89 – 80……..…….3 points per semester hour

C = 79 – 75……..…….2 points per semester hour

D = 74 – 60……..……1 point per semester hour

59 and below = F……..0 points per semester hour

IP (In Progress) ……..…0 points per semester hour

W (Withdrawn)……..…0 points per semester hour

I (Incomplete)……..0 points per semester hour

AUD (Audit) ……..…0 points per semester hour

IP (In Progress) is given only in certain developmental courses. The student must re-enroll to receive credit. COM (Completed) is given in non-credit and continuing education courses. To compute grade point average (GPA), divide the total grade points by the total number of semester hours attempted. The grades "IP," "COM" and "I" do not affect GPA.

XVI. PORTFOLIO

The student will maintain all written work and care plans in a portfolio that will be available to the clinical Instructor at all times. Students are required to submit their portfolio prior to final clinical evaluation**.** It is the student's responsibility to maintain and update skills checklist during the OB clinical rotation.

RNSG 1160
SCANS AREAS OF COMPETENCY

The U.S. Department of Labor Secretary's Commission on Achieving Necessary Skills (SCANS) to enter the workplace has determined that a total of 43 competencies must be addressed and method(s) of determining competency listed:

Three SCANS competencies are addressed:

Employ Interpersonal Skills:

#12. Participate as a team member

Each week in the clinical area, each student participates as a member of a team, with a licensed nurse as team leader. The student receives report from the leader, consults with her about the assigned clients, helps the leader with other clients, and reports to her at the end of the clinical shift.

#13. Teach others

Each student implements a written health teaching plan a minimum of four times during the course. Each health teaching plan, implementation and evaluation is graded. Client teaching is evaluated each clinical day as part of the clinical performance.

Apply Thinking Skills:

#38. Exhibit reasoning skills

Each student performs client care each clinical day and develops a nursing care plan for the assigned clients. The nursing process is a problem-solving process consisting of assessment, analysis, planning, implementation and evaluation.
Each nursing care plan is graded, and the grade average counts for twenty-five percent of the final course grade.

Display Appropriate Personal Qualities:

43. Display integrity/honesty

Integrity and honesty are integral to the nursing profession. Students are held accountable for their action. They must maintain client confidentiality at all times. These behaviors are evaluated each clinical day. A breach of these expectations will result in a student's failing the course.

RNSG 1160: Clinical Nursing, Nursing Care of the Childbearing and Childrearing Family

Student Name (print):_____
Last First

Scale:

A = 90-100

B = 80-89

C = 75-79

D = 60-64

F = below 60

OB Module:

Article review and presentation_____ X 0.20 = _____

Data Collection Analysis/Nursing Care Plans X 0.50= _____
Two care plans and two data analysis (15+15+10+10)_____

Weekly Clinical Behavior _____ X 0.30 = _____

Excessive absences will be a *deduction of **10% per occurrence** to the final grade* _____

RNSG -----POLICY AND PROCEDURE STATEMENT, CLINICAL BEHAVIORS

The practice component for the ADN courses is graded using weekly performance evaluations and a summative evaluation at the end of each clinical course. The purpose of this statement is to identify the procedure and consequences for unsatisfactory behaviors. These procedures should be initiated upon the occurrence of the unsatisfactory behavior or action rather than at the conclusion of the clinical course. **A one-time violation of any starred (*) item on the clinical evaluation tool will result in clinical failure.** Clinical behaviors that are normally dealt with fall into three categories. The first level identified as **BNI** (behaviors needing improvement) involve incidents such as uniform infractions and misunderstanding of care plan assignments. The second level, identified as **RNI** (reportable negative incidents) is more serious infractions which necessitate more serious recognition and remediation. An example might be the failure to report vital signs not within the normal range or repeated failure to report to the clinical area without the appropriate preparation. The third level, identified as **RNCI** (reportable negative critical incidents) indicates a **very serious infraction** which has endangered or impaired a life. These behaviors correspond to the Critical Elements that the faculty has identified as *Safety, Accountability, and Confidentiality*. An example might be a medication error that impaired a life or side rail left down resulting a patient injury. Student behaviors related to the Critical Elements are starred on the Clinical Evaluation Tools. **Three RNI's or the occurrence of 1 RNCI (reportable negative critical incident) may result in a student being dismissed for the ADN program upon recommendation of five-member faculty committee.**

PROCEDURE:

Level I - BNI (Behaviors Needing Improvement)

1. Identify the behavior to the student and counsel as needed.
2. Document behavior or action via the ADN's "Prescription for Success" form or an HCCS Contact Action Form.
3. Observe and document correction of behavior or action.

Level II – RNI (Reportable Negative Incident) - May be a more serious offense as described above or repetition of a particular BNI.

1. Identify the behavior or action to the student.
2. Fill out a Contact Action Form and designate the incident as a RNI and submit it to the ADN Department Chair.
3. The Department Chair will then activate a five- member faculty hearing committee to determine if the offense warrants designation as an RNI.
   Three RNI's approved by a 5-member faculty hearing committee may result in the student 's being dismissed for the ADN program at any point during the course of study.
4. If the RNI is not approved, the incident is filed as a BNI and the student will be assigned remediation as designated by the committee.

Level III - RNCI (Reportable Negative Critical Incident - One in which life is impaired or endangered)

1. Steps 1 and 2 as above, however, the Contact Action must be identified as an RNCI (reportable negative critical incident).
2. Step #3 as above; however, the Faculty Committee must now determine if this behavior warrants removal of the student from the program or decide if this is one of the three RNI's.
3. If the Reportable Negative Critical Incident report is accepted by the committee, then institutional policy is followed to remove the student from the program.
4. If an RNI status is granted, then assigned remediation must be performed by the student.

RNSG 1160– OB Weekly Clinical Performance

Student: _____ Facility: _____
Faculty: _____ Semester: _____

Clinical Week	1	2	3	4	5	6	7
1. Reports to clinical on time or notifies clinical instructor of tardy or absence							
2. Prepared for clinical experience as evidenced by completion of pre-clinical paper- work							
3. Receives report on client. Reviews client data to ensure proper care for shift (labs, medications, procedures)							
4. Completes physical assessment & collaborates significant findings with staff							
5. Knowledgeable about client's plan of care and identifies signs and symptoms of disease process							
***6. Performs all clinical skills and procedures safely according to policy of assigned affiliate agency**							
a. Vital signs							
b. Asepsis							
c. Personal care/hygiene							
d. Other							
7. Medications							
a. Checks medications to be given, availability, & client allergies							
b. Demonstrates knowledge of drugs and nursing implications							
*** c. Correct preparation and calculation of medications**							
*** d. Administers medications safely**							
e. Evaluates client response							
9. Client diet: Identifies type, amount taken, nutrition needs							
10. Communicates appropriate and accurate knowledge about client's plan of care							
a. Discuss labs, medication and clinical procedures							
b. Discuss significant assessment findings and collaborate significant findings with staff							
c. Discuss prioritized nursing diagnoses, goals and interventions							
11. Communicates effectively with peers, faculty, members of the health care team and client on his or her developmental level of comprehension							
12. Accurately documents client care information							
***13. Reports pertinent information critical to client care to instructor or other health care team members in a timely manner**							

14. Prioritizes and organizes client care according to growth, development and disease process							
***15. Demonstrates confidentiality of client information/follows HIPAA guidelines**							
***16. Seeks & uses feedback from instructor/ nursing staff; seeks clarification of assignments & role responsibility when in doubt**							
***17. Seeks and/or requests learning experiences to enhance own learning; investigates unfamiliar medications, procedures, or equipment**							
18. Implements health teaching appropriate to the clinical area							
***19. If error is made, reports to instructor or staff immediately**							
20. Maintains standard of performance under stress							
21. Demonstrates through appearance, verbal or written communication, and person to person interactions, a courteous, constructive and positive attitude.							
22. Follows directions, organizes materials, manages time and actively participate in post clinical conference							
***23. Demonstrates sensitivity, courtesy to others, honesty, constructive positive attitude, accountability and scholastic integrity/ Professional behaviors**							
Total							
Student's initial							

***Indicates the behavior is critical to performance**.

Evaluation Codes: Satisfactory = S
Needs Improvement = NI
Unsatisfactory = U
NO = not observed
NA = not applicable

<u>CRITICAL BEHAVIORS</u> - If performance is less than satisfactory on any <u>critical behavior</u>:

<u>First occurrence</u>: 25 points deducted from grade and documented remediation within one week
<u>Second occurrence</u> of same behavior: Zero for the clinical day
<u>Third occurrence</u> of same behavior: Zero in clinical performance for the course (25% of course grade)

<u>NON-CRITICAL BEHAVI0RS</u>:

Each <u>U</u> (unsatisfactory) received: 10 points deducted from grade
Each <u>NI</u> (needs improvement): 5 points deducted from grade

Additional Comments:

FINAL EVALUATION:

Faculty:

Student:

Faculty Signature_____
Student Signature_____

Date:_____

HOUSTON COMMUNITY COLLEGE SYSTEM

JOHN B. COLEMAN HEALTH SCIENCE CENTER

RNSG 1160(CLINICAL)

MATERNAL/CHILD HEALTH NURSING

OB COURSE MATERIALS

SUMMER- 2017

HOUSTON COMMUNITY COLLEGE SYSTEM

RNSG 1160

ARTICLE REVIEW AND ANALYSIS

Follow the sequence outlined when you write up your journal article review

(Submit this form with the completed assignment)

1. Attach copy of article. Article must be current (within last 2 years), relate to nursing care, and published in a professional nursing journal (no editorials accepted). 10%

2. Summary of article: 25% (Length: Minimum of 12 sentences)

3. Relevance of the article to nursing care of the client in your assigned clinical area: 25%

   (Describe how the information you reviewed in the article can be used to assist you in the care for clients in your assigned clinical area on the day you present.) Journal article selection must be related to the clinical area you have been assigned to on the day you present.

   (Length: Minimum of 8 sentences)

4. Agreement / disagreement with article: State why you agree or disagree with the information provided. Use information obtained in text books, other journals, clinical practice or personal experience as sources to site when you agree or disagree. 15%

   (Length: Minimum of 6 sentences)

5. Oral presentation: 20%

6. Reference (APA Format): 5%

Nursing Diagnosis #1:_____

Goal: _____MET/NOT MET/PARTIALLY MET

Outcome Criteria: (The goal has been met if the client…)

1. _____MET/NOT MET

2. _____MET/NOT MET

3. _____ MET/NOT MET

Priority Nursing Interventions	Scientific Rationale for Every Intervention	Evaluation of each Nursing Intervention
1.		
2.		
3.		
4.		
5.		

Care Plan to be continued: yes_____ no_____

Revisions to plan of care:_____

Reference: (must use pediatric reference as primary resource; include pages)_____

Nursing Diagnosis #2:_____

Goal: _____MET/NOT MET/PARTIALLY MET

Outcome Criteria: (The goal has been met if the client…)

1. _____MET/NOT MET

2. _____MET/NOT MET

3. _____ MET/NOT MET

Priority Nursing Interventions	Scientific Rationale for Every Intervention	Evaluation of each Nursing Intervention
1.		
2.		
3.		
4.		
5.		

Care Plan to be continued: yes_____ no_____
Revisions to plan of care:_____

Reference: (must use pediatric reference as primary resource; include pages)_____

Nursing Diagnosis #3:_____

Goal: _____MET/NOT MET/PARTIALLY MET

Outcome Criteria: (The goal has been met if the client…)

1. _____MET/NOT MET

2. _____MET/NOT MET

3. _____ MET/NOT MET

Priority Nursing Interventions	Scientific Rationale for Every Intervention	Evaluation of each Nursing Intervention
1.		
2.		
3.		
4.		
5.		

Care Plan to be continued: yes_____ no_____
Revisions to plan of care:_____

Reference: (must use pediatric reference as primary resource; include pages)_____

HEALTH TEACHING

Circle clinical area the teaching took place: AP PP L&D NURSERY

ASSESSMENT DATA

Describe specific details that you assessed that demonstrated a need for your teaching activity.

NURSING DIAGNOSIS:

Select a health teaching nursing diagnosis and specify what the teaching need.

PLAN

1. Client goal (include a time frame)
2. Detailed teaching outline (attach)
3. *If pamphlets or brochures are used, attach a copy*
4. Reference(s). (Use APA format)

IMPLEMENTATION OF PLAN

1. Client readiness to learn (Describe client's behavior during teaching activity)
2. Strategies used to teach
3. Setting or location of teaching activity
4. Duration of teaching
5. Teaching materials used

EVALUATION

1. Was the goal met?
2. Site evidence to support that the goal was met.
3. Revisions: If the goal was not met include other strategies that may be used to facilitate Learning.

MEDICATION INFORMATION SHEET

Medication/Class & FDA Pregnancy Category	**Action/Use *For this client***	**Dosage client received**	**Route**	**Time**	**Client's Critical Lab Values**	**Client's Pertinent V.S.**	**Side Effects Contraindications**	**Nursing Implications/ Teaching *for this client***

Narrative Nursing Documentation: q2hr or PIE Format

Date & Time	Document plan of care: Patient assessment findings, interventions, evaluation and revisions (Write signature and title at the end of each documentation entry)

HOUSTON COMMUNITY COLLEGE SYSTEM

RNSG 1160 OB CLINICAL GUIDE

Drug cards or completed medication forms for each clinical area must be reviewed before clinical. (listed on page 33).

Be prepared for questions to evaluate preclinical prep. All pre-clinical assignments are due at the beginning of the clinical day.

Due date for complete care plan is determined by the clinical instructor. Papers submitted after the due date will have 10 points deducted from the grade each day. Papers submitted more than one week after the day of clinical will receive a grade of 0. Papers will be graded and returned no later than one week after they are received.

Follow the instructions on page 30 to prepare for clinical rotation.

Please note: APA format must be used for all references. ***No text references more than 5 years' old***

Before clinical day:

Antepartum	**Triage, Birth center or L&D**	**Postpartum**	**Nursery**
1. Read chapter 4 pp. 48-62, chapter 11 pp. 239-271 & 12. Focus on the AP assessment & maternal nutritional requirements. **2. Select one of the following topics to present to your peers during post-clinical conference. Students will not be allowed to present the same topic.** Use the criteria outlined on the pathophysiology form for the presentation: 1. Pre-eclampsia 2. Preterm Labor 3. Diabetes Mellitus: Gestational and pre-gestational 4.Placenta Previa 5.Pyelonephritis during pregnancy 6. Placental abruption 7. Anemia during pregnancy 8. HELLP syndrome 9. Cardiac disease during pregnancy 10. Preterm rupture of membranes	**Before clinical day:** **1.** Read related Chapters in the OB text: Chapters15,16, 17 &18. Focus on assessment & pain management during labor.	**Before clinical day:** **1.** Read related Chapters in the OB text: Chapters 20, 21, 22 & 23. Focus on postpartum assessment.	**Before clinical day:** Read related Chapters in the OB text: 24,25,26. Focus on newborn assessment, measurements, & normal range of vital signs.

DAY OF CLINICAL

Antepartum (AP)	Triage, Birth Center or L&D	Postpartum PP	Transition Nursery (NSY 1)
If possible, select a client 20 weeks' gestation or more. **1.** During clinical, complete AP data base and 3 priority nursing diagnoses **2.** Clinical conference TBA	**If possible select a client admitted in triage, in active labor or going for a cesarean section.** **1.** During clinical, complete data base for labor and delivery and 3 priority nursing diagnoses. (Use all forms that apply to your client) **2.** Clinical conference TBA **3.** Submit copy of client documentation & health teaching at end of clinical	**If possible, select the most recent admission to the post-partum unit** **1.** During clinical, when you receive your client assignment, use the PP assessment worksheet to record assessment data, complete the PP assessment data as it applies to your client, and 3 priority nursing diagnoses **2.** Clinical conference TBA **3.** Submit copy of client documentation & health teaching at end of clinical	**If possible, select the most recently admitted newborn** **1.** During clinical, when you receive your client, complete NB assessment, 3 priority nursing diagnoses, & complete appropriate forms **2.** Clinical conference TBA **3.** Submit copy of client documentation & health teaching at end of clinical

POSTCLINICAL

Antepartum (AP)	Birth Center (L&D)	**Postpartum (PP)**	Transition Nursery (NSY 1)
When a care plan is due submit: **1.** *One completed nursing care plan with 3 or more nursing diagnoses. Include pathophysiology page *r/t reason for hospitalization.* Include grading form. (When a care plan is indicated) **2.** All forms completed for pre-clinical & during clinical. **For data collection**: **Submit** completed assessment forms, lab forms, list of nursing diagnoses, grading form, and documentation, Consult with clinical instructor for time of submission.	**When a care plan is due submit:** **1.** *One completed nursing care plan with 3 or more nursing diagnoses. Include grading form. **2.** All assessment forms completed for pre-clinical & during clinical. **For data collection**: **Submit** completed assessment forms, lab forms, list of nursing diagnoses, grading form and, documentation, Consult with clinical instructor for time of submission.	**When a care plan is due submit:** **1..** *One completed nursing care plan with 3 or more nursing diagnoses. Include grading form. **2.** All assessment forms completed for pre-clinical & during clinical. **For data collection**: Submit completed assessment forms, lab forms, list of nursing diagnoses, grading form and, documentation, Consult with clinical instructor for time of submission.	**When a care plan is due submit:** **1.** *One completed nursing care plan with 3 or more nursing diagnoses. Include grading form. **2.** All assessment forms completed for pre-clinical & during clinical. **For data collection**: **Submit** completed assessment forms, lab forms, list of nursing diagnoses, grading form and, documentation, Consult with clinical instructor for time of submission

Each student is expected to achieve a grade of 75 or above on OB nursing care plans. Each nursing care plan must be in a different clinical area.

MEDICATION LIST

A typed or handwritten medication sheet or pre-printed card for the following medications is recommended.

Medication	Area mostly likely to be used:
Feisul (ferrous sulfate)	PP, AP
Colace (docusate sodium)	PP, AP
Prenatal Vitamins (select one)	PP, AP
Ibuprofen	PP
RhoGAM (Rho (d) immune globulin, human)	PP, AP
Methergine (methylergonovine)	PP, L&D
Ancef (cefazolin)	L&D, AP, PP
Pitocin (oxytocin) (text, p 767-8)	PP, L&D
Hemabate (carboprost) p 675	L&D, PP
Stadol (butorphanol)	L&D
Demerol (meperidine)	L&D
Sublimaze (fentanyl)	L&D
Nubain (nalbuphine)	L&D
Magnesium Sulfate (Intravenous for OB use) (text, p 500)	L&D, AP, PP
Calcium Gluconate	L&D, AP, PP
Ilotycin (Erythromycin Ophthalmic Ointment) - for neonate	NB
AquaMEPHYTON I.M. (Vitamin K) - for neonate	NB
Triple Dye - for neonate	NB
Hepatitis B Vaccine	NB
HBIG (Hepatitis B Immune Globulin)	NB
Brethine (terbutaline)	AP
Celestone (Glucocorticoid / Betamethasone)	AP
ZOfran	
TORADAL	AP, PP, L&D

Medication information for <u>each</u> medication that your patient <u>receives</u> *should be submitted with your care plan and/or data collection*.

DATA COLLECTION GUIDES FOR CLIENT ASSESSMENT AND CARE PLAN

PATIENT PRIORITIZED NANDA NURSING DIAGNOSIS LIST

Based on the assessment data list 2 nursing diagnosis in order of priority on this page:

1. Problem:

   Related to (etiology/predisposing factors):

   As evidenced by/ defining characteristics:

2. Problem: Risk for infection

   Related to (etiology/predisposing factors):

   As evidenced by/ defining characteristics:

3. Problem: Risk for infection

   Related to (etiology/predisposing factors):

   As evidenced by/ defining characteristics:

STUDENT'S NAME_____ DATE_____

ANTEPARTUM DATA COLLECTION FORM

PATIENT DATA:

I. Identifying Information:

A. Age_____
B. Marital status_____
C. City of Residence_____
D. Ethnic group_____
E. Educational level_____
F. Occupation_____
G. Religion_____

LNMP: (Last normal menstrual period) _____ Gestational age ----------

Height: _____

EDB: (expected date of birth) _____

Blood Type and Rh _____Date of Delivery: _____

Weight: _____

Gravida: _____ Para _____: T_____P_____A_____L_____

(number of pregnancies) (number of births after 20 weeks) (Term, Preterm, AbortionLliving)

Allergies: _____

Social Habits (e.g. alcohol, drugs, smoking):

_____

_____

Admission Diagnosis: _____

_____

_____

HISTORY OF CHIEF COMPLAINT: _____

_____

_____

Identify patient Teaching/learning needs specific to client's data._____

_____

_____

_____

_____

Laboratory Values

TEST and NORMAL Pregnancy VALUES **(Record pre-clinical))**	DATE Of TEST	CLIENT'S VALUES Record during clinical	State the reason for the test during pregnancy. (**Record before clinical)** State the clinical Significance of the client's Abnormal Values **during clinical**.
(Record pre-clinical)) Hemoglobin			
Hematocrit			
HIV			
RPR or VDRL			
Blood type and Rh			
Rubella Titer			
HbsAg			
Bilirubin (For nursery only)			
Group B Strep			

Student's Name: _____ Date: _____

Assessment of Fetal Monitor Strip

1. FHR (beats/minute):

2. Check one of the following:

_____ Tachycardia (above 160 bpm or more than 30 bpm from normal baseline for at least A 10 minutes duration)

_____ Average (110 to 160bpm)

_____ Bradycardia (below 110 bpm or less than 30 bpm from normal baseline for at least a 10 minute duration)

3. What is the baseline variability: (check one)?

_____ Decreased/Minimal variability: 0 to 5 bpm

_____ Moderate: 6 to 25 bpm

_____ Marked: greater than 25 bpm

4. Accelerations

_____ Number of accelerations

5. Are there any periodic changes (changes associated with uterine contractions) in the FHR? (Check all that apply)

_____ Accelerations

_____ early deceleration (head compression)

_____ late deceleration (uteroplacental insufficiency)

_____ Variable deceleration (cord compression)

6. If client has uterine contractions, determine the following:

_____ Frequency (or interval) (from beginning to beginning)

_____ Duration (beginning to end)

_____ Intensity

_____ Resting tone

7. Based on the review of the above information are there any abnormal fetal heart rate patterns?

_____

_____

8. Please list the category of your interpretation of the fetal heart pattern. _____

9. List nursing interventions *based on the data above*:

Name of Test: _____

All sections of this form must be completed when the patient has had a test done.

Indicate the clinical reasons for this test:

_____
_____
_____
_____

Describe patient preparation:

_____
_____
_____
_____

Briefly describe the procedure:

_____
_____
_____
_____
_____
_____

Outline the post Test Care:

_____
_____
_____
_____
_____

Normal Findings	Abnormal results & clinical significance

Newborn Assessment

The following is information with which you should be familiar before assessing a newborn infant:

MOTHER

General age (adolescent, "elderly" primigravida, etc.) _____

Marital status_____

Socio-economic status_____

Educational level_____

Language spoken_____

PREGNANCY COMPLICATIONS

_____
_____
_____
_____

LABOR AND DELIVERY

Length of labor: _____

Complications: _____

Medication/Analgesia/Anesthesia: _____

4. CONDITION OF BABY AT BIRTH:

Apgar at one minute _____

Apgar at five minutes _____

Complications

_____
_____

NURSERY NEW ADMISSON ASSESSMENT

Identifying Information:

Date and Time of birth _____

Sex_____ Birth Weight_____grams / _____pounds_____oz. Length_____cms

Breastfeeding: Yes____ No____ Temperature_____Heart Rate_____Resp_____

Mother's blood type_____Rh_____Serology_____

Aqua Mephyton (vitamin K) _____mg IM

Eye Prophylaxis Yes_____ No_____ Type_____

Meconium stool: Time _____

Voided: Time: _____

Other: _____

NEWBORN ASSESSMENT FLOW SHEET

Record every hour for newly admitted newborns (transition phase) or per facility's policy/procedure

Time					
Temperature (route)					
Blood pressure/ site					
Heart Rate					
O2 saturation					
Respiration: Rate Rhythm					
Weight (kg and lbs.)			N/A	N/A	N/A
Feeding (bottle: amount) (breast: time on each breast)					
Elimination: Urine Stool (color)					
Activity					
Color					

- Please review facility's newborn admission policies and/ procedures.

Identify Parent teaching:

_____
_____
_____

Student's Name__________

Worksheet for Second Stage of Labor

1. Record time second stage began (full dilatation): _____

2. List the woman's *symptoms* that indicated the onset of the second stage of labor:

_____

_____

_____

3. Relate the woman's emotional responses:

_____

_____

_____

4. Describe contractions, descent of the presenting part, and FHR during second stage:_____

_____

_____

_____

5. Record length of second stage:

_____

6. Describe the woman's bearing-down efforts, note whether effective or ineffective, and assess reasons_____

_____

_____

_____

7. Describe the procedures carried out by the nurse to prepare the woman for delivery:_____

_____

_____

_____

_____

8. Describe your observations during the delivery process under the following headings:

   A. Medications_____

   B. Analgesia/Anesthesia_____

   C. Episiotomy (specify type) or laceration_____

   D. Use of forceps or vacuum extractor_____

9. Describe the care of the neonate as to techniques for:

   A. Maintaining an open airway, including suctioning_____

B. Clamping of cord_____

C. Providing warmth_____Identification_____

10. Assign a score to each item after 1 and 5 minutes after birth. Total the scores to obtained below.
Apgar score:1 minute_____5 minutes_____

_____

ASSESS	COLOR	CRY	MUSCLETONE	HEART RATE	RESPIRATION
SCORE: 1/5	/	/	/	/	/

FOURTH STAGE OF LABOR / RECOVERY POST CESAREAN SECTION

Gravida: _____ Para: _____ Analgesia/Anesthesia: _____

Type delivery: Episiotomy/Laceration: EBL: _____ Baby's Sex: _____

(estimated blood loss)

Length of each stage of labor for vaginal delivery only: First _____

Second _____

Third_____

Total_____

RECORD EVERY 15 MINUTES FOR A DURATION OF ON HOUR

Time				
Fundus				
Lochia: **Color** **Amount**				
BP				
Pulse				
Resp				
Perineum				
Pain **Type**				
I/O				
Bonding **Behaviors**				
Comments				

Overall Assessment of Fourth Stage *based on the above data*

_____

_____

_____

_____

Identify Teaching needs related to the above assessment data:

_____

_____

POSTPARTUM ASSESSMENT DATA

I. Identifying Information:

A. Age_____
B. Marital status_____
C. City of Residence_____
D. Ethnic group_____
E. Educational level_____
F. Occupation_____
G. Religion_____

II. **HISTORY**: Data Regarding Mother and Family before delivery

A. **PREGNANCY**:

Identify complications that occurred during this pregnancy:

_____
_____
_____
_____
_____

LABOR & DELIVERY: Date_____ Time_____

Type of Delivery_____ Presentation_____

Episiotomy/laceration_____

Anesthesia-_____

Estimated blood loss during delivery (EBL) _____

Identify complications that occurred during labor and delivery:

_____
_____
_____

NEWBORN DATA

Baby's weight: grams_____pounds/oz_____ Baby's Sex _____

Feeding Method: Breast_____ Bottle _____ Both_____

PSYCHOSOCIAL ASSESSMENT :

A. Emotional Status:

____Euphoric

____Happy, contented

____Worried, concerned

____Characteristics of appearance; behavior and verbalization appropriate

____Interacts frequently and affectionately with newborn

____Other: _____

B. Self-care and newborn care:

____Expresses/performs newborn caretaking appropriately (bathing, feeding, diapering, handling, comforting)

____Performs self-care appropriately (perineal care, sits bath, breast care, bathing)

____Refuses to interact with or care for baby

____**Describes danger signs for postpartum complications and what to do if these occur**

____Other: _____

C. Family Adaptation:

____Parents interact with newborn in a loving and nurturing way

____Effective family communication

____Identifies support systems

____Other: _____

D. Cultural Practices:

_____

E. Patient complaints or concerns:

_____

_____

_____

F. Based on all the assessment data on the first page and above how do you think the client is adjusting to the postpartum period?

_____

_____

_____

_____

_____

G. Identify teaching needs based on the collected data:

_____

_____

_____

CLIENT WITH C-SECTION (Additional Data) Record once per shift:

Days (or hours) post op _____

Dressing_____

Incision (REEDA) _____

Chest Sounds_____

Bowel Sounds_____

Foley_____

I.V._____

Intake_____

Output_____

Diet (Quality & Quantity) _____

Current Medications:

Complete medication sheets:

_____

Planned Method of Birth Control_____

Complications of Puerperium_____

Teaching needs based on client's data:

_____
_____
_____
_____
_____
_____
_____

POSTPARTUM ASSESSMENT FLOWSHEET

Time	Record once per shift
Vital Signs	
Breasts/Nipples	
Uterine Fundus (position/location)	
Bowel — Bowel sounds present; Defecation?	
Bladder — Distention?; Voiding?	
Lochia — Color?; Amount?	
Episiotomy/Perineum	
Hemorrhoids	
Homan's sign (Doppler assessment and confirmation by provider only); Leg Circulation (pulses)	
Emotional Status	
Immunizations — Rubella; RhoGam	
Bonding Behaviors (**describe**)	

Pain Assessment (Scale 0-10 & Location)	
Complete medication sheets for all meds given during the shift.	

OBSTETRICAL ASSESSMENT DATA (LABOR &DELIVERY)

Age_____ LMNP_____ EDC_____ Gestation_____ wks. Parity: G___ T___P___A___L___

Allergies: _____ Reason for admission: _____

Onset of labor (Date & Time) Contractions: Yes No Induction: Yes No

Membranes: (Circle) Intact SROM AROM Time_____AM/PM Clear Meconium

Nitrazine : Pos. Neg. Vaginal Discharge/Bleeding: None _____ Show_____

Last Oral Intake: Time_____AM/PM Fluids_____ Solid_____

OB HX Year Mode Gest Wt. Sex Comments / outcome

1st Preg. _____

2ndPreg. _____

3rd Preg. _____

4th Preg. _____

PRENATAL HX: Complications: PIH GEST DM BLEEDING INFECTIONS

Describe_____

FAMILY HX: _____

MEDICAL PROBLEMS: Yes No Describe: _____

SEXUALLY TRANSMITTED DISEASES: Yes No Describe: _____

DRUG ABUSE: Yes No Type/Amount: _____

SMOKE: Yes No Amount: _____ ALCOHOL: Yes No Amount: _____

Medication Name - Dose - Frequency Brought in Taken Today Sent Home On Unit

Anesthesia Preference: Feeding Preference: Breast Bottle

Childbirth Education: Yes No

INTRAPARTUM FLOW SHEET (per AWHONN guidelines)

Date	Use √ when findings relate to	Time	Time	Time

	outlined criteria.			
F	Monitor: External / internal			
E	Baseline rate 110-160 WNL			
T	Tachycardia > 160bpm			
A	Bradycardia < 110bpm			
L	Variability: Decreased: not detected Minimal: < 5 bpm			
H	Moderate: 6-25 bpm			
E	Marked: >25bpm			
A	Accelerations: Spontaneous			
R	Decelerations: Early			
T	Deceleration: Variable / Late			
	Category			
C	Monitor: Internal / external			
O	Frequency			
N	Duration			
T	Intensity			
R	Resting Tone			
A C	Interprétation : Reassuring			
T I O N	Interprétation : Non -réassurant Document interventions in narrative nurses notes			
	Cervical exam :			

	dilation/effacement/station			
	Status of membranes: Ruptured or intact			
P	Assessment: 0 -10			
A I N	Management: anesthesia / analgesics Drug, dose & route Alternative methods			
I	Primary: Site / type / rate			
V	Secondary: Type / rate			
	IV medication: Type / rate			
VS	Temp / Pulse / Resp / BP			
	Maternal position			
IN	NPO / Ice chips / Fluids			
O	Urine			
U	Emesis / BM			
T	Other			

Guidelines for completion of Intrapartum Flow Sheet

1. Write the date at the top of the first column.
2. Note if external or internal fetal and contraction monitors are in use. Record the mode of monitoring for fetal heart rate and contractions. Use descriptors in second column.
3. Review a minimum of ten minutes of fetal heart rate tracing.
4. Pay attention to the fetal heart rate tracing between uterine contractions.
5. Document the baseline rate that is the most consistent heart rate between contractions, periodic or non-periodic changes, over a period of ten minutes. Record the average/mean fetal heart rate rounded to 5 bpm.
6. If the rate is greater than (>) 160 place a check mark in the column in line with the word tachycardia.
7. If the rate is less (<) 110 place a check mark in the column in line with the term bradycardia.
8. Note the fluctuations in fetal heart rate. When fluctuations are not detected place a check mark in the column in line with the descriptor – absent decreased variability. For fluctuations < 5 bpm place a check mark next to the descriptor - minimal variability.
9. For fluctuations between 6-25 bpm record a check mark in a column in line with moderate variability.
10. Fluctuations greater than 25 bpm are labeled - marked variability.
11. Accelerations (access) are an increase in fetal heart rate from the baseline by 15 bpm for 15 seconds in term fetuses and 10 beats x 10 seconds in fetuses less than 37 weeks. They are labeled spontaneous when their occurrence is unrelated to uterine contractions. Accelerations are considered periodic when occurring simultaneously with uterine contractions. Indicate with a check mark in the appropriate column the presence of accelerations.
12. Note for any appearance of drops in fetal heart rate or decelerations (decels). Use your text to become acquainted with descriptions of the different types of decelerations. Use descriptors provided to document the type of deceleration.
13. Document the frequency of the contraction from the beginning of one contraction to the beginning of the next. Use minutes to describe the frequency.
14. Review the contraction pattern and record the information. Document the duration of contraction in seconds from the beginning to the end of a contraction.
15. Palpate uterus with palms and fingers during uterine contractions. Describe intensity in terms of mild-easily indented, moderate-slight indentation possible, and strong–difficult to indent. If client has an intrauterine pressure catheter (internal monitor for monitoring contractions) document intensity using millimeters of mercury as shown on fetal heart rate tracing.
16. Palpate uterus in the absence of uterine contractions and describe the tone as soft or firm. It should be soft. Any other finding other than soft must be reported to primary nurse of instructor for verification.
17. Review the criteria for a reassuring and non - reassuring tracing in textbook. Based on that criteria determine if your tracing is reassuring or non-reassuring. Use a check mark to indicate reassuring or non-reassuring heart rate patterns.
18. Document interventions carried out to treat the client and fetus when a tracing is non-reassuring. You may choose to write a narrative note if the space in the column is inadequate and write in the column, see narrative note.
19. Write cervical examinations every time the cervix is evaluated. Write the dilation, the effacement and the level of the presenting part in that order.
20. Indicate whether the membranes have been ruptured or intact. Use the terms SROM to describe spontaneous rupture of membranes or AROM to describe artificial rupture of the membranes by the health care provider. Also write the color and odor of the amniotic fluid.
21. Use the pain scale to assess pain. Record pain level. Indicate the method used to control pain. Document the drug used for analgesia or anesthesia including dosage, route and effect.
22. Record all Intravenous infusions (IV) as described on flow sheet. Document the location of the IV site and the condition of the site in terms of pain swelling redness and heat. If there are no signs of inflammation state intact. Must record the type of infusion & the dosage of medication added to the IV when documenting IV drug administration

23. Document vital signs (VS), intake (IN) and output (OUT) as described. Record maternal position and any other event by writing the event to be noted alongside the label other.

Student's Name_____

Worksheet for Second Stage of Labor

1. Record time second stage began (full dilatation): _____

3. List the woman's *symptoms* that indicated the onset of the second stage of labor:
_____
_____
_____

4. Relate the woman's emotional responses:
_____
_____
_____

5. Describe *contractions, descent of the presenting part, and FHR during second stage:*
_____
_____
_____
_____

7. Record length of second stage: _____

8. Describe the woman's bearing-down efforts, note whether effective or ineffective, and assess reasons_____

8. Describe the procedures carried out by the nurse to prepare the woman for delivery:
_____
_____
_____
_____
_____

9. Describe your observations during the delivery process under the following headings:
   E. Medications_____
   F. Analgesia/Anesthesia_____
   G. Episiotomy (specify type) or laceration_____
   H. Use of forceps or vacuum extractor_____

10. Describe the care of the neonate as to techniques for:
   D. Maintaining an open airway, including suctioning_____
   E. Clamping of cord_____
   F. Providing warmth_____Identification_____

11. Assign a score to each item after 1 and 5 minutes after birth. Total the scores to obtain below. Apgar score:1 minute_____5 minutes_____
_____

ASSESS	COLOR	CRY	MUSCLETONE	HEART RATE	RESPIRATION
SCORE: 1/5	/	/	/	/	/

FOURTH STAGE OF LABOR / RECOVERY POST CESAREAN SECTION

Gravida: _____ Para: _____ Analgesia/Anesthesia: _____

Type delivery: Episiotomy/Laceration: EBL: _____ Baby's Sex: _____ (estimated blood loss)

Length of each stage of labor for vaginal delivery only: First _____

Second _____

Third_____

Total_____

RECORD EVERY 15 MINUTES FOR A DURATION OF ON HOUR

Time				
Fundus				
Lochia: Color Amount				
BP				
Pulse				
Respiration				
Perineum				
Pain Type				
I/O				
Bonding Behaviors				
Comments				

Overall Assessment of Fourth Stage *based on the above data*

_____

_____
_____
_____
_____

Identify Teaching needs related to the above assessment data:
_____
_____
_____

RNSG 1160: Student Evaluation of Clinical Instructor

Clinical Instructor's Name: _____ Date: _____

Scale: This evaluation is on a Likert Scale of 1-5 with 1 being the lowest score and 5 being the highest score.

	1	2	3	4	5
1. The instructor provides adequate and accurate information to students about clinical requirements.					
2. The instructor is physically present in the clinical area on assigned days and hours to supervise students.					
3. The instructor conducts a conference session with students.					
4. The instructor returns student written work within one week with constructive criticism and comment.					
5. The instructor provides opportunities for students to demonstrate nursing skills prior to Evaluation.					
6. The instructor demonstrates required skills for the students when necessary.					
7. The instructor provides meaningful dialogue with the student about program					

Instructions for clinical each clinical day:

1. Report to the hospital lobby at the designated time. Submit preclinical paperwork to the instructor. *Everyone should be on their unit at the designated time.* If you are going to be late, or absent from clinical, please call your instructor's voice mail and leave a message. *Failure to*

notify the instructor of absence will be averaged in the clinical performance grade as a 0 for that day.

2. Students are asked not to sit around the nurse's station. Charts should not be taken away from the nurse's station without permission.

3. During the shift, be prepared to discuss your plan of care with the instructor and/or primary nurse; this includes planned interventions and expected outcomes for the shift you are on and nursing diagnoses based on client data.

4. *When giving medications*, check to see if the medications are on the unit. Have your medications set up and ready 30 minutes before the scheduled time to administer them. **Do not administer IV medication. Follow agency policy regarding narcotic administration by students. Do not administer any medications without your instructor or primary nurse present.** You must know safe and therapeutic dosage, rationale, classification, action of the drug and major adverse effects that might occur. *Students will not administer medications in L&D.*

5. For security purposes, always have your student picture ID in full view and always identify yourself as a nursing student at HCCS.

6. *Nursing procedures* other than vital signs, physical assessment, baths and linen changes must be done in the presence of the instructor or primary nurse. If you are uncomfortable with any of these tasks, please discuss with your instructor or primary nurse.

7. Documentation should be begun (chart opened) within 2 hours of arrival on the unit. Please have your client assessment completed before documentation. Document every 2 hours. Some areas may use a flow sheet instead of, or in addition to, narrative documentation. Students do not document on the medical record in L&D unless asked. Documentation on the hospital medical record on other units is per agency policy.

8. Submit your narrative documentation, or what you would document (even if you are not allowed to document on the actual medical record) to your instructor at the end of the shift.

9. Students are expected to review daily lab values for discussion. Lab reports for abnormal values *and/or expected normal values* should be included in your client data base.

10. You may have a 15-minute shift break and a 30-minute lunch break for the 9 hour clinical.

11. Report to your primary nurse by at the end of the shift, & report promptly to post-clinical conference.

12. Post clinical written assignments are due at the end of the clinical day. Complete nursing care plans are due on the date/time designated by the clinical instructor.

During your clinical rotation, please feel free to page your instructor. Your clinical experience should be a positive one and your instructor will be available to you as a resource.

Name (Please print) _____

Student Signature _____Date____

Electronic Media Policy:

Protected Health Information (PHI):
Students are allowed to access electronic medical records only for gathering information. The information obtained must be handwritten; it cannot be photographed or electronically transmitted. Auxiliary drives (USB drives, portable drives, discs, data storage cards, etc.) **are not to be inserted into any facilities EMR system.**

Do Not access any medical records that you are not using for patient care. This includes your own medical records, your child's, a family member's, someone famous, or someone you saw on the news. This is a breach in patient information and privacy and may result in consequences up to failing your clinical rotation, fines, and dismissal from the program. Hospitals consider PHI violations as critical errors in judgment resulting in grounds for immediate dismissal.

Password Security:
Do not share any facility password or your username with anyone. Please be advised that facility staff members are not allowed to share their password or username with any student or faculty member.

I agree to abide by the above Electronic Media Policy.

Student Signature: _____Date: _____

RNSG 1160 - CLINICAL
COURSE EXPECTATIONS CONTRACTUAL AGREEMENT –FALL-2017

I, _____ have read the syllabus and fully understand the expectations of me as a student in this clinical course.

I acknowledge that I am aware that the A.D.N. Student Handbook is on the RNSG 1160 website and I am accountable for following the policies and procedures discussed in the handbook.

I understand that I will be removed from the clinical area if my behavior endangers my life or the lives of clients, client's families or other health care workers.

My signature below signifies my willingness to comply with the course requirements. I also understand that the syllabus is online and it is my responsibility to get a printed copy.

_____
Printed name

_____
Signature

_____
Date

RNSG1160: Care Plan Grading Criteria

Student Name:_____ Grade:_____

Faculty Signature:_____ Student Signature:_____

The care plan is typed or written in ink and is neat and legible, illegible care plan will not be graded.

10 Points deducted for each day late. Must be turned in at appointed time or is considered late.

S=Satisfactory NI=Needs Improvement U=Unsatisfactory

S **2 pts**	NI **1 pt**	U **0 pts**	**Assessment & Data Collection - 20%**
			A. Assessment guide is complete (NO blanks) and pertinent. All pages of assessment guide are completely filled out with factual information about patient.
			B. Minimum of 3 medications the patient receives are listed and calculated correctly and documentation of drug reference.
			C. Significant laboratory results are documented, including significance of result to patient's condition/plan of care and the reference.
			D. Patient/family teaching needs, based on assessment data, are listed.
			E. All pertinent date that leads to the formulation of the nursing diagnoses are listed.
S **6-5 pts**	NI **4-1 pts**	U **0 pts**	**Analysis/Nursing Diagnoses - 30%**
			A. Analyzes assessment data.
			B. Significant data collection findings are documented and related to patient's NANDA Diagnoses.
			C. Five (5) relevant nursing diagnoses are listed, supported by sufficient assessment findings, and correctly states three parts: NANDA + Etiology (r/t) + defining characteristics (AEB).
			D. NANDA diagnoses are prioritized according to Maslow's hierarchy of needs.
			E. The patient's three (3) most significant nursing diagnoses, based on assessment data

S **5-4 pts**	NI **3-1 pts**	U **0 pts**	**Planning/Patient Goal - 10%**
			A. The short-term goal is clearly stated, realistic, and relates to the NANDA Diagnosis.
			B. Three (3) outcome criteria are clearly stated, realistic, related to the goal, measurable, and within a realistic time frame.
S **6-5 pts**	NI **4-1 pts**	U **0 pts**	**Implementation -20%**
			A. Documentation of sufficient and developmentally appropriate nursing actions
			B. Each nursing action is supported by an appropriate scientific rationale with documentation of reference and page numbers. (in text citations)
			C. Interventions are individualized by including medications, treatments, diet,
			D. Nursing interventions are listed in terms of priority according to Maslow's hierarchy of needs.
			E. Patient/family teaching is implemented in the plan of care with the reference.
S **4-3 pts**	NI **2-1 pts**	U **0 pts**	**Evaluation- 20%**
			A. Specific results based on the patient goal criteria are correctly documented. (I & O, Vital Signs, Weight, Pain Score, Medications/Responses, etc.)
			B. Correctly documented whether or not the goal was met, not met, or partially met and includes a rationale
			C. Correctly noted if the plan is to be continued, discontinued, or altered and includes rationale
			D. Appropriate revisions, based on client response to nursing interventions, are identified. Revisions include a new intervention listed and a rationale for the new intervention.
			E. Narrative Nursing Documentation is complete. Each entry is signed by the student and correct date and time are noted. Documentation is legible and adequately reflects the client's plan of care

Additional Comments

RNSG 1160

GRADING FORM FOR DATA COLLECTION/ANALYSIS

GRADING CRITERIA

(Turn in this form with your completed data collection assignment)

Student Name _____ Date of Clinical _____

NCP (circle) Antepartum L&D Newborn Postpartum

Medical Diagnosis (Antepartum)

Grade _____ Comments:

S **7-10 pts**	**NI** **3-6 pts**	**U** **0-2 pts**	I. ASSESSMENT Data Collection - 50%
			A. Assessment guide is complete and pertinent.
			B. Medication sheets on all meds *received by client* completed with the reference.
			C. Client laboratory test/diagnostic procedure worksheets Completed with reference.
			D. All pertinent data which leads to the formulation of the nursing diagnoses are listed.
			E. Client's teaching needs, based on assessment data, are listed.

S **7-10 pts**	**NI** **3-6 pts**	**U** **0-2 pts**	II. Analysis/Nursing Diagnosis 50%
			A. Analyzes assessment data
			B. Each nursing diagnosis correctly states three parts: 1. Actual or potential health problem (NANDA) 2. Etiology (related to): 3. Characterized (as evidenced) by:
			C. Each nursing diagnosis is supported by relevant and sufficient data.
			D. The client's 3 *most significant* nursing diagnoses, based on assessment data, are listed.
			E. The nursing diagnoses are prioritized (numbered) according to Maslow's hierarchy of needs.