RNSG 1162-101
Complex Concepts of Adult Health Clinical
Spring 2022

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Student hours and location: As stated in grid

Required Textbook/Materials:

Gulanik, M, Myers, J (2017). *Nursing Care Plans, diagnosis, interventions, and outcomes* – 9th edition. St. Louis: Elsevier, Inc.

Lewis, S., Bucher, L., Heitkemper, M., & Harding, M. (2019). *Medical-Surgical Nursing: Assessment and Management of Clinical Problems*, 11th Edition. St. Louis: Elsevier, Inc.

Mulholland, J.M., & Turner, S.J. (2015). *The nurse, the math, the meds: Drug calculations using Dimensional analysis* (3rd ed.). St Louis, MO: Elsevier/Mosby.

EHR Tutor. (2020). Academic electronic health record training program. Available from https://my.ehrtutor.com/

Lilley, L., Rainforth., Collins, S., & Snyder, J. (2017). *Pharmacology and the nursing process* (9th Ed.). Elsevier, Inc.: St. Louis, MO.

Skills Kit for Lab: To be purchased at the College of the Bookstore

Course Description: This course is an introduction to the clinical aspects of nursing care of adults experiencing common health alterations in multiple settings. Opportunities are provided for the application of theory, concepts, and skills being acquired.

Course requirements (may include any/all of the following):

1. **Math Competency Assignment**- Required as ticket to take math comp #1
2. **Math Competency Quiz** - Assesses proficiency in dosage calculations. Students will be required to pass a Math Competency Examination with a 100% before administering medications during clinical settings and to pass the course. Students will be allowed three (3) attempts to successfully pass the examination. The highest possible score to be calculated in the course grade for attempt 2 or 3 is a 75%. **All students level 3 clinical students will take one math comp exam for the combined Pedi/OB and Complex Concepts clinical courses. If the student is unsuccessful in obtaining a 100% on the 3rd math comp exam, the student will be withdrawn from both clinical courses and will receive a "D" in one clinical course.**

3. **Weekly Documentation** – Assesses the understanding of care that identifies patient goals/outcomes, nursing interventions. Assesses the ability to understand, collaborate and communicate in a timely manner with the healthcare team to plan, deliver, and evaluate patient-centered care in the inpatient setting.
4. **Major Care Plan**- Assesses the ability to analyze data to create an individualized plan of care. Assesses the ability to collaborate and communicate in a timely manner with the healthcare team to plan, deliver, and evaluate patient-centered care.
5. **SBAR-** Assists the student in the creation of an appropriate SBAR for a patient in congestive heart failure
6. **Skills Lab** -A hands on learning environment to prepare for new skills including: blood administration, central line dressing changes, and tracheostomy care
7. **Clinical Evaluation** - Assesses clinical competency.

Late Work, Make-Up, and Extra-Credit Policy:

All course assignments are expected to be completed and submitted on the specified due date. See Grade Determination & Calculation in the Nursing Student Handbook.

Clinical Day of the Week	Paperwork due by 2359
Tuesday	Thursday
Thursday	Saturday
Friday	Sunday

All other clinical assignments will be due on **Saturdays at 2359 on the dates specified on the calendar**.

Attendance Policy:

See the attendance policy in the Nursing Student Handbook

Communicating with your instructor: ALL electronic communication with the instructor must be through your COM email. Due to FERPA restrictions, faculty cannot share any information about performance in the class through other electronic means. (Faculty may add additional statement requiring monitoring and communication expectations via Blackboard or other LMS).

Academic Dishonesty:

Any incidence of academic policy will be dealt with in accordance with college policy and the Student Handbook. Academic dishonesty, such as cheating on exams, is an extremely serious offense. See Behavior/Conduct policy in the Nursing Student Handbook.

Plagiarism: Plagiarism is using someone else's words or ideas and claiming them as your own. Plagiarism is a very serious offense. Plagiarism includes paraphrasing someone else's words without giving proper citation, copying directly from a website and pasting it into your paper, using someone else's words without quotation marks. An assignment containing any plagiarized material will receive a **grade of zero** and the student will be referred to the Office of Student Conduct for the appropriate discipline action.

Student Learner Outcome	Maps to Core Objective	Assessed via this Assignment
1. Demonstrate professional student responsibilities by following policies and procedures of the ADN Program and the clinical facility practice guidelines		
2. Assume responsibility and accountability for the quality of nursing care provided to patients and their families under the supervision of clinical faculty and assigned primary nurse.		
3. Assess the physical and mental health status of adult patients with common health needs using a structured data collection tool with primary and secondary sources of information		
4. Analyze assessment data to prioritize problems that can be addressed by nursing.		
5. Develop a plan of care that identifies patient goals/outcomes and nursing interventions using information from evidence-based practice in collaboration with patients, their families, and the health care team.		
6. Implement the plan of care to provide safe, compassionate, ethical nursing care for adult patients and their families in acute care settings.		
7. Evaluate attainment of patient goals and related nursing interventions and modify the plan of care in response to changing patient needs.		
8. Use standards of nursing practice to provide and evaluate patient care by seeking supervision when practice behaviors and judgments fall outside individual knowledge and expertise		
9. Collaborate and communicate in a timely manner with patients, their families, and the health care team to plan, deliver, and evaluate patient-centered care.		
10. Serve as a health care advocate in assessing and promoting safety and quality for adult patients with common health needs and their families		
11. Communicate and manage information using technology to support decision making to improve patient care		

Student Concerns: If you have any questions or concerns about any aspect of this course, please contact the course faculty using the contact information previously provided. If, after discussing your concern with me, you continue to have questions, please contact the course facilitator. If questions remain after this, please contact the Director of Nursing- Dr. Debra Bauer at dbauer3@com.edu

Determination of Course Grade/Detailed Grading Formula:

Assignment	%
Math Competency Quiz*	10
Weekly Documentation (2 at 15% each)	30
Major Care Plan	40
SBAR	20
Clinical Performance Evaluation	Pass/fail
TOTAL	100
* The student must pass with a 100% in three attempts to continue in this course	

Grading Scale:

A = 90 - 100.00
B = 80 - 89.99
C = 75 - 79.99*
D = 60 - 74.99
F = < 60

*A minimum final grade of "C" is required to pass this course.

Clinical Guidelines

Guidelines for Clinical Experience

1. Mandatory facility "Orientation" date and time is noted on the course calendar. Additional instructions regarding directions to the facility, parking fees, etc., will be given in class.
2. Dress code includes wearing scrubs at all clinical facilities including during on campus Simulation Lab. You will be sent home for inappropriate dress, this will be considered a clinical absence. This will be up to your clinical instructor.
3. Wear your school name tag at all times in the clinical setting. You may be required to get an additional photo and badge at some facilities.

Student Activities during the Clinical Day

During a typical clinical day, the student will:

1. Arrive at the clinical facility at the designated time, dressed appropriately, and without any dangling jewelry from the ears, neck, or wrists (safety issue), and with no excessive cosmetics or perfume, and avoiding any provocative dress or behavior that would call undue attention to oneself.
2. Meet with your clinical instructor at the time and place for pre-conference.
3. Go to your unit and put your books, etc. in the designated place for students. Do not bring anything like your books or backpack, etc., out into patient care areas.
4. Do not bring valuables to clinical, e.g., large amounts of money or credit cards or expensive jewelry (leave them locked in your car if brought unintentionally).
5. Meet with the charge nurse for the shift report/staff assignment.
6. Collaborate with your nurse preceptor for taking lunch (30 minutes). Do not leave the facility without informing your instructor.
7. Consult with your clinical instructor freely.
8. Arrive and participate in post conference at the designated time and place.

Guidelines for Medication Administration
Pharmacology is an important aspect of the clinical experience. You will discuss your patient's medications daily with the clinical instructor. You will be responsible for knowing about all your patient's medications (both scheduled & prn), classification, action, indications for use, dosage, time, route, side effects, nursing implications, and target symptoms for your client.
Monitoring patients for medication effectiveness is also an important aspect of the nurse's role.

Guidelines for Charting
You may read the patients chart, but do not make copies of anything in the patient record without permission from the charge nurse and your instructor. You will be expected to report only pertinent data from any medical and/or lab tests for Care Plans etc., so it should not be necessary to copy any forms from a patient chart.

The student will be expected to abide by the guidelines of the institution when charting in the institutional EHR. The student will submit documentation through the simulated electronic health record at www.ehrtutor.com. Documentation should be done on the patient **at least every two hours** and should be complete and accurate.

The student will submit documentation through the simulated electronic health record at www.ehrtutor.com Students will utilize two methods of charting, flow sheets and narrative. The assessment will include:

- Physical head to toe focused assessment
- Pertinent medical history
- Pertinent diagnostic and lab results (explanation of each test result should be included)
- Patient medications including home medications
- Medication profile
- Medical orders
- Patient Education
- Nursing note at least every two hours (complete and accurate)

Reporting Patient Information using SBAR

- Complete and use the SBAR tool to communicate the patient's situation with instructor and other members of the health care team.
- http://www.ihi.org/resources/pages/tools/sbartoolkit.aspx
- The SBAR acronym (**S**ituation **B**ackground **A**ssessment **R**ecommendation) is a tool used to communicate with members of the healthcare team.

Due Dates/Times
All documentation should occur during the clinical day not after the fact. The steps and each patient encounter must be documented in real-time in EHR Tutor.

- Assessment should occur early and be documented immediately after completion.
- Diagnosis/Planning should be documented prior to care and should flow from physical assessment data and institutional EMR information/data.
- Interventions/Direct patient care should be documented immediately after care is provided (including med administration - students should use their drug books to review meds prior to administration...drug cards are not necessary!)
- Evaluation should occur at the end of the shift before reporting off to the patient care nurse.

All documentation should be completed BEFORE the student leaves the unit for the day...just as in real life.

- Reporting must happen throughout and at the end of each clinical day. Students should take no more than 30 minutes to construct the SBAR prior to reporting to the patient care nurse and instructor. A completed SBAR should be prepared for post conference each clinical. The student will communicate a verbal care plan to the instructor each week before the end of the clinical day.
- All documentation should be completed by the end of the clinical day of clinical day. In the event the student does not have internet access at the facility, the student will utilize a down-time form, which must be completed before leaving clinical. The student will be allowed time to complete data entry into EHR Tutor.

Clinical Facilities for this course will be Texas Orthopedic Institute, Kindred Place or HCA Houston Healthcare Mainland. All documentation for these units will be completed in EHR.

Permissible Common Concepts of Adult Health Clinical Nursing Skills

The student will perform only those procedures and treatments, which have been taught in the nursing skills course or nursing skills laboratory.

Independent	**RN Supervision Only**
Ambulation assistance	Medication administration
Binder or bandage application	IV insertion/site maintenance
Heat/Cold application	IV flow rate/calculations
Hygiene care/bed bath	Restraint application
Incontinence care	Specimen collection
Nutritional care (feeding)	Wound care
Physical Assessment	Sterile dressing changes
ROM exercises	Tracheostomy/endotracheal care/suctioning
Transfers	Urinary catheterization
Vital Signs	Oxygen administration

Non-permissible Nursing Skills

Skills that will not be performed throughout nursing school at COM are: administration of blood or blood products, administration of medications by IV push, and care of a patient with an airborne illness requiring the use of an N95 face mask. The student may observe the nurse administer blood or blood products. Performance of these skills by a nursing student is considered unsafe and can result in dismissal from the program.

Institutional Policies and Guidelines

Grade Appeal Process: Concerns about the accuracy of grades should first be discussed with the instructor. A request for a change of grade is a formal request and must be made within six months of the grade assignment. Directions for filing an appeal can be found in the student handbook.<https://build.com.edu/uploads/sitecontent/files/student-services/Student_Handbook_2019-2020v5.pdf. *An appeal will not be considered because of general dissatisfaction with a grade, penalty, or*

outcome of a course. Disagreement with the instructor's professional judgment of the quality of the student's work and performance is also not an admissible basis for a grade appeal. https://build.com.edu/uploads/sitecontent/files/student-services/Student_Handbook_2019-2020v5.pdf

Academic Success & Support Services: College of the Mainland is committed to providing students the necessary support and tools for success in their college careers. Support is offered through our Tutoring Services, Library, Counseling, and through Student Services. Please discuss any concerns with your faculty or an advisor.

ADA Statement: Any student with a documented disability needing academic accommodations is requested to contact Holly Bankston at 409-933-8520 or hbankston@com.edu. The Office of Services for Students with Disabilities is located in the Student Success Center.

Counseling Statement: Any student needing counseling services is requested to please contact Holly Bankston in the student success center at 409-933-8520 or hbankston@com.edu. Counseling services are available on campus in the student center for free and students can also email counseling@com.edu to set up their appointment. Appointments are strongly encouraged; however, some concerns may be addressed on a walk-in basis.

Textbook Purchasing Statement: A student attending College of the Mainland is not under any obligation to purchase a textbook from the college-affiliated bookstore. The same textbook may also be available from an independent retailer, including an online retailer.

Withdrawal Policy: Students may withdraw from this course for any reason prior to the last eligible day for a "W" grade. Before withdrawing students should speak with the instructor and consult an advisor. Students are permitted to withdraw only six times during their college career by state law. The last date to withdraw from the 16-week spring semester session is April 25th, 2022.

F_N Grading: The F_N grade is issued in cases of *failure due to a lack of attendance*, as determined by the instructor. The F_N grade may be issued for cases in which the student ceases or fails to attend class, submit assignments, or participate in required capacities, and for which the student has failed to withdraw. The issuing of the F_N grade is at the discretion of the instructor. The last date of attendance should be documented for submission of an F_N grade.

Early Alert Program: The Student Success Center at College of the Mainland has implemented an Early Alert Program because student success and retention are very important to us. I have been asked to refer students to the program throughout the semester if they are having difficulty completing assignments or have poor attendance. If you are referred to the Early Alert Program you will be contacted by someone in the Student Success Center who will schedule a meeting with you to see what assistance they can offer in order for you to meet your academic goals.

COVID-19 Statement: All students, faculty, and staff are expected to familiarize themselves with materials and information contained on the College of the Mainland's Coronavirus Information site at www.com.edu/coronavirus. In compliance with Governor Abbott's May 18 Executive Order, face coverings/masks will no longer be required on COM campus. Protocols and college signage are being updated. We will no longer enforce any COM protocol that requires face coverings. We continue to encourage all members of the COM community to distance when possible, use hygiene measures, and get vaccinated to protect against COVID-19. Please visit com.edu/coronavirus for future updates.

Statement of Eligibility for an Occupational Licensure: Effective September 1, 2017, HB 1508 amends the Texas Occupations Code Section 53 that requires education providers to notify potential or enrolled students that a criminal history may make them ineligible for an occupational license upon program completion. The following website provides links to information about the licensing process and requirements: https://www.bon.texas.gov/licensure_eligibility.asp. Should you wish to request a review of the impact of criminal history on your potential Registered Nurse License prior to or during your quest for a degree, you can visit this link and request a "Criminal History Evaluation": https://www.bon.texas.gov/licensure_endorsement.asp. This information is being provided to all persons who apply or enroll in the program, with notice of the requirements as described above, regardless of whether the person has been convicted of a criminal offense. Additionally, HB 1508 authorizes licensing agencies to require reimbursements when a student fails to receive the required notice.

Acute Care Clinical Documentation (Non-Major Care Plan Day)	Points
GENERAL CHARTING:	
Pathophysiology- include diagnosis, pertinent signs and symptoms and treatment	5
Labs for last 24 hours- include rationale for any abnormal	1
Imaging/diagnostics for last 24 hours- include results	1
At least two sets of vital signs.	2
Assessment (head to toe)	10
SBAR	4
NARRATIVE NOTES (every 2 hours and with all interventions- at least 5 per shift)	10
CARE PLAN:	
Documentation of two priority nursing diagnoses	8
Subjective assessment- related to each nursing diagnosis	4
Objective assessment- related to each nursing diagnosis	4
Identifies SMART short term goal (STG) #1 - for one nursing diagnosis	5
Identifies SMART short term goal (STG) #2 - for one nursing diagnosis-	5
Identifies SMART long term goal (LTG) #1 – for one nursing diagnosis- all goals must be written for same nursing diagnosis	1
Identify and Implement 5 nursing interventions for STG #1 with scientific rationale and patient response for each intervention. (**The intervention must have documentation of rationale and how the intervention affected the patient to receive all three points**).	15
Identifies and Implements 5 nursing interventions for STG #2 with scientific rationale and patient response for each intervention **(The intervention must have documentation of rationale and how the intervention affected the patient to receive all three points).**	15
Evaluates STG #1 & modifies if applicable.	2
Evaluates STG #2 & modifies if applicable.	2
Medication Profile: Up to 10 scheduled medications	
Classification on all meds	1
Indication on all meds	1
Dosage on all meds	1
Frequency on all meds	1
Adverse Effects/pt education on all meds	1
References: must have for patho, meds, and care plan	1
Total	100

Grading Criteria of Major Care Plan
Completed on EHR

Acute Care Clinical Documentation (Major Care Plan Day)	Points
GENERAL CHARTING:	
Pathophysiology- include diagnosis, pertinent signs and symptoms and treatment	4
Labs for last 24 hours- include rationale for any abnormal	1
Imaging/diagnostics for last 24 hours- include results	1
Nutrition: What diet is patient ordered? What did they eat?	1
At least two sets of vital signs.	1
Assessment (head to toe)	10
SBAR	4
NARRATIVE NOTES (every 2 hours and with all interventions- at least 5 per shift)	10
CARE PLAN: create three diagnoses, develop two	
Documentation of three priority diagnoses	12
Subjective assessment- related to each nursing diagnoses (1 point per diagnosis)	2
Objective assessment- related to each nursing diagnoses (1 point per diagnosis	2
Nursing diagnosis #1: Identify 2 SMART short term goals (STG) (5 points per goal)	10
Nursing diagnosis #1: Identify 1 SMART long term goals (LTG)	2
Nursing diagnosis #2: Identify 2 SMART short term goals (STG) (5 points per goal)	10
Nursing diagnosis #2: Identify 1 SMART long term goals (LTG)	2
Nursing diagnosis #1: Identify and Implement 4 nursing interventions for **each** STG with scientific rationale and patient response for each intervention. (**The intervention must have documentation of rationale and how the intervention affected the patient to receive all three points**).	24
Nursing diagnosis #2: Identify and Implement 4 nursing interventions for **each** STG with scientific rationale and patient response for each intervention. (**The intervention must have documentation of rationale and how the intervention affected the patient to receive all three points**).	24
Nursing diagnosis #1: Evaluate each STG & modify if applicable.	2
Nursing diagnosis #2: Evaluate each STG & modify if applicable.	2
Medication Profile: Up to 10 scheduled medications	
Classification on all meds	1
Indication on all meds	1
Dosage on all meds	1
Frequency on all meds	1
Adverse Effects/pt education on all meds	1
References: must have for patho, meds, and care plan	1
Total	130

SBAR Assignment

The student will complete a Congestive Heart Failure SBAR. The assignment is to assist the student with communicating a patient's medical problem to a physician. The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. Use the tool found on Blackboard and upload.

1. S = Situation- a concise statement of the problem
2. B = Background- pertinent and brief information related to the situation
3. A = Assessment- analysis and considerations of options
4. R = Recommendation- action requested/recommended

Congestive Heart Failure SBAR Grading Rubric

Criteria	Possible Points	Points Earned
Situation	25	
Background	25	
Assessment	25	
Recommendation	25	
Total Points	100	