RNSG 2261-101
Care of the Childbearing and Child Rearing Clinical
Fall 2021

Instructor Information: Karen Bell: kbell22@com.edu 409-933-8716
Office Hours: Tuesdays 12-4, Wednesdays 9-12:30
Rene Lovett: rlovett@com.edu 409-933-8282
Office Hours: Mondays 11-1,Tuesdays 11-2:30, Wednesdays (virtual) 8-10

Student hours and location: As stated in grid

Required Textbook/Materials:
McKinney, E.S. (2018) Maternal-Child Nursing (5th ed.) St. Louis, MO: Elsevier
EHRtutor
Shadow Health

Course Description: Clinical application of the concepts related to the provision of nursing care for childbearing and childrearing families. Application of systematic problem-solving processes and critical thinking skills, including a focus on the childbearing family during the perinatal periods and the childrearing family from birth to adolescence; and competency in knowledge, judgment, skill, and professional values within a legal/ethical framework.

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 If the student is unsuccessful in obtaining a 100% on the 3rd math comp exam, the student will be withdrawn from both clinical courses and will receive a "D" in one clinical course.**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. **HESI Patient Reviews (HPRs)** - Elsevier/Evolve- Assess understanding of core content in preparation for challenging clinical situations. Please print a copy for yourself after completing the activity. Instructors will be able to track your completion of the activity online but may need to see your copy if there are any discrepancies There will be only one attempt allowed for each HPR. A grade of zero (0) will be given for any late HPR. The average of all assigned HPR's will be calculated for the final HPR grade.
4. **Health Promotion Teaching Paper**- Assesses the understanding and application of appropriate patient/family teaching on an assigned Pediatric or OB topic.
5. **Elder Portfolio** - Monitors the progress in the ongoing evaluation and relationship building with an elder in the community; focuses on the elder's role in the lives of children in his or her family or community.

6. **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 inpatient, outpatient, and school settings.
7. **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.
8. **Shadow Health**- Virtual patient assessments for a variety of pediatric disease processes.
9. **Simulation Lab** -A simulated patient care environment which assesses critical thinking ability in various scenarios
10. **Volunteer Experience**
11. **School Nurse-** public or private school setting
12. **Case Studies-** as assigned
13. **Clinical Evaluation** - Assesses clinical competency.

Determination of Course Grade/Detailed Grading Formula:

Assignment	%
Math Competency Quiz*	10
Elder	10
Shadow Health	15
Weekly Documentation (2 at 9% each)	18
Major Care Plan	25
Health Promotion Paper	10
HESI Patient Reviews (12 at 1% each)	12
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.

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	Clinical Shift	Paperwork due by 2359 (major care plan, daily care plan and labor and delivery paper)
Wednesday	Night	Saturday
Thursday	Day	Saturday
Thursday	Night	Sunday
Friday	Day	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)

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 patients with diverse 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 pediatric patients, their families, and the health care team.		
6. Implement the plan of care to provide safe, compassionate, ethical nursing care for maternal and child 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 patients and their families		

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 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. Amanda Ordonez at mordonez@com.edu.

Course outline:

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:

- Chief Complaint
- 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 Facility for this course will be UTMB and HCA Southeast. Units assigned will be any/all of the following areas: NICU (neonatal intensive care unit), APU (antepartum unit), MBU (mother baby unit), L&D (labor and delivery), Nursery, or Gynecologic Med/Surg. All documentation for these units will be completed in HER except for Labor and Delivery which will be submitted via Blackboard.

Clinical Conferences
Students are expected to attend any pre- and post-conferences at the times and place designated by the clinical instructor. Post conference learning activities are at the discretion of the clinical instructor and all students are expected to comply and complete the requested assignments.

Course outline: Please see course calendar for specific assignments due each week. All clinical assignments will be due at 2359. The only exception to this is Shadow Health modules which close at 2355 per the company policy

Medication

Pediatric Medication Administration

Student Learning Outcomes
Upon completion of this module, the student will:
1. Describe proper techniques that will assure safe administration of medication to children.
2. Demonstrate an understanding of pediatric dosage calculation.
3. Examine factors related to growth and maturation that significantly alter an individual's capacity to metabolize and excrete drugs.
4. Demonstrate the administration of medications as authorized by law and determined by the BON.

Learning Content
I. Effects of immaturity on drug metabolism and excretion.
II. Dosage calculation.
   A. Dose per Kilogram of Body Weight
III. Methods of administration

A. Oral administration
B. Intramuscular (IM) administration
C. Subcutaneous and intradermal administration
D. Intravenous (IV) administration

IV. Parenteral fluid therapy
A. Selection of IV site and site care
B. Recording and reporting of IV intake
C. Use of Volume Control Devices (Buretrol, etc.)
D. Use of infusion pumps
E. Peripheral Venous Access Devices (VAD's)

V. Nasogastric, orogastric or gastrostomy administration
VI. Rectal administration
VII. Optic, otic, and nasal administration

Medications Commonly Used in Maternal-Newborn Nursing

The following drugs are those commonly encountered in this course.
Acetaminophen/Codeine - Tylenol #3
Methergine
Acetaminophen IV
Metoclopramide-Reglan
Betamethasone - Long-acting Corticosteroids
Morphine
Butorphanol – Stadol
Naloxone-Narcan
Docusate – Surfak
Oxytocin-Pitocin
EMLA cream
Phytonadione-Aqua Mephyton
Erythromycin ophthalmic
Prenatal vitamins
Famotidine – Pepcid
Rubella vaccine
Hepatitis B vaccine
Sodium Citrate-Bicitra
Immune Globulin - Rhogam
Terbutaline-Brethine
Lansinoh Cream
Magnesium sulfate
Meperidine – Demerol

Learning Activities

Required readings:

- McKinney 5th ed., Chapter 18, 38

Required activities:

- Pre-clinical Math Assignment is the "ticket" to take first Math Comp Exam. The exam will complete

the requirement for both RNSG 2261 (Nursing Care of the Childbearing and Child Rearing Family) and RNSG 1162 (Complex Concepts of Adult Health).

Clinical Skills Checklist- Pediatric

Students are expected to perform all skills designated in previous courses and must satisfactorily demonstrate the following skills in the lab and/or clinical area prior to performing with assigned nurse or clinical faculty.

	Skill	S/U	Comments
1.	Use of pediatric restraints and safety nets.		
2.	Crib safety (include types of cribs in relations to children needs).		
3.	Positioning the child per safety/comfort needs - appropriate to disease process/injury.		
4.	Calculation and administration of medications adapted to pediatric client (calculate safe dosage range).		
5.	ADL's per age and developmental level.		
6.	Nutritional needs of the pediatric client.		
	A. Infant feeding		
	1. Breast		
	2. Bottle		
	3. Gavage		
	4. G-tube		
	5. Parenteral		
	B. Progressive feeding		
7.	Therapeutic baths		
	A. Tepid		
	B. Medicated		
8.	Pediatric intake and output		
9.	Pediatric enema administration		
10.	Maintenance of pediatric IV		
11.	Tests and specimens		
	- urine, specimen collection techniques		
	- urine, catheter		
	- dip stick		
	- specific gravity		
	- stool - ova and parasites		
	- occult blood (guaiac)		
	- culture and sensitivity		
	- sputum, suctioning for specimen		
	- blood		
	- bedside glucose monitoring		
12.	Physical assessment		
	- infant, child, adolescent		
	- assist with pediatric exam		
13.	Admission, transfer and discharge of pediatric client		
14.	Pediatric vital signs		
15.	Pediatric Oxygen administration		
	- pulse oximeter		
	- oxy hood		
	- nasal cannula		
	- croup tent		
	- incubator		
	- O_2 concentration monitoring		

Permissible Childbearing Family 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	Faculty Supervision Only
Ambulation assistance	Colostomy care	Medication administration
Binder or bandage application	External catheter application/care	Endotracheal suctioning
Heat/Cold application	Isolation care	Enema administration
Hygiene care/bed bath	IV flow rate regulation	IV calculations
Incontinence care	IV site maintenance	IV insertion
Nutritional care (feeding)	IV tubing/fluid changes	IV locks
Physical Assessment	NGT maintenance	NGT feeding
ROM exercises	Non-sterile dressing change	NGT insertion/removal
Transfers (bed to chair)	Oxygen administration	NGT medications
Transfers (bed to stretcher)	Pre-op care/Post-op care	Phlebotomy
Vital signs measurement	Pressure Ulcer care	Providing Cast Care
	Restraint application/monitoring	Sterile dressing change
	Specimen collection	Tracheostomy suctioning & care
	Traction monitoring	Urinary catheterization
	Wound drainage device care	

Non-permissible Nursing Skills

Skills that will not be performed throughout nursing school at COM are: administration of blood or blood products 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 1st 8-week session is October 6. The last date to withdraw from the 16-week session is November 19. The last date to withdraw for the 2nd 8-week session is December 2.

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.

Acute Care Clinical Documentation (Non-Major Care Plan Day)	Points
GENERAL CHARTING:	
Pathophysiology	5
Diagnostic/Lab: For past 24 hours	
Testing completed/Results/Rationale for abnormal labs	3
Nutrition: Actual order and 2 sample meals for your patient	3
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	6
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	4
Identifies SMART short term goal (STG) #2 - for one nursing diagnosis-	4
Identifies SMART long term goal (LTG) #1 – for one nursing diagnosis- all goals must 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	5
Diagnostic/Lab: For past 24 hours	
Testing completed/Results/Rationale for abnormal labs patient?)	3
Nutrition: Actual order and patient intake for your shift	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: create three diagnoses, develop two	
Documentation of three priority diagnoses	15
Subjective assessment- related to nursing diagnoses (3 pts per diagnosis)	6
Objective assessment- related to nursing diagnoses (3 points per diagnosis	6
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 5 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**).	30
Nursing diagnosis #2: Identify and Implement 5 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**).	30
Nursing diagnosis #1: Evaluate each STG & modify if applicable.	4
Nursing diagnosis #2: Evaluate each STG & modify if applicable.	4
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	160

Health Promotion Paper

In APA format, type a two-page double spaced paper.

1. **Assessment:** Describe the condition that you will be teaching your patient and/or family.
2. **Outcome:** What is the goal for the education being provided? What should they do to avoid a certain condition, or what should they do if they are affected by the condition?
3. **Teaching Plan:** This should be the actual educational steps provided to family. What teaching methods would be most effective for patient/family education? Handouts or booklets with pictures? Audio or video?
4. **Evaluation:** What criteria will be used to assess the family's understanding of the education provided? Verbalization? Return skill demonstration?
5. **Reference** page with at least 2 approved **SCHOLARLY** references (No Wiki or WebMD for example). Your textbook can be used as a reference. Any nursing journal cannot be more than 5 years old.
6. Submit to your clinical instructor via Blackboard on your assigned paperwork due date.
7. **SafeAssign** will be enabled for this paper, and the match percentage must be **no higher than 25%.**

Health Promotion Paper Grading Rubric

Criteria	Possible Points	Points Earned
Assessment- describe condition	20	
Outcome- goals for education	20	
Teaching Plan- steps for teaching	30	
Evaluation- criteria used for understanding	20	
Length of Paper Grammar References APA format 25% Safe Assign	10	
Total Points	100	

Labor and Delivery Paper

In APA format, type a one-page double spaced paper. Choose one patient and address the following:

1. Situation: Why is the patient here?
2. Background: What is the medical history (including GP status)
3. Assessment: Include pertinent assessment findings, VS, FHT, labor station
4. Recommendation:
5. Nursing Notes: This is a narrative section to describe any interventions completed by nursing or assisted by nursing to the physician. This should be time specific to when events/interventions occur. Include any education provided to the laboring mother.

Labor and Delivery Paper Rubric

Criteria	Points	Score
Situation	10	
Background	15	
Assessment	20	
Recommendation	15	
Nursing Narrative	40	
Total	100	

Faculty comments:

Elder Portfolio Guidelines

The Elder Portfolio reflects the effort of the COM faculty to ensure that the assessment and care of the elderly population is addressed throughout the curriculum. The portfolio is a compilation of documents which will be used throughout the program in each clinical course.

For this course, the student will complete the Level III required activities, and submit the portfolio to the clinical instructor via Blackboard. The electronic forms can be found under the "Content" tab in the RNSG 1262 Blackboard course.