Cedar Crest College

Nursing Department

NUR 331 Health Promotion III

Course Syllabus Summer 2010

Placement: Senior year, Summer 2010

<u>Prerequisites:</u> Cumulative GPA of 2.5, satisfactory completion of all general education requirements, junior-level nursing courses, and Health Promotion III.

<u>Course Description:</u> This is the first of a two-semester course that focuses on the role of the professional nurse in promoting optimal health for the young and middle-aged adult. Risk factors for illness and injury will be identified and strategies for health promotion will be explored in the areas of perioperative care, as well as in the management of fluid and electrolyte imbalances, altered tissue perfusion, and neurological impairment.

Course Objectives:

Upon successful completion of the course, the student will:

- 1. Appraise a developed plan of nursing care based on the multidimensional needs of young and middle-aged adults and their families from varied cultural backgrounds.
- 2. Evaluate the effectiveness of therapeutic communication skills used in the care of young and middle-aged adult patients and their families from various cultural backgrounds.
- 3. Apply pertinent nursing research findings to specific patient care situations.
- 4. Identify the role of the professional nurse as one of leader, advocate and teacher.
- 5. Collaborate with other members of the health care team to meet the needs of young and middle-aged adult patients, their families, and their communities.
- 6. Demonstrate accountability for professional actions.

This course is taught using principles of adult learning. The student is responsible for the attainment of knowledge while the professor is responsible for the facilitation of learning. Students should expect to be challenged in this course, as it is a culmination of previous nursing knowledge for the application of complex health care principles. Eighty percent of the evaluation for this course is based on examination/quiz competency. In addition to the clinical component, students must demonstrate proficiency in the course examinations in order to successfully complete the course.

Required Textbooks:

Hogan, M. & Wane, D. (2007). <u>Fluids, electrolytes & acid-base balance: Reviews & rationales.</u> (2nd Ed.) Upper Saddle River, NJ: Pearson Education.

Smeltzer, S. and Bare, B. (2006). <u>Brunner & Suddarth's Textbook of Medical-Surgical Nursing.</u> (11th Ed.) Philadelphia: Lippincott.

Winningham, M. and Preusser, B. (2009). <u>Critical Thinking in medical-Surgical Settings: A Case Study Approach</u> (4th Ed.). St. Louis: Elsevier.

Any NCLEX review book

Classroom response system (clickers)

Recommended Textbooks:

Porth, M. (2006). <u>Essentials of Pathophysiology: Concepts of Altered Health</u> States. (2nd Ed.) Philadelphia: Lippincott

American Psychological Association (2002). <u>Publication Manual of the American Psychological Association</u> (5th ed.). Washington, DC: APA

Any Nurses' Drug Guide.

Fischbach, F. (2008). <u>A Manual of Laboratory & Diagnostic Tests</u> (8th ed.). Philadelphia: Lippincott. (Or any comparable text)

Teaching Methods:

Audio-visual materials
Lecture and discussion
Case Studies
Reflective writing

Course Evaluation:

Exam 1 15%

Exam 2 15%

Exam 3 15%

Cumulative Quiz Score 10%

Medication Calculation Exam 5%

Skills Video Taping 5%

Final Exam 25%

ATI 3%

Scholarly Paper 7%

Total 100%

Reflective Clinical Journals P/F

Course Evaluation Methods

Clinical Student Performance: on a daily basis, the respective clinical instructor will evaluate the student's clinical performance. Evaluation criteria are based on satisfactory completion of the clinical course objectives. The student is evaluated by his/her respective clinical instructor(s) and student performance is graded as either satisfactory (S) or unsatisfactory (U). (Students can refer to the Clinical Evaluation Tool and the Clinical Behaviors and Consequences Guideline for detailed performance ratings.) The student must receive a satisfactory rating for each course objective to obtain an "S" in clinical and to satisfy requirements for the nursing major. The student must pass both clinical and theoretical components of N331.

Medication Calculation Proficiency: This exam contains questions related to the calculation of oral, IM/Sub Q and intravenous medication administration. An 85% proficiency rate is needed to pass the medication calculation exam. If a student is unsuccessful at achieving an 85% on the first attempt, the test may be repeated. The maximum number of times the medication calculation test may be taken is 2 times. The med calculation exam is worth 5% of the total grade for the course. The result received on the first attempt will bet he grade counted toward the course grade.

If the student does not achieve a minimum score of 85 after the second attempt, the student must withdraw/fail from the course. If the student is concurrently enrolled in NUR 333, the student must withdraw from that course also.

Prior to the student re-taking the test, remediation must be demonstrated. A student will not be able to administer medications to patients in the clinical area until 85% proficiency has been achieved. Students should be aware that the clinical grade takes medication administration into account; therefore, timely remediation is essential to pass both theoretical and clinical components.

Quizzes: Preparation for class on a consistent basis is imperative to the student's success. A short quiz will be administered each class except for exam days focusing on the content area of the upcoming class. The quizzes can be given either at the beginning or the end of class; to be determined by the instructor on the day of the quiz. The quizzes will be comprised of introductory information related to the required topical readings assigned for the class. If a student is absent or late for class a quiz grade of zero will be obtained. Once the quiz has been started, late arriving students will not be permitted to begin the quiz and a grade of zero will be obtained. All the quiz grades will be averaged into a cumulative quiz grade that is equivalent to one exam grade. The two lowest quiz grades will be dropped. The answers to the quiz will be reviewed immediately following the quiz in class and will not be available for review at a later date by students.

<u>Scholarly Paper:</u> Each student will submit a scholarly paper of no more than 8 pages in length. The scholarly paper will be based on a patient that you have cared for on the clinical unit. It will analyze the patient's progression through their hospital stay along with evaluation of treatment. Research will be used to assess the treatment process and plan of care.

For further details, refer to "Guidelines for Scholarly Paper" at the end of the syllabus. The accompanying grading criteria sheet must be submitted with the scholarly paper. As this is one of the final senior level courses, no revisions will be allowed once the completed paper has been submitted for a grade. If the student wishes review of grammar, spelling and/or APA format, they are encouraged to seek the services of Academic Advising prior to the paper submission. All papers will be handed into the instructor along with an electronic version in the course drop box on the due date, papers may be submitted earlier than the due date and placed in the wood drop box in the hallway by HBB 9. Rough drafts of papers will not be read, however specific questions regarding content can be reviewed. If the paper grade is grieved, the following criteria must be met: 1) Grade must be a 73 or less; 2) Request for re-read must be made 5 days or less from the date that the original grade was given. The new blinded copy will be read by another instructor. The new grade will be averaged with the old grade which could result in a higher or lower grade than the original. Papers handed in after the class starts will be considered late and are subject to the lateness policy. Please refer to the policy on assignments that are late.

Skills Competency: Each student will complete a skills competency by video tape during the NUR 331 clinical rotation. The video taped skills are graded accordingly to the number of errors made in the process. A grade of 100, 85, 75, 65 or 0 will be given to each video. This grade will be 5% of the course grade. A score of 65 or below requires the video to be redone. However, only the first grade will be counted toward the course grade. A Satisfactory grade is required in order to pass the course. A complete directive and scenario with grading criteria for the skills competency is located on the course site under doc sharing. ATI: The ATI pharmacology proctored exam will be included in the graded course evaluation. The raw score will be worth 3% of the final course grade. 10 extra points will be added to the score if the ATI pharmacology practice exam is completed by the due date and time designated by the course instructor. The complete ATI directive is located at the end of the syllabus.

General Policies: Classroom

Cumulative Knowledge

The student is reminded that knowledge in nursing is cumulative and that she/he will be held accountable for prior learning. Furthermore, the student is expected to be knowledgeable about anatomy, physiology, pharmacology, and health/physical assessment as they relate to material covered in this course. The student is responsible for material discussed in class as well as information covered in the required readings. Copies of journal articles may be placed on reserve in the Cressman Library.

All lectures are presented with an accompanying power point presentation. The power point presentations are posted on the eCollege course site and will be made available to students in outline form after the lecture is taught. This is to encourage students to read the content and decipher what material is important prior to having it outlined by the professor.

Assignment Due Dates

All written assignments are due on the designated date. They will be collected before class starts unless otherwise specified by the instructor. Lateness will be reflected in a lower grade of 10 points per day. Weekend days are counted toward deductions. Assignments submitted after the assigned time on the due date will be considered one day late, and subsequent points will be deducted in 24 hour increments according to the policy.

Assignments are not to be slid under the professor's door. Extenuating circumstances will be evaluated on an individual basis by the professor. If a dispensation is granted, it must be documented in writing and signed by both the professor and student. Extenuating circumstances are less likely to be considered once the assignment is late. If a student is experiencing difficulty, it is

recommended that he/she meet with the instructor prior to the due date of an assignment to discuss possible alternatives or solutions.

Examinations

Examinations must be taken when scheduled. Failure to abide by this policy will result in a grade of zero for the examination. No exams will be administered early. Final exams will be administered according to the schedule of the Registrar or by the instructor. A student that arrives after the scheduled time will be given no extra exam time. If the student arrives late enough that an exam has been handed in, the student will not be allowed to take the exam and receive a zero for the exam. If a student fails to call, email or communicate to the instructor before the exam that they are unable to take the test; the student will receive a zero on the exam.

The professor will decide time frames for the exam. Generally, this will follow the one-minute per question rule. This is consistent with NCLEX preparation guidelines.

Students are reminded that they must adhere to the policies of the Cedar Crest College Honor Code. During exams, the professor or administrator may be present in the room. All belongings must be lined up along the perimeter of the room. Students may not have cell phones, calculators, PDAs, or any other electronic device during an exam. If permitted, calculators will be provided by the nursing department for examinations.

No one will be permitted to leave the room at any time while the exam is in progress. If the student needs to leave for any reason other than authorized by the instructor, the exam must be turned in to the instructor as completed. Examinations will not be reviewed in class. If a student would like to review the exam, he/she may do so by appointment only. Any problem areas found in the analysis of the test will be reviewed and given in a framework available to the student to focus on those content areas.

Hard Copy of Students' Work

Students are required to keep a hard copy of all written work assignments for this course. In the event an assignment is lost, it is the student's responsibility to provide an additional copy of the written assignment. Failure to provide this copy will result in a grade of zero for the assignment.

Attendance

<u>Class attendance is required</u> for the successful completion of this course. Attendance will be taken at the beginning of each class. Students are required to contact the professor if they will be late or absent from class. Excessive absences from class will be reflected in a lower final grade. Attendance is mandatory and necessary to complete the course objectives. Students who are absent run the risk of failing the clinical portion of the course.

Any student who needs to make up a clinical day outside the make-up schedule will be charged an additional fee as determined by the nursing department chairperson.

Students, who miss clinical due to an illness, may return to clinical after a note detailing <u>medical clearance/restrictions</u> is obtained from the student's physician. If a note is not obtained resulting in further missed clinical days, the student will be charged an additional fee.

Students who miss a clinical day(s) as a result of delinquent required forms (CPR, health forms, malpractice, etc) will be charged an additional fee for each day missed.

Honor Code:

Students are reminded to review the Honor Code and Plagiarism statements as found in the Cedar Crest College Customs Handbook. Students found guilty of Honor Code offenses will receive a zero for the assignment in question.

Dishonesty results in an "F" in this course.

<u>Plagiarism</u> is the presentation of someone else's paper or work under one's own name with or without additions or modifications; downloading and turning in a paper from the internet or including concepts, phrases, sentences, or paragraphs from print or electronic sources whether verbatim or paraphrased in one's own paper without proper attrition. <u>A paper suspected of plagiarism will receive a grade of 0 for the assignment.</u>

*Either plagiarism or careless scholarship, or both, may result in additional points being taken off the grade of this paper, so that the grade may be lowered down to and including a 0. This includes, but is not limited to omitting quotation marks for a quoted sentence or phrases, even if the rest of the documentation is present.

(Penalties for academic dishonesty may be even more severe. See "Academic Dishonesty or Plagiarism" in the Student Handbook)

As well, all papers are to be the student's original work. Submission of a paper from a previous course or from a previous assignment in this nursing course is unacceptable and will result in a F for the course.

Grading Policy

Α	93-100%
A-	90-92%
B+	87-89%
В	83-86%

B-	80-82%
Ċ C	77-79%
C	73-76%
C-	70-72%
D ⁺	67-69%
D	60-66%
F	<60%

A grade below C is not passing. Failure in the clinical component of the course requires the student to repeat the entire course.

Rounding

The final grade will not be rounded to a 73. Example: If a grade of 72.8 is achieved it is still below 73 and a failure for the course. There are no expectations to this rule. Grades over 73 will be rounded if needed.

General Policies: Clinical

Transportation

Transportation to, from and within the clinical agency is the student's responsibility and is necessary to complete the nursing course requirements.

Student Illness

Students who are truly ill are expected to call the instructor prior to the clinical day. Students who are unable to attend clinical due to illness are required to call the assigned nursing floor the morning of clinical, and leave a message on the floor for the clinical instructor as well as leave a message on the clinical instructor's voice mail. If a student fails to inform the instructor of their absence before the start of the clinical day, except for extraordinary circumstances; the student will receive an F in the course. Calls should be made between 0600 and 0615 of the day in question. Absence from clinical requires a note from the Health Care Center or personal physician and must state the student is able to return to clinical or specify limitations.

Make-up Time

Students who miss clinical will be expected to make up the time. Rescheduling will be at the discretion of the instructor. Initiation of make-up work and submission of missed journals are the responsibility of the student. Students who fail to complete the clinical portion of this course will be unable to meet course objectives.

<u>Uniforms/Personal Appearance</u>

Required student attire consists of Cedar Crest student nurse uniforms with photo badge. CLEAN white shoes and hose, watch with second hand, scissors, hemostat, stethoscope, and black pen. White leather sneakers may be worn in place of nursing shoes. These sneakers must be completely white without color

throughout the shoe or sole, and must be worn exclusively for nursing. Students may wear a sweater or lab coat when not in direct contact with patients. Hair that touches the shoulders must be secured with a barrette or in another suitable fashion. Books and notebooks are not permitted in patient rooms. Jewelry must be minimized, limited to one pair of small stud earrings, no tongue or other facial rings, and only one ring on the finger. Shirts must be tucked in at all times and clothes must be clean, neat, and without wrinkles. Buttons to shirt collars must be buttoned.

When obtaining clinical assignments, students are required to wear a lab coat with identification badge over business casual clothes. Jeans or denim of any color are not suitable attire. Open-toed or open-heeled shoes are not permitted. As this is a senior-level nursing course, it is expected that students understand and comply with the uniform guidelines. Students who are found in noncompliance with the guidelines stipulated in this syllabus will be excused from clinical and will be required to repeat the clinical day at an additional charge. If a student does not comply with the dress code requirements for clinical prep, the student will be required to repeat a clinical day at an additional charge. Hospital Regulations

The hospital is not responsible for personal belongings taken to the unit. Parking information will be discussed in orientation. Students must follow parking directions. Violations will be reflected in the clinical grade.

Students may examine the Medical Administration Records when preparing for their clinical assignment, but are not to open the medication carts and examine the patient's medications at any time.

Clinical or Class Cancellation

Class or clinical experiences may be canceled due to inclement weather, instructor illness, or other emergent events. In the event of inclement weather, a voice message will be placed on the instructor's Cedar Crest College phone extension. Decisions will be made by 0545 hours the morning of clinical and the message will be available at 0600. Please do not tie up the phone prior to 0600 as the instructor may be trying to leave a message. Do not call the clinical instructor at home. If you need to speak with the instructor, you may leave a message after the voice message. Students who have a distance to travel should wait until 0600 before leaving home. In this occasion, lateness will be taken into consideration. In the event of emergent issues of instructor illness, students will be notified via phone by the nursing office, or by the instructor.

It is rare that clinical will be cancelled for inclement weather. Generally, a delay will be issued and the conditions re-evaluated in an hour or so. Updates will be posted on the voice message as needed. Students should make every effort to attend clinical and class, however, safety of the student must be the first priority.

Clinical Requirements

This clinical requirement is met through patient care on medical-surgical and intensive care units at Lehigh Valley Hospital and Health Network, I-78 & Cedar Crest Blvd., Allentown, Pennsylvania, Switchboard: 610–402–8000 Clinical Experiences

See Clinical schedule and clinical summary handout for specific units Observation Experiences (Per Schedule)
Refer to clinical summary handout

Clinical Assignments on Med/Surg Units

The goal of the clinical component of NUR 331 is to provide comprehensive, holistic care to two patients. Instead of task-oriented provision of care to a regular nursing patient assignment, it is the philosophy of this course to allow students to develop a deeper understanding of the concepts of care for a limited numbers of patients. The focus is on the quality of care, not the quantity of patients cared for. Additional courses such as the Independent Practicum allow students an opportunity to increase the numbers of patients they are responsible for with their assignment. Students in NUR 331 will be expected to provide thorough, competent care to two patients. Under no circumstance should the student care for more than two patients.

Students will choose their assignments on the evening before the scheduled clinical day and place the patient's name(s) on the student assignment sheet. Students may consult with the charge nurse for suitable patient assignments. In preparation for clinical, the student will read the patient's medical record, meet and speak with the assigned patient(s) so as to develop a therapeutic relationship. All students will listen to morning report and obtain information about their respective patients from the chart, Kardex, and RN preceptor. All students must be prepared to discuss the patient's health problems, procedures, medications, therapeutic management, and nursing care with peers and instructor.

NOTE: If the assigned patient has been transferred or discharged, the student must select another patient and write the patient's name and room number on the assignment sheet.

Morning Report

❖ Students must meet with the instructor between 0700 and 0800 hours the day of the clinical experience to give report and discuss the nursing care of the assigned patient(s). The student must present sufficient evidence that he/she is competent to provide safe care to the patient for the day. This includes review of unfamiliar procedures and tests as well as a well thought out, appropriate, plan of care for the day. If it is the opinion of the clinical instructor that the student is not well prepared or not competent to provide safe care to the assigned patients, the student will be sent home.

This will result in an unsatisfactory performance for the day and the student will be required to repeat the day at an additional charge. See the Guidelines for Report sheet for additional information.

Medication Administration

The student is expected to administer all medications as assigned in a safe, efficient manner. This includes:

- ❖ Identifying the correct patient according to hospital policy with two forms of identification
- **❖** Confirming patient allergies prior to administration;
- Discussing knowledge of action, classification, purpose, dose, side effects, nursing implications (if applicable), generic name;
- ❖ Relating the pharmacological therapy to specific patient needs;
- Utilizing the administration time to teach the patient about the medications;
- Charting medication administration on the medication record in a timely fashion;
- Documenting the patient response to the medication(s) on the progress notes;
- Ensuring that the patient receives all medications and IV solutions required for the day, excluding IV push/bolus medications;
- Providing correct colored bands for allergies and anticoagulant therapies as appropriate

Students are responsible for discussing the patients' medication without viewing their reference material. Students may bring medication cards and/or a drug manual to the clinical area for reference in case of new medication orders.

The student is responsible for checking the Medication Administration Record on the morning of clinical. Students giving medications must locate and notify the instructor at least 15 minutes before the medication(s) is due to be administered. Students should expect the possibility of a delay with administration, as there will be others students on the floor who need assistance with the instructor. It is the responsibility of the student to alert the instructor to urgent situations that require immediate attention. In this situation, the student must interrupt the instructor's administration of regularly scheduled medications and notify the instructor of the need for timely mediation administration. Under no circumstances are students permitted to administer medications without prior instructor or RN verification and approval. It is the policy of LVH that all narcotics be signed out by staff nurses. Students and clinical instructors may NOT sign or co-sign any narcotic removal from the secured parcotic drawer at Lebigh Valley Hospital. Once the parcotic is signed.

and clinical instructors may NOT sign or co-sign any narcotic removal from the secured narcotic drawer at Lehigh Valley Hospital. Once the narcotic is signed out, the student may administer the medication with the instructor. Students are permitted to document administration of narcotics. Intravenous Therapy

The student is expected to administer intravenous (IV) medications (IV push/bolus excluded) and solutions in a safe, efficient manner. This includes discussing the reason why the patient is receiving the IV medication. The student is responsible for the drip rate of IV solutions (piggybacks, as well as primary IV solutions). The primary nurse and instructor must be notified if the IV solution is not on time. The student must show evidence of math calculations for drip rate of all IVs in the morning report with the instructor regardless of the drop factor or rate. Bards will be utilized to administer some IV medications as appropriate. Students may not administer IV push medications under any circumstance, not even if accompanied by the clinical instructor. IV saline flushes may be administered under direct supervision of the clinical instructor.

Health Assessment

The student is expected to be knowledgeable about health assessment and demonstrate correct techniques. Assessments will be done on each assigned patient prior to 0900 hours. Abnormal findings will be reported to the instructor and primary nurse.

Procedures

Prior to the performance of a new procedure, it is the student's responsibility to review the specific patient procedure and to discuss procedural methods with the instructor. Procedure manuals are available online for student review.

RECOMMENDED ORGANIZATION FORMAT FOR HOSPITAL ROUTINE

All students will be on the unit and ready for report at 0645 hours.

0645 – 0715 Report – Meet with nurses covering your patients. Be sure to introduce yourself to the primary nurse and advise her of your assignment (i.e. giving all meds including IV infusions, doing all treatments, bathing the patient).

0715 - 0800 Make patient rounds. Take VS, begin assessment and baths. Meet with instructor. Record VS and weights, if indicated, in the computer.

0800 Breakfast for patients.

0800-1000 Complete baths/assessment. Administer meds/treatments as ordered. 1000-1100 During this time, the first note must be recorded on the chart. Charting will include the assessment and nursing observations. Notes must be written on another piece of paper and checked by the instructor before the entry can be transcribed on the chart.

AM ASSESSMENT CHARTING MUST BE COMPLETED BY 1100.

1115 <u>Lunch assignments for students (30 minutes allowed.)</u> Students will be assigned a time for lunch. It is the student's responsibility to organize activities so that she/he can eat lunch during the assigned time. Prior to leaving for lunch, VS should be taken, recorded and report must be given to the assigned primary nurse. The student will also report to another student who will cover the patient assignment. The instructor must be notified when the student leaves the unit. 1200 Lunch for patients

1230-1330 Update charting. If there is no change in the patient's condition, then do not repeat information discussed in the morning note. Complete all procedures. Document on the patient record. Administer final meds. 1330-1400 Restock supplies, straighten room and bedside stand. Calculate I & O and verify results. Advise patient that you will be leaving if clinical is an 8-hour day. Give report

Assigned time: Attend post-conference.

Observation Clinical

Purpose:

To observe nurses in diverse clinical areas.

To provide an experience with complex acute care patients and help synthesis classroom theory with the clinical picture.

Objectives:

The student will:

- 1. Begin to develop a personal style and routine for delivering patient care through observation of his or her preceptor/coordinator.
- 2. Describe the nurse's role for caring for the patient in the observation experience and how it differs from other experiences in nursing care.
- 3. Identify the critical thinking skills and attributes needed to be a nurse caring for complex patients.
- 4. Describe the various assessment and communication skills that the nurses need for care of their complex patients.
- 5. Participate in patient care and assessment of complex acute care patients.

Process:

- This is an observation only experience. You may not give or prepare any medications even under guidance of the preceptor/coordinator.
- You may participate and perform nursing skills that you have done before or have been checked off on in the nursing lab.
- Students can document under guidance of the preceptor if comfortable and by policy of the facility.
- The students should be involved in patient care as directed by the preceptor or coordinator. These activities can include (but are not limited to):
 - Assessment of patients/History taking
 - Analyzing laboratory results/rhythm strips
 - Discussion of current and past medications
 - Observing discharge and teaching instructions
 - Using therapeutic communication with patients and family
 - AM or PM care

- You must have the preceptor/coordinator of the experience fill out the attendance contract. See below
- Please be on time for the clinical experience. If you are to be late or absent, you must call the observation site along with the instructor. This is a mandatory clinical experience and any absence may result in a failure for the clinical and course.

NUR 331

Observation Contract

I,	_(preceptor's/coordinator's printed
name)	
certify that the Cedar Crest College student	
	(student's printed name)
has satisfactorily completed the observation	experience with me
on(date), from (time)	(time) to
signature)	(preceptor's/coordinator's
Unit Name/Hospital:	

Purpose:

This paper will discuss the patient's course of illness during their admission and also evaluate the patient's response to medical and nursing interventions. Research will be used to compare the actual course of treatment that the patient received to the recommended or progressive management found in the literature.

Objectives:

- 1. Evaluate a patient's plan of care and progression during their hospital stay.
- 2. Describe the medical and nursing management of the patient for the primary medical diagnosis, and the rationales behind those decisions in comparison of the current research.
- 3. Analyze how the patient's past medical, cultural, and psycho/social history impact on his or her current and future condition.

Paper Guidelines:

1. Synopsis of the patient's admission

Discuss the patient's hospital course beginning with the admission in an organized and chronological order of events that occurred during their hospital stay. If it was a lengthy stay, include only the significant events. This should be no more than 1-2 pages.

2. Evaluation of the plan of care

Analyze the plan of care and treatment of the patient by discussing the actual physical assessments, past medical history, lab/diagnostic data, medications and psychosocial/cultural implications that defined the patient's course of care relating to the primary medical diagnosis. Compare the actual course of treatment and disorder progression with current nursing/health research on the patient's disease management. Discuss why different medical therapies and nursing interventions were used for this specific patient's primary diagnosis. Incorporate all forms of management associated with the patient's problems including alternative or complimentary forms of treatment that are available. This section should be the majority of your paper.

Rationale must be obtained from health care literature. Sources must be no more than 5 years old unless the article is considered to be a classic, and references must include at least 5 non-text sources.

The submitted paper must be at least 5 and no more than 8 pages in length and must follow APA format. An introduction and conclusion of the paper are to be included. Any text submitted beyond page 12 (excluding title page, abstract and references) will not be read by the instructor. All papers must be submitted to the professor on the assigned date. No rewrites will be allowed.

A copy of all references, excluding books, must be provided to the professor with 2 copies of the paper. One copy should have the student's name; the other is blinded with the name omitted. The student's name must also be omitted from all copies of the references so as not to break the blinded grading procedure. The 1 copy of the paper and all reference copies are to be submitted in a folder. The second copy will be submitted electronically on the course site under drop box, case study paper. Textbooks do not need to be submitted. Paper copies of Internet reference material are required.

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131	ADING	\mathbf{c}	FRIA	- 36.66	ARI	1 -	AFFR

* <u>Criteria</u>	<u>% Points</u>
1 Introduction ~ 5%	

1. Introduction ~ 5% ______

2. Synopsis ~10%	
3. Evaluation of the plan of care~ 55%	
4. Conclusion ~5%	
5. Adherence to APA format ~ 5%	
6. Sentence structure ~ 7%	
7. Spelling ~ 5%	
8. Organization~ 3%	
9. Reference list ~ 5%	
Total	
Comments:	
(Copies of paper and references submitted.)	

Clinical Behaviors and Consequences Guideline

**This list is meant to serve as a guide for students and clinical instructors. It is not exclusive. Clinical instructors and the course professors may evaluate specific circumstances and determine appropriate consequences as they deem fit.

Student Behavior	<u>Consequence</u>
Failure to report to any clinical experience without calling the assigned floor, clinical instructor and course professor prior to absence	Unsatisfactory in the clinical component of the course Results in course failure
Student arrives on the floor after 0650	As a first offense, the student will receive a "D" for: ◆ Reports to clinical on time If this is a second offense, the student may be sent home or permitted to stay at the discretion of the instructor. The student will receive an unsatisfactory for the day. This will need to be made up at the student's expense.
Selection and prep on a patient who is not considered to have a complexity of care appropriate for a senior level medical surgical course. Examples of this may include: lack of IV access and/or fluid, lack of IV medications, or simple diagnosis without co-morbidities. Acceptable patient assignments will be reviewed in clinical orientation.	As a first offense, the student will be instructed to choose another patient and immediately re-prep. If this is a second offense, the student will receive an unsatisfactory for the day and will be sent home. This day must be made up at the expense of the student.
Inadequate prep and verbal report of the patient assignment that is deemed by the clinical instructor to put the patient at risk. This is an unsafe student behavior.	If the clinical instructor deems the student unsafe as evidenced by the poor quality of report, the student will receive an unsatisfactory for the day and be sent home. This day must be made up at the student's expense.

Inadequate demonstration of medication knowledge as evidenced by the student's inability to comprehensively discuss all medications for both assigned patients.	Based on the level of competence, the instructor may evaluate this behavior as "S" "A", "M", or "D". Students will not be permitted to administer any med for deficiencies evaluated as "D".
Breech of the "5 Rs" (Correct med, route, dose, time, patient). This includes IV flushes, forgetting to cut tablets for half doses, the wrong number of pills, calculation errors or omissions for IV meds, incorrect type of insulin, incorrect amount drawn in syringe, forgetting to verify expiration dates, administration of injection into extremity that is to be preserved, improper injection technique, omission of patient allergies, etc	Student will receive a "D" for: ◆ Demonstrates thorough med prep ◆ Administers med safely ◆ Provides safe patient care
Inaccurate or omission of IV calculation (required for all IV infusions, even if IV is on a pump)	Student will receive a "D" for: ◆ Calculates IV infusion accurately
Omission of patient identification by two methods prior to medication administration or performance of a procedure	Student will receive a "D" for: ◆ Administers medications safely ◆ Provides safe patient care
Failure to document medication administration in the computer in a timely manner after meds are given (within a 30 minute time frame). This should be unprompted by the instructor.	Student will receive an "M" or "D" for: ◆ Documents patient care and medications
Falling asleep during post conference	Student will be asked to leave the post conference and receive a "D" for: • Participates in post conference • Communicates effectively with faculty

RN Content Mastery and Review Program

Students are required to participate in the Assessment Technologies Institute's (ATI) Content Mastery and Review Program. This program aids in the review and remediation process for the state-licensing exam in nursing. Each module combines thorough content mastery assessment with review questions based on case studies.

In this course, the student will take a proctored assessment on the <u>Pharmacology</u> content area. In the Pharmacology course, the student received a review module s a resource as well as codes for non-proctored assessments. To review for the proctored assessment, the student must complete the **2.0** <u>non-proctored</u> assessment by **July 8**. This assessment may be taken as many times as possible to prepare for the final exam and the proctored assessment. The <u>proctored</u> assessment be administered on **July 22**.

The **proctored assessment** is a 60-item test that assesses basic comprehension and mastery of pharmacologic principles and knowledge of prototype drugs. Questions will be related to:

- 1. pharmacologic principles (e.g., pharmacodynamics, pharmacokinetics, safe medication administration across the lifespan, medication error prevention)
- knowledge related to the safe administration and monitoring of prototype drugs that are used to treat infections, pain, and inflammation and that affect the blood, immune, cardiovascular, respiratory, renal, digestive, endocrine, reproduction, and nervous systems.

An individual score of <u>66%</u> (see ATI Testing Policy) must be achieved to successfully complete the module.

ATI Testing Policy

- 1. A <u>non-proctored</u> computerized assessment will be made available to students in the beginning of the semester for computerized test-taking practice. Students are encouraged to take this assessment as many times as they would like. An ATI study book and DVD will also be provided.
- 2. Students will take a **proctored** computerized assessment on the scheduled day. This assessment will occur prior to the final course examination. There will be no change of testing dates. The score for a missed assessment will be a 0% on the Individual score and the student will be required to remediate as outlined below in Step #4. If there are extenuating circumstances, these must be brought to the attention of the professor prior to the assessment date.
- 3. It is expected that students will demonstrate a mastery of concepts <u>at or above 66%</u> on the Individual Score. A <u>66% meets the Proficiency Level 1</u> standard and is considered to meet the absolute minimum expectation for performance in this content area.

- 4. Those students who <u>do not</u> demonstrate a mastery of concepts <u>at or above 66%</u> on the Individual Score <u>must</u> take a 2nd non-proctored test until a <u>76%</u> Individual Score is accomplished. This assessment can be taken as many times as needed to achieve 76%.
- 5. For those students who take the 2nd non-proctored test, a paper copy of accomplishing 76% on the 2nd non-proctored test needs to be presented to the professor for admission to the final exam for that course.
- 6. Failure to present proof of remediation in the 2nd non-proctored exam **before** the final course exam will result in a zero for the final exam.

Entrance/Orientation