RNSG-1261-101CL-SP2023
Common Concepts of Adult Health Clinical
Spring 2023
Mondays, Wednesdays, Fridays, and Saturdays

Instructor Information:
Benjamin "Jay" Ketcherside, II, MSN, RN, Course Facilitator
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Student hours and location:
Mondays 09:00 am -10:00 am (TEAMS only)
Wednesdays 8:00 am – 11:30 am (office)
Thursdays 12:30 pm – 3:30pm (office)

Other instructors:
Terri Davis MSN RN
Dr. Stephanie Griggs DNP RN

Required Textbook/Materials:

ATI EHRTutor (online application) http://www.ehrtutor.com/

Center for Work Ethic Development (2019). *Bring your 'a' game participant workbook.* Denver, Co: The Center for Work Ethic Development.

Elsevier (2018). *HESI Assessment | RN Patient Reviews*. St. Louis: Elsevier, Inc.

Gulanick, M., & Myers, J. (2017). Nursing Care Plans: Diagnoses, interventions, and outcomes, 9th edition. St. Louis: Elsevier, Inc.

Harding, M., et al. (2023) *Elsevier Adaptive Quizzing for Medical-surgical nursing: Assessment and management of clinical problems, 12th 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.

All other books listed in RNSG 1341 – Common Concepts of Adult Health

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. See catalog admitted under for pre- and co- requisites. (Credit 2: Lecture 0, Clinical 6, 96 Contact Hours)

Course Objectives/Student Learning Outcomes
Upon completion of this course, the student will:

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 and preferences 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 with common health needs, their families, and the health care team.
6. Implement the plan of care to provide safe, compassionate, ethical nursing care for adult patients with common health needs 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 adult patients with common health needs, 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.

Course requirements: (including description of any special projects or assignments)

1. **Pre-clinical assignments**
    a. Pre-clinical orientation
    b. "Bring your A Game" pre-clinical activities
2. **Math Competency Exam** – Assesses proficiency in dosage calculations. This must be completed with 100% score to pass medications and to continue in the semester. You will have 3 opportunities to meet this requirement. You will use dimensional analysis as your method of calculation. This will count as 10% of your final grade.
3. **Weekly Observational Assignments:**
    a. **Care Plans** (**1**)- Assess understanding of the nursing process. You will complete one care plan during your hospital visits based on your assessment and clinical activities on a patient selected by you and your precepting nurse. This will be documented in EHRTutor, and graded according to the rubric in

the back of this syllabus. This Care plan will account for 50% of your grade, and must be complete by your second clinical hospital visit. If you make less than 75% on your care plan, you will be allowed to complete a one-time make-up care plan.

b. **Weekly SBAR documentation.** Using the COM Nursing SBAR form in contents of the D2L for this class, the student will fill in the the SBAR and use to report during post-conference. The SBAR will then be uploaded into ASSIGNMENTS in D2L for a "pass/fail" grade by the instructor.

4. **Clinical Performance Evaluation –** Assesses clinical competency and application of theory to practice. This is assessed two times by the student and then the faculty member:
   a. **Two times (self-eval) by student**
   b. **Two times by the clinical instructor (pass/fail)**
      - Mid-term (second hospital visit)
      - Final (last hospital visit)
5. **Elder Portfolio –** Assesses understanding of geriatric nursing standards of practice across the curriculum. This will be worth 20% of your final grade. Rubric is part of the Elder portfolio packet in the D2L module under contents.
6. **Clinic visits** – Each student will visit a Harris Health healthcare clinic for three visits this semester. The student will write a 300 word report about their visit using the rubric below. An average of the three visits will be worth 20% of your grade.

Clinic Visit Report Rubric	Yes	No
1. Define the objectives of their precepting clinic nurse/healthcare provider.		
2. Describe how the clinic meets the healthcare needs of a diverse community.		
3. Define the objectives of their precepting clinic nurse/healthcare provider.		
4. Define the interventions of the precepting health worker used to meet those objectives.		
5. Describe the communication used to inform and educate the patient to meet those objectives.		
6. Describe how the healthcare worker evaluated the interventions to measure successful outcomes.		
7. Use APA format.		
8. Write in 300 or more words		
9. Write using good grammar and punctuation.		

7. **Instructor check-offs** – each student will receive a check-off by the instructor for two clinical skills:
   a. Medication administration
      - Student may not have check-off until they have passed the med administration exam
   b. Head to Toe Assessment

   These will be graded in the gradebook by your instructor as pass/fail. Both must be passed in order to complete this class successfully.

Determination of Course Grade/Detailed Grading Formula: (methods of evaluation to be employed to include a variety of means to evaluate student performance)

Late Work, Make-Up, and Extra-Credit Policy:
All course assignments are expected to be completed and submitted on the specified due date. See Late Assignments policy in the Nursing Student Handbook.

Attendance & Tardiness Policies: 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 dishonesty 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.

Student Concerns: If you have any questions or concerns about any aspect of this course, please contact me using the contact information previously provided. If, after discussing your concern with me, you continue to have questions, please contact the Course Facilitator. If, after discussing your concern with the Course Facilitator, you still have questions, please email nursing@com.edu to request an appointment with the Director of Nursing. Please see the Student Concerns Policy in the Nursing Student Handbook for further instructions.

Course Outline

Date/Time	Place	Details	MISC
Pre-clinical orientation	STEAM 120	Thursday, January 19th – 1300 to 1700 (1pm to 5pm)	
Major Care Plan - Midterm		Per clinical instructor	Due two days after clinical
Mid-term Evaluation		Due with Midterm careplan	
Final Evaluation		Due on final clinical day	
Weekly SBAR submission		Due one day after clinical	
Weekly Clinic report		Due two days after clinical	
Elder Care Project		Due on next to last clinical day	
Math Comp Quizzes 1, 2, and 3		1 - Friday January 20th, 0900 Testing 2 – Thursday, January 26th, 1230 Testing 3 – Thursday, February 2,	

Clinical Guidelines

Guidelines for Clinical Experience

Students will be expected to adhere to the rules and regulations outlined in the college catalog and the nursing program's Student Handbook. In order to provide the student with the most diverse experiences, he/she will be assigned to clinical facilities and faculty on a rotating basis by random selection as recommended by Board of Nursing.

Student Activities During a Typical Clinical Day

The student will be expected to complete all pre and post clinical work as specified in the course syllabus. The typical clinical day will include the following experiences:

- Completing pre-conference clinical assignments
- Pre-clinical conference with clinical instructor
- Attending the change of shift report
- Obtaining vital signs and physical assessment of assigned patients(s)
- Completing AM care for patient(s)
- Assisting patient(s) as needed with ADL's
- Collecting specimens as ordered
- Preparing the patient(s) for tests as ordered
- Observing surgery/recovery room, etc. as scheduled
- Providing pre and post-operative nursing care
- Practicing basic skills of patient management
- Administering prescribed medications
- Completing treatment(s) ordered
- Documentation of patient observations and nursing care given with clinical instructor
- Applying concepts taught in nursing theory courses to clinical experiences
- Post-conference with clinical instructor

Guidelines for Selecting Patients

On the clinical morning, each week, students will work with a staff nurse, and provide care to patients on these units as assigned by clinical instructor. Students will select their own patient(s). To provide the student with the most diverse clinical experience, patient assignments will be changed weekly. Students will be responsible for caring for one (1) to two (2) patient(s) each week.

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	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, 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 and administer medications via IV push. Performance of these skills by a nursing student is considered unsafe and can result in dismissal from the program.

Guidelines for Physical Assessment
The instructor will designate one day for each student to perform a physical assessment on one patient. This assessment is not graded, but the student's performance will be reflected in the clinical performance evaluation.

Key Elements	
1.	Introduction: ID PATIENT, explain role purpose, provide patient privacy
2.	Orientation: oriented x3; disoriented; response
3.	Skin: color; moist; dry; turgor
4.	Eyes: PERRLA; sunken; reddened; clear; sclera
5.	Ears: discharge; tinnitus; earache; hearing aid
6.	Mouth: halitosis; bleeding gums, mucous membranes; tongue
7.	Respiratory: symmetry; type of respirations; cough; breath sounds;
8.	Cardiovascular: chest pain; palpitations; edema; pulses; capillary refill
9.	Abdomen: N/V; distention/bowel sounds; pain; BM's
10.	GU: voiding; incontinent; indwelling catheter; dysuria; color
11.	Extremities: moves all; numbness; weakness; paralysis
12.	Environment: equipment; special mattress; NG tube; suction; trach; traction; dressing; IV; IV
13.	Closing: Ensure patient is comfortable, SAFETY-call light within reach, bed low and locked

Guidelines for Medication Administration
The instructor will designate medication administration day(s) for each student. Students must have shown competency in math by successfully passing a math competency exam prior to administering medications. Only the clinical instructor will supervise medication administration. The agency's policy regarding medication administration by the student nurse will be followed at all times. Students are expected to be able to demonstrate an understanding of the prescribed medications their patient will be receiving during the time students are providing care for their patient to promote safety.

Documentation
Students will document de-identified information for assigned patients in the simulated EHR via http://www.ehrtutor.com from data gathered directly from the patient and the patient's EHR at the health care facility. Printed documents will not be removed from the facility in order to comply with HIPPA rules.

Clinical Conferences
Students are expected to attend pre- and post-clinical conferences at the times and place designated by the nursing instructor. To further the students' clinical learning experiences, the clinical instructor may assign additional projects for post conference. Students will be expected to complete all required assignments.

Clinical Facilities
As assigned

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.

Grade Calculation
All assignments, including pass/fail, must be submitted to pass the course. See Grade Determination and Calculation in the Nursing Student Handbook.

Assignment of Course Grade	%
Pre-Clinical Assignments (points removed from final grade for every hour orientation missed, per student handbook policy)	
ORD#1.1 - ADN Clinical Orientation (Attendance mandatory)	Pass/Fail
ORD#2 - Bring Your "A Game" Orientation (Attendance mandatory)	Pass/Fail
Weekly Assignments	
Weekly SBAR submission	Pass/Fail
Care Plan #1*	50%
Medical Clinic visit reports (averaged)	20%
Clinical Performance Evaluation	
Clinical Performance Evaluation – High Fidelity Clinical Simulation – Sim Lab	Pass/Fail
Clinical Performance Evaluation #1 - Mid-term	Pass/Fail
Clinical Performance Evaluation #2 – Final**	Pass/Fail
Clinical Performance Evaluation (subtotal)**	Pass/Fail
Other	
Elder Portfolio	20%
Math Competency Exam*	10%
TOTAL	100%
* 100% score required to attend clinical experiences & to pass the course	
** The student must meet expectations on all critical competencies on the Final	

Methods of Instruction Nursing Skills
Laboratory Clinical Simulations Clinical
Conferences Clinical Assignments
Individualized Instruction in clinical area Electronic
Charting (ehrtutor.com) Dosage Calculation Exams

Surviving Active Shooter Event Reference and Training Videos

Run, Hide, Fight * **(Mandatory)**

https://www.youtube.com/watch?v=5VcSwejU2D0

Last Resort ACTIVE SHOOTER SURVIVAL Measures by Alon Stivi
https://www.youtube.com/watch?v=r2tIeRUbRHw

Surviving an Active Shooter Event - Civilian Response to Active Shooter
https://www.youtube.com/watch?v=j0It68YxLQQ

Make the Call * **(Mandatory)** https://www.youtube.com/watch?v=AWaPp-8k2p0

Discussion Questions:

1. What is your plan while in class to consider running, hiding, or fighting to survive?
2. How would you lock your classroom and/or barricade entry into the classroom?
3. What would you use to improvise weapons to take down the shooter / aggressor?
4. If you have to fight, would you COMMIT to the fight to save your life and others?
5. If you have a License to Carry and are concealed carrying, what guidelines would you follow?
6. Do you have the campus police emergency number and non-emergency number programmed into your phone?
    a. COM Police Emergency number (409-933-8599)
    b. COM Police Non-Emergency number (409-933-8403).
7. When the police arrive why would you have your hands up and follow all commands?
8. Why is it important to make the call to report any suspicious person or activity to campus police?

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 or not 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.

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.

Major Care Plan Rubric

Nursing Process	Key Elements	Sub Elements & Directions	Points	Score	Instructor Grading Comments
Assessment	Objective Data	Shift Assessment (documented under "assessment" under flowsheet tab	10		Subtract 1 point for each system or mandatory assessment item not addressed.
		Vital Signs	1		2-3 recorded vital signs (0.5 point for each set. Max points = 1 point)
		Intake and Output	1		0.25 for oral/alimentary intake 0.25 for alimentary output 0.25 for parenteral intake (IV, blood products, TPN) 0.25 for parenteral/non-alimentary output (urinary/wound drainage)
		Nutrition	1		meal components, % of food eaten documented
		Lab results	1		Most recent labs (repeat most pertitent ones at least once). Ex: GI Bleed would need more than one H&H
		Imaging results	1		
	Care Plan*	Subjective Data (pt stated symptoms)	3		one for each Nursing diagnoses (1 point x 3 =3)
		Objective data (summarized in care plan)	3		one for each Nursing diagnoses (1 point x 3 =3)
Diagnosis	Nursing Diagnosis #1	Prioritized by ABCs and Maslow's Hierarchy of needs?	1		
		Based off of subjective, objective and assessment data?	1		
		Documented in Care Plan tab?	1		
	Nursing Diagnosis #2	Prioritized by ABCs and Maslow's Hierarchy of needs?	1		
		Based off of subjective, objective and assessment data?	1		
		Documented in Care Plan tab?	1		
	Nursing Diagnosis #3	Prioritized by ABCs and Maslow's Hierarchy of needs?	1		
		Based off of subjective, objective and assessment data?	1		
		Documented in Care Plan tab?	1		
Planning/ Analyze	Medical Record	Medication Profiles	10		1 point per med (max points = 10). For each point, 0.14 points for each of these elements: Indication, Route, Action, Adverse Effects, Contraindication, Patient Teaching, Nursing Implications. If <10 meds, recalibrate each point component so that complete work can = 10 points.
	Care Plan: Pathophysiology*	Disease pathology	1		
		Pre-disposing factors	1		
		signs and symptoms	1		
		Medical Dx and collaborative treatment	1		
	Nursing Dx #1: Short term goal #1*	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		

		Is it time based?	1		
	Nursing Dx #1: Short term goal #2*	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		
		Is it time based?	1		
	Nursing Dx #1: Long term goal*	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		
		Is it time based?	1		

Nursing Process	Key Elements	Sub Elements & Directions	Points	Score	Instructor Grading Comments
Planning/ Analyze	Nursing Dx #2: Short term goal #1*	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		
		Is it time based?	1		
	Nursing Dx #2: Short term goal #2*	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		
		Is it time based?	1		
	Nursing Dx #2: Long term goal*	Is it specific?	1		
		Is it measurable?	1		
		Is it achievable and realistic?	1		
		Is it time based?	1		
Interventions / Implementation	Nrsg Dx #1 STG #1*	Intervention #1	1		0.25 points: evidence-based, 0.25 rationale, 0.25 reference included, 0.25 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	1		
		Intervention #3	1		
	Nrsg Dx #1 STG #2*	Intervention #1	1		0.25 points: evidence-based, 0.25 rationale, 0.25 reference included, 0.25 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	1		
		Intervention #3	1		
	Nrsg Dx #1 LTG*	Intervention #1	1		0.25 points: evidence-based, 0.25 rationale, 0.25 reference included, 0.25 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	1		
		Intervention #3	1		
	Nrsg Dx #2 STG #1*	Intervention #1	1		0.25 points: evidence-based, 0.25 rationale, 0.25 reference included, 0.25 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	1		
		Intervention #3	1		
	Nrsg Dx #2 STG #2*	Intervention #1	1		0.25 points: evidence-based, 0.25 rationale, 0.25 reference included, 0.25 documented in
		Intervention #2	1		

		Intervention #3	1		nurses notes (tied to specific nursing diagnosis & goal)
	Nrsg Dx #2 LTG*	Intervention #1	1		0.25 points: evidence-based, 0.25 rationale, 0.25 reference included, 0.25 documented in nurses notes (tied to specific nursing diagnosis & goal)
		Intervention #2	1		
		Intervention #3	1		
Evaluation	Nrsg Dx #1*	Evaluation of STG#1	1		1.0 point for documented attainment. If not attained: - 0.50 for documented failure of attainment - 0.50 for documented revision of goal (if applicable), OR reason why it was not attained.
		Evaluation of STG#2	1		
		Evaluation of LTG	1		
	Nrsg Dx #2*	Evaluation of STG#1	1		1.0 point for documented attainment. If not attained: - 0.50 for documented failure of attainment - 0.50 for documented revision of goal (if applicable), OR reason why it was not attained.
		Evaluation of STG#2	1		
		Evaluation of LTG	1		
	Medical record	Nurses notes (every two hours, a minimum of 4 notes)	4		1.0 point for each note. Max = 4 points
	Communication: SBAR	Situation documented	1		
		Background documented	1		
		Assessment documented	1		
		Recommendation/request documented	1		
			100		

*These elements are for the Major Care Plan only, and are not necessary in the routine weekly EHR Tutor documentation.