# Oakland University School of Nursing

# Comprehensive Adult Nursing II – Clinical

## NRS 3315 (481)
## CRN #11285

**Faculty:**

**Margaret M. Glembocki, DNP, RN, ACNP-BC, CSC, SANE-A, FAANP**

**Assistant Professor**

**Winter 2018**

**COURSE NUMBER** **NRS 3315 (481) – CRN #11285**

| **CREDITS & HOUR ALLOCATION:** | **Credits** | **Hrs/Wks** | **Total Hours Semester** |
|---|---|---|---|
| **Clinical** | **2** | | **84** |

**COURSE TITLE:** **Comprehensive Adult Nursing II Clinical**

**CLASS TIME & LOCATION:** **January 3, 2018 – February 17, 2018**
**TBA**

**FACULTY OF RECORD:** **Margaret Glembocki, DNP, RN, ACNP-BC, CSC, FAANP, SANE-A**
**Assistant Professor**
**Office: 3052 Human Health Building, (HHB)**
**Office Telephone: (248) 364-8759**
**Office Hours: By appointment only**
**E-mail:** mmglembo@oakland.edu

## PREREQUISITES and/or COREQUISISTES

Prerequisites: NRS 280, NRS 380, NRS 381
Co-requisites: NRS 480

## COURSE OVERVIEW

This course focuses on competencies necessary for nursing care assessment and management of adults and older adults through integration of theory, rational, and specific nursing interventions in the clinical setting.

## COURSE OBJECTIVES

1. Utilize the nursing process to assess; diagnose; plan; implement, and evaluate care given to adults and older adults in the acute care setting that is culturally appropriate.

2. Integrate relevant information related to pharmacological agents, diagnostics, and procedures to plan and implement nursing care for adults and older adults in the acute care setting.

3. Integrate relevant research finds into clinical practice.

4. Collaborate with patients and their families, the inter and intra- disciplinary health care teams, and appropriate community agencies, as needed, to plan and implement nursing care for adults and older adults in the acute care setting.

5. Demonstrate and model personal and professional accountability in all health care settings.

## TECHNICAL REQUIREMENTS

All e-Learning courses at Oakland University are delivered using a learning management system called Moodle that allows instructors to design entire courses online or to enhance a classroom-based course. The Moodle software resides on a server allowing students to access it via a web browser, e.g. Mozilla, Firefox. Each course is uniquely designed by the instructor who may include some of the following components in his/her web-based or web enhanced course: course syllabus, course material/content, course assignments, quizzes/tests, hyperlinks to other websites on the Internet and/or other OU web pages, discussion boards, Internal email, and the course grade book.

**Logging into Moodle**
Students login to Moodle with their NetID (oakland.edu email) account password. Please remember that anytime you change your NetID password, it will be reflected in your Moodle login.

- Open the Moodle Login page: https://moodle.oakland.edu
- Log-in using the first part of your NetID username and password, e.g. if your email is jwilson3@oakland.edu then:
    - Username: jwilson3
    - Password: whatever your Oakland University email password is

If you have any problems/issues with Moodle, you need to contact or fill out a help desk request form for e-Learning and Instructional Support.

To view course materials in MOODLE you will need the latest version of Adobe Reader that can be downloaded free of charge at www.adobe.com

## REQUIRED TEXTBOOKS

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.

Carpenito, L. J. (2012). *Nursing diagnosis: Application to clinical practice* (14th ed.). Philadelphia: J. B. Lippincott.

Chernecky, C.C., & Berger, B.J. (Eds.). (2013). *Laboratory tests and diagnostic procedures* (6th ed.). Philadelphia, PA: Elsevier Saunders. Or any laboratory and diagnostic text book already purchased.

Hodgson, B., & Kizior, R. (2016). Saunders nursing drug handbook 2015. Philadelphia, PA: W. B. Saunders. Or any current drug book already purchased.

Ignatavicius, D. I., Workman, N. L., & Misler, M. A. (2015). *Medical surgical nursing: Patient-centered collaborative care* (8th ed.). Philadelphia: Saunders/ Elsevier. (ISBN-10: 1455772550).

Vallerand, A. H., & Sanoski, C. A. (2015). *Davis's drug guide for nurses*. (14th ed.). Philadelphia, PA: FA Davis.

## REQUIRED MATERIALS

Clinical syllabus

Stethoscope

Penlight

Bandage scissors

Watch with 2nd hand

Pocket calculator

## CLINICAL REQUIREMENTS

1. In an effort to best assist each student in his or her clinical experiences, all students must complete the Learning Needs Assessment Tool by the first clinical day

2. Attendance at all clinical experiences is mandatory in order to successfully complete the objectives of this course. Tardy and absence from clinical experiences are recorded. A student is considered "tardy" when he or she is not in the clinical setting ready to begin at 07:00 A.M or the clinical time stated by their clinical instructor. For each 1- 15 minutes a student is tardy, 1 (one) point will be deducted from the clinical evaluation tool score. Every day a new clock starts. Clinical faculty must be notified in the case of tardiness.

3. Clinical absenteeism will be weighted as a percentage of the total hours of the clinical rotation and those points will be deducted from the clinical evaluation tool score. A student missing over 20% of any clinical rotation will fail the clinical rotation except in the case of extenuating circumstances as determined by both the clinical faculty and the faculty of record for the clinical course. Clinical days missed cannot be made up. **Two (2) missed clinical days constitutes an automatic failure.** Please note that if the university is closed, clinical will be cancelled for the day with no student penalty. Clinical faculty must be notified in the case of absenteeism as soon as possible.

   As a dedicated college student, regular punctual attendance in classes and clinical practice is expected and is a component of experiential learning. Students should notify the instructor and the faculty of record if they are unable to attend clinical day. Attendance at all clinical days is mandatory.

   Special Circumstances: The following are examples of events that qualify as a Special Circumstance for the purposes of missing any clinical days:
   - You are ill on the day of the examination or receiving health treatment
   - Death in your immediate family
   - Jury Duty or Court Summons
   - Incarceration
   - Military Service

- Natural Disasters

In the event that you find yourself in any of these circumstances you must e-mail Professor Glembocki (through course moodle email) **and** your clinical instructor. Final determination of whether an absence is excused is made by the faculty of record.

Documentation of Special Circumstances: Students must supply appropriate original documentation to support their request for their clinical day to be excused. Documents can include:

- Health Care Provider note
- Court notice of summons
- Jury duty notification
- Death Certificates

It is the student's responsibility to provide faculty with written proof of any emergencies that required the student to miss a laboratory session or examinations. Students are expected to maintain honesty in their studies. Documents must be presented to faculty within 48 hours of missing the examination.

4. Any clinical assignment(s) that is turned in more than 12 hours late, for any reason, will **receive a 10% deduction on their final score. After 12 hours, a score of (0) will be given with no possibility of make-up.** The clinical faculty may consult with the Faculty of Record regarding special circumstances.

5. Students are expected to be consistently and thoroughly prepared for safe clinical practice. This includes having all required materials and understanding the skills which may be deemed necessary to take care of patients successfully. The student may be sent for remediation in the case the clinical instructor feels the student was not adequately prepared.

6. **Neither clinical faculty nor nursing students may leave the clinical site early (for any reason.) Disciplinary measures will be taken for any such occurrence.**

7. Dress and attire for ALL clinical experiences must adhere to the SON Undergraduate Student Handbook. Additionally, SON students must adhere to dress and attire standards identified at the clinical site. If a student arrives at the clinical site dressed inappropriately/unprofessionally, the student will be sent home and will be marked **ABSENT** for that clinical day. Hair must be kept off the shoulders at all times and tattoos must be covered at all times. Sweatshirts/hoodies are NOT appropriate attire. **GUM CHEWING IS NOT ALLOWED WHILE CARING FOR PATIENTS.**

8. A formative mid-term evaluation will be conducted at the clinical site. The evaluation tool is included in the syllabus. Any student who is failing at mid-term will meet with their clinical instructor to develop a work plan in order to identify specific ways to achieve clinical goals.

9. Final evaluations will be administered by the clinical faculty at OU and/or an OU satellite office with approval from the FOR and Program Director.

10. For student safety: **No Off Site Lunches/Dinners are allowed.**

11. **Absolutely no cell phone use** during the clinical experience for any reason regardless of institution policy. The clinical faculty may send the student home and the student will be marked **ABSENT** for that clinical day.

12. Moodle will be used to communicate course activities and changes. Students are expected to check Moodle ***minimally every 48 hours***.

**Student Nurse Code of Academic and Clinical Conduct**

The Code of Academic and Clinical Conduct developed by the National Student Nurses' Association provides guidance for nursing students in the personal development of an ethical foundation in caring for human beings in a variety of health care environments. This includes the clinical and academic setting. Students are expected to read and follow the principles set forth in this document during any course activities.

**National Student Nurses' Association, Inc. Code of Academic and Clinical Conduct**

As students are involved in the clinical and academic environments, we believe that ethical principles are a necessary guide to professional development. Therefore, within these environments we:

1. Advocate for the rights of all clients.
2. Maintain client confidentiality.
3. Take appropriate action to ensure the safety of clients, self, and others.
4. Provide care for the client in a timely, compassionate and professional manner.
5. Communicate client care in a truthful, timely and accurate manner.
6. Actively promote the highest level of moral and ethical principles and accept responsibility for our actions.
7. Promote excellence in nursing by encouraging lifelong learning and professional development.
8. Treat others with respect and promote an environment that respects human rights, values and choice of cultural and spiritual beliefs.
9. Collaborate in every reasonable manner with the academic faculty and clinical staff to ensure the highest quality of client care.
10. Use every opportunity to improve faculty and clinical staff understanding of the learning needs of nursing students.
11. Encourage faculty, clinical staff, and peers to mentor nursing students.
12. Refrain from performing any technique or procedure for which the student has not been adequately trained.
13. Refrain from any deliberate action or omission of care in the academic or clinical setting that creates unnecessary risk of injury to the client, self, or others.
14. Assist the staff nurse or preceptor in ensuring that there is full disclosure and that proper authorization are obtained from clients regarding any form of treatment or research.
15. Abstain from the use of alcoholic beverages or any substances in the academic and clinical setting that impair judgment.
16. Strive to achieve and maintain an optimal level of personal health.
17. Support access to treatment and rehabilitation for students who are experiencing impairments related to substance abuse and mental or physical health issues.
18. Uphold college policies and regulations related to academic and clinical performance, reserving the right to challenge and critique rules and regulations as per college grievance policy.

NSNA. (2001). Retrieved from: http://www.nsna.org/Portals/0/Skins/NSNA/pdf/pubs_ cod e_of_ac.pdf

## COURSE ASSIGNMENTS & EVALUATION TECHNIQUES

**Students should familiarize themselves with university expectations regarding academic integrity by reviewing the Academic Code of Conduct, http://www.oakland.edu/?id=24228&sid=482. Student acts that are in violation of the Academic Student Code of Conduct will be referred to the Dean of Students' Office.**

1. **Clinical Score**
    a. ***Students must achieve a minimum grade of 2.5 on the Undergraduate Clinical Evaluation Tool in order to pass this course.***

    b. The score on the clinical evaluation tool is derived from an evaluation of the student's cognitive and psychomotor skills. Both are essential in demonstrating competency in the clinical experience; thus, both components are weighted and recorded on the Undergraduate Clinical Evaluation Tool.

    c. Faculty will provide students with a midterm evaluation using the Undergraduate Clinical Evaluation Tool at the halfway point of the clinical experience. If the student successfully passes the midterm evaluation, the student will receive a final clinical evaluation using the Undergraduate Clinical Evaluation Tool after the final clinical day has been completed (*date to be determined by university*).

2. **Completion of the Learning Needs Assessment Tool (Appendix A)**

3. **Care Plan #1 (Appendix B)**

4. **Care Plan #2 (Appendix B)**

5. **One Presentation (Appendix C)**

**CLINICAL GRADE**

| | |
|---|---|
| Undergraduate Clinical Evaluation Tool | 60% |
| Care Plan #1 | 15% |
| Care Plan #2 | 15% |
| Discovering Nursing Presentation | 10% |
| Total: | 100% |

Mid-term evaluation: MUST BE COMPLETED **AFTER 42 HOURS** OF CLINICAL

- Final evaluation: MUST BE COMPLETED AT OAKLAND UNIVERSITY'S MAIN CAMPUS AS SCHEDULED AT THE END OF NRS 3315 **(84 HOURS)**

- Students MUST PROVIDE NURSING CARE TO 3 PATIENTS to successfully complete NRS 3315. If a student is unable to successfully care for 3 patients by the end of NRS 3315, the student will fail the course.

If students want a copy of their final clinical evaluation for NRS 3315, they MUST request a copy via email to donnelly@oakland.edu NO LATER THAN ONE WEEK after the **end date** of the semester attended. Please provide the following information when making your email request: Student's name, Grizzly ID number, Course name/number and semester attended. Please identify the correct spelling of your name as it appears on your clinical evaluation tool for faster processing.

**CLINICAL FACULTY <u>CAN NOT</u> MAKE ANY CHANGES TO THE GRADING SCALE OR COURSE ASSIGNMENTS FOR ANY REASON, AND EXTRA CREDIT (OF ANY KIND) IS NOT ALLOWED.**

Planned Clinical Hours: THIS FOLLOWING IS AN **<u>EXAMPLE</u>** OF A CLINICAL SCHEDULE. Clinical hours & days may change depending on the clinical site. Any changes will be posted in Moodle.

**8 hour schedule**

| **CLINICAL PREPARATION**<br>**ACE requirements**<br>**Site-specific requirements** | | **Complete on your own time, MUST BE COMPLETED ACCORDING TO TIME GUIDELINES OF SON OR AGENCY REQUIREMENTS!** | | |
|---|---|---|---|---|
| **Day 1** | **Orientation to Facility**<br>**Syllabus Review** | **7:00am – 11:00 am** | **4 hour orientation** | **4** |
| **Day 2** | | **7:00am – 3:30pm** | | **8** |
| **Day 3** | | **7:00am – 3:30pm** | | **8** |
| **Day 4** | | **7:00am – 3:30pm** | | **8** |
| **Day 5** | **Care Plan #1 Due** | **7:00am – 3:30pm** | | **8** |
| **Day 6** | | **7:00am – 3:30pm** | | **8** |
| **Day 7** | ***Midterm Evaluations** | **7:00am – 3:30pm** | | **8** |
| **Day 8** | **Care Plan #2 Due** | **7:00am – 3:30pm** | | **8** |
| **Day 9** | | **7:00am – 3:30pm** | | **8** |
| **Day 10** | **Student Presentations** | **7:00am – 3:30pm** | | **8** |
| **Day 11** | **Student Presentations** | **7:00am – 3:00pm** | | **8**<br>**84 Total Hrs** |
| | | | **Evaluations MUST be held at OU main campus and/or OU Anton/Frankel Center with approval from FOR.** | |

****All final evaluations are to be turned into the FOR.**
**DUE DATES ARE FINAL AND ARE NOT TO BE CHANGED BY THE CLINICAL INSTRUCTOR.**

# Appendix A

**Learning Needs Assessment Tool – Due the 1st Clinical Day**

**Student Name:**

1. I expect to learn the following about critical thinking in my clinical experience:

2. I am interested in learning more about:

3. To me, critical thinking means:

   And I believe that I know _____ a little about critical thinking.
   _____ a moderate amount.
   _____ a lot.

4. I have had a course in:
   Logic _____ Philosophy _____
   Statistics _____ Drama _____
   Speech _____ Debate _____

5. I am taking _____ semester hours this semester. I will be able to spend _____ hours per week preparing for this clinical experience.

6. I am employed _____ hours per week this semester.

7. I have other responsibilities in my life, for instance:
   a. Others for whom I have or share responsibility are:

   b. The age(s) of others I have or share responsibility are:

   c. Community responsibilities that I have include:

## Appendix A (con't)

8. I learn best in the following way:

9. Instructor behaviors which assist me in learning include:

10. Instructor behaviors that inhibit my learning include:

11. To help me participate to my fullest and to be successful in this course, the instructor should know:

12. My 3 goals for the semester include:

    1.

    2.

    3.

# Appendix B

## Care Plan Assignment

While nurses no longer have to fill out lengthy care plans anymore on their patients, you still need to know how to prioritize your patient's care for the day. Each patient is different, even if they have the same reason for admission.

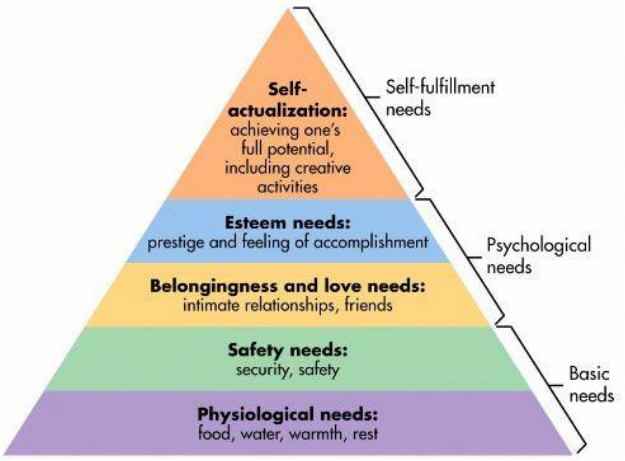
Your assignment is to complete a care plan based on one of your patients. I suggest you choose one of the more complex patients as you will need to come up with several problems. Use the provided tables found within the Word Document. You can work directly on the template. This assignment does need to be typed and written in APA with references. The directions for this assignment is as follows:

1. Fill out the basic information for your patient including initials, age, gender, and any allergies. Be sure to include any reaction your patient may have to an allergy as they may have a sensitivity instead of an allergy.

2. Identify the reason your patient was originally admitted. There may be more than one reason for admission. If the reason your patient is still hospitalized is different than the reason for admission, include this as well. For example, you may have a patient who was admitted for left toe gangrene secondary to diabetes who underwent toe amputation and now has pneumonia. Include all of this as it is pertinent to what is going on with your patient.

3. List all of your patient's family history (with ages if applicable), past medical and surgical history including dates.

4. Rank in order of priority (#1 being the highest) a minimum of four patient problems. This may include potential or "at risk of" problems. Remember that as a nurse, you need to be able to prevent potential problems (i.e. aspiration, falls) and these are just as important as actual problems. I suggest you use the following pneumonic: A (Airway), B (Breathing), C (Circulation), S (Sepsis), S (Safety). If you have addressed all of these, or they are not applicable, you may use Maslow's Hierarchy of Needs (below). Make sure you include rationale for each problem in <u>your own words</u>.




http://www.simplypsychology.org/maslow.html

You need to include both subjective and objective data for each problem. You will have overlapping data for multiple problems. You need to be thorough and include everything that is pertinent to the problem you are describing.

5. List each medication your patient is taking. You must include both the brand and the generic name. The reason for this as that on your NCLEX you may be asked either name when having to identify treatment options. You should get used to this now. You also need to identify the dose, route, and frequency. Explain why your patient is taking this medication. Be specific. For example, they may be taking Motrin as an anti-inflammatory for leg swelling and Norco for breakthrough pain. Finally, list the potential side effects that are specific to the patient you are caring for. If your patient isn't geriatric, then the geriatric side effects don't apply. Think of what you need to be aware of when taking care of this specific patient.

6. Identify any applicable laboratory and radiology testing your patient may have undergone. Make sure you include microbiology or any cultures obtained. Make sure you include the normal values for the labs and think about what each test result means for your patient.

7. Choose two nursing diagnoses based on your one or two top problems and rank them in order of priority. If you can create two nursing diagnoses off of your top problem that is ideal as it is most likely the reason your patient is receiving care. If not, then use your first two problems. Fill out each table completely. When you are thinking of nursing interventions, make sure that you include interventions that are applicable to your patient. Each diagnosis includes many different interventions and many of them may not relate to your patient. Each intervention needs to be ranked in order of priority and include supporting rationale. The intervention and rationale may be from Carpenito, but must be written in your own words. You only need to cite once at the end of each table if your interventions and rationale is from the same source. Make sure when you discuss your evaluation, you are evaluating your outcomes, not your interventions. Your evaluation needs to be written in SOAP (subjective, objective, assessment, plan) format.

8. Write a 1-2 page paper on the pathophysiology on why the patient is receiving care. This is going to be your number one problem. Make sure you include an analysis of the problem and a conclusion.

9. Use APA throughout your care plan and paper. You only have to cite your drug and lab book once. You need to reference at least one scholarly nursing journal with at least three references in total, counting textbooks. You can put your citation underneath each table. Do not use quotations! Everything should be in your own words. Make sure you have the rubric next to you while you work on this assignment so you don't lose unnecessary points. Be thorough!

## Criteria for Care Plan Assignment: Part 1 – 70 points available

| | Criteria Fully Met | Good Attempt | Fair Attempt | Poor Attempt |
|---|---|---|---|---|
| **Basic Patient Information** | (4)<br>All patient data is included including reaction to allergies. | (3)<br>The majority of the patient data is included but one piece may be missing. | (2)<br>Some of the patient data is included but at least two pieces may be missing. | (0-1)<br>The patient data included is lacking detail or is entirely missing. |
| **Reason for Admission/Past Medical & Surgical History** | (4)<br>Extremely thorough; All information is included. | (3)<br>Somewhat thorough; At least one piece of information is missing. | (2)<br>Somewhat lacking; At least two pieces of information is missing. | (0-1)<br>Severely lacking; the majority of information is missing. |
| **Patient Problems with Rationale** | (7-8)<br>Problems are relevant and ranked correctly; Rationale is thorough, concise, and relevant for each problem | (5-6)<br>Problems are relevant but ranked incorrectly; Rationale is thorough, concise, and relevant for each problem | (3-4)<br>Problems are irrelevant and/or ranked incorrectly; Rationale is somewhat thorough, concise, and relevant for each problem | (0-2)<br>Problems are irrelevant and ranked incorrectly; Rationale is severely lacking and/or missing |
| **Assessment Data** | (7-8)<br>Subjective and objective assessment data is included, is extremely thorough and relevant to its identified problem | (5-6)<br>Subjective and objective assessment data is included, is somewhat thorough but missing 1-2 pieces of information and relevant to its identified problem | (3-4)<br>Subjective and objective assessment data is included, is somewhat thorough but missing at least 2 pieces of information and is somewhat relevant to its identified problem | (0-2)<br>Subjective and objective assessment data is severely lacking and/or missing and/or not relevant to its identified problem |
| **Medications with Patient Implications** | (4)<br>Extremely thorough; All medications are included with no missing data, reasons for medications and nursing considerations are thorough and relevant | (3)<br>Somewhat thorough; All medications are included with no missing data, reasons for medications and nursing considerations are somewhat thorough and relevant | (2)<br>Somewhat lacking; The majority of medications are included with some missing data, reasons for medications and nursing considerations are not very thorough and/or relevant | (0-1)<br>Severely lacking; More than 2-3 medications and/or pieces of data are missing, considerations are not thorough and/or relevant |
| **Laboratory/radiology findings with rationale** | (4)<br>Extremely thorough; All patient laboratory/radiology findings are included and nursing considerations are pertinent | (3)<br>Somewhat thorough; May be missing 1 patient laboratory/radiology findings and nursing considerations are somewhat pertinent | (2)<br>Somewhat lacking; The majority of patient laboratory/radiology findings are included and nursing considerations are somewhat pertinent | (0-1)<br>Extremely lacking; The majority of patient laboratory/radiology findings are missing and nursing considerations are not pertinent |
| **Two complete nursing diagnoses with rationale** | (4)<br>Nursing diagnoses are both written correctly, contain all relevant parts. | (3)<br>One nursing diagnosis is written incorrectly and/or does not contain all relevant parts. | (2)<br>One nursing diagnosis is written incorrectly and/or does not contain all relevant parts. | (0-1)<br>Both nursing diagnoses are written incorrectly and/or does not contain all relevant parts. |
| **Goals/Outcomes** | (4)<br>The goals/outcomes are well written, correlates with each nursing diagnosis, is measurable and attainable | (3)<br>The goals/outcomes are well written, correlates with only one nursing diagnosis, and/or is not measurable or attainable | (2)<br>The goals/outcomes could have been better written, lacks correlation with one or both nursing diagnoses; is not measurable or attainable | (0-1)<br>The goals/outcomes was poorly written, does not correlate with either nursing diagnosis; is not measurable or attainable |

**Continued on next page*

## Criteria for Care Plan Assignment: Part 2 – 70 points available

| | | | | |
|---|---|---|---|---|
| **Priority nursing interventions with rationale** | (7-8)<br>At least 6 detailed nursing interventions, in correct priority are given; rationale is thorough, concise, and relevant for each intervention | (5-6)<br>Nursing interventions are either not detailed or are incorrect priority in 1-2 instances or rationale is not very thorough, concise, and/or relevant for each intervention | (3-4)<br>Nursing interventions are either not detailed or are incorrect priority in 3 instances; Rationale is somewhat lacking | (0-2)<br>Nursing interventions are not detailed in more than 4 instances and/or in incorrect priority in more than 4 instances; Lacks rationale |
| **Patient Responses/Evaluation** | (4)<br>Extremely thorough; Patient responses are well written, detailed, and address each outcome, SOAP format is included and correctly written | (3)<br>Somewhat thorough; Patient responses are somewhat well written and/or detailed and address each outcome, SOAP format is included but missing 1-2 elements | (2)<br>Somewhat lacking; Patient responses are not well written and/or do not address each outcome, SOAP format is included but missing 3 elements | (0-1)<br>Extremely lacking; Patient responses are not well written or detailed and do not address each outcome, SOAP format is included but missing more than 4 elements |
| **Pathophysiology Paper** | (12-14)<br>Extremely thorough; The paper demonstrates that the patient's diagnosis is well understood and is well written; 1-2 pages. Concluding remarks are included and show analysis and synthesis of ideas. | (9-11)<br>Somewhat thorough; The paper demonstrates that the patient's diagnosis is somewhat well understood and and/or is somewhat well written; 1-2 pages. Concluding remarks are included and show analysis and synthesis of ideas. | (4-8)<br>Somewhat lacking; The paper demonstrates that the patient's diagnosis is not well understood and and/or is not well written; less than 1 page. Concluding remarks are included but do not show analysis and synthesis of ideas. | (0-3)<br>Extremely lacking; The paper demonstrates that the patient's diagnosis is not well understood and is not well written; less than 1 page. Concluding remarks are not included and do not show analysis and synthesis of ideas. |
| **APA Format** | (4)<br>Minimum of 3 scholarly references used (1 of which is a nursing journal); 0-1 errors in APA format | (3)<br>Minimum of 3 scholarly references used, no nursing journals used; 2-3 errors in APA format | (2)<br>May be lacking 1 scholarly article; 4 errors in APA format | (0-1)<br>Lacking multiple components - missing articles; 5 or more errors in APA format |

# Appendix C

## Discover Nursing Presentation

Upon graduation, you will have the opportunities to take one of the many paths nursing has to offer. While you hear med-surg repeatedly in nursing school, you should be aware that there are dozens of different avenues you can pursue. You will find that having your bachelor's degree will offer you many different nursing careers that you may choose from. This is a time to explore a different area of nursing that you may have some interest in, but you didn't know existed. Some examples include:

1. Case management
2. School-based health nursing
3. Psychiatric nursing
4. Nursing administration
5. Diabetes nurse educator
6. Trauma nursing coordinator
7. Travel nursing
8. Home care nurse
9. Health policy nurse
10. Perioperative nurse
11. Nursing education
12. Forensic Nursing
13. Nurse Researcher
14. Furthering your education as a nurse practitioner, clinical nurse specialist, PhD, DNP

**Guidelines:**

- Students are expected to disseminate information on their designated topic to their clinical group in the form of an oral presentation during post-conference. Each presentation should last no more than 10 minutes. A few minutes after the presentation should be allowed for questions and/or comments.
- A visual aid is required during the presentation to assist fellow students in following the presentation (tri-fold handout, power point slides, topical outline, etc.). If you have handouts, make sure there are enough for your entire clinical group.
- Each student must choose a different topic. Topics should be chosen towards the beginning of the clinical rotation. The due date is specified on the course schedule.
- A separate handout with references in APA format needs to be turned into your clinical instructor.
- You must use **at least 2 scholarly** nursing articles, no more than seven years old as a reference within the presentation in addition to any text books utilized. These articles should be pulled from a nursing database such as CINAHL or PubMed (WebMD does not count).
- Content should include the following:
    - A brief overview of your topic of interest. Why did you choose this topic?
    - What is nursing's role or nursing considerations related to your topic of interest?
    - How are patients impacted? How is nursing impacted? How is healthcare impacted?
    - Are there any organizations that support your topic? If so, what are they and what benefits do they offer?
    - Can nursing change or improve practice in this area? Give suggestions and examples as discussed in the literature.
    - Based on your findings, would you consider choosing this career route upon graduation? Why or why not?

## Criteria for Presentation – 40 points available

| | Criteria Fully Met | Good Attempt | Fair Attempt | Poor Attempt |
|---|---|---|---|---|
| **Clarity, focus, organization** | (4) Purpose of presentation and intent clear throughout, transition to different sections in a logical and orderly fashion, well prepared to discuss/address content | (3) Purpose of presentation and intent clear throughout most of presentation, transition to different sections in a logical and orderly fashion majority of time, well prepared to discuss/address content | (2) Purpose of presentation and intent not clear at times, transition to different sections are not logical or orderly, switches back and forth between data, could have been better prepared to discuss/address content | (1) Purpose of presentation and intent unclear, lacks transition between different sections, presentation disorderly, poorly prepared |
| **Overview of topic** | (4) Detailed discussion of topic, evident why topic is important; scholarly support from articles | (3) Good discussion of topic, may lack scholarly support from articles | (2) Fair discussion of topic, may lack minor evidence and/or scholarly support from articles | (1) Poor discussion of topic, lack major evidence and./or scholarly support from articles |
| **Nursing's Role/ Nursing Considerations** | (10-12) Detailed discussion of nursing consideration and/or nursing's role; scholarly support from articles, policies | (7-9) Good discussion of nursing considerations and/or nursing's role; may lack scholarly support form articles, policies | (4-6) Fair discussion of nursing considerations and/or nursing's role; may lack minor evidence and/or scholarly support from articles, policies | (1-3) Poor discussion of nursing considerations and/or nursing's role; lacks major evidence and/or scholarly support from articles, policies |
| **Impact** | (7-8) Detailed discussion of impact on patient, nursing, and healthcare, scholarly support from articles, policies | (5-6) Good discussion of impact on patient, nursing, and healthcare, may lack scholarly support from articles, policies | (3-4) Fair discussion of impact on patient, nursing, and healthcare; may lack minor evidence and/or scholarly support from articles, policies, in 1-2 instances | (1-2) Poor discussion of impact on patient, nursing, and healthcare; lacks major evidence and/or scholarly support from articles, policies in multiple instances |
| **Changes/Practice Improvement** | (4) Detailed discussion of changes and/or ways to improve practice, scholarly support form articles, policies | (3) Good discussion of changes and/or ways to improve practice; may lack scholarly support form articles, policies | (2) Fair discussion of changes and/or ways to improve practice; may lack minor evidence and/or scholarly support from articles, policies | (1) Poor discussion of changes and/or ways to improve practice; lacks major evidence and/or scholarly support from articles, policies |
| **Visual Aid** | (4) 2 scholarly articles used; visual aid provided, well done and relevant to presentation | (3) 2 scholarly articles used; visual aid provided, good but could have been a little more thorough or relevant to presentation | (2) May be lacking 1 scholarly article or visual aid provided but could have been more thorough or appropriate for presentation | (1) Lacking multiple components- missing articles and/or poor attempt on visual aid |
| **APA Format** | (4) A separate reference page is handed in to clinical instructor; zero errors in APA format | (3) A separate reference page is handed in to clinical instructor; 1-2 errors in APA format | (2) A separate reference page is handed in to clinical instructor; 3-4 errors in APA format | (0-1) A separate reference page is handed in to clinical instructor; more than 4 errors in APA format. A reference page is not handed in to clinical instructor (0 points) |

# Appendix D

## Medication Errors

While medication errors occur in practice, it is essential to understand these errors can potentially lead to disastrous consequences. Unfortunately, they are all too easy to make. They can include giving an medication intravenously instead of orally, forgetting to cut the pill in half, not checking patient allergies, giving the medication to the wrong patient, etc. Many nurses have made some type of medication error in practice, even it did not lead to harmful consequences to the patient.

Medication errors can lead to:

- More than 7,000 deaths every year in the United States.
- Additional patient costs between $2,000 and $8,750.
- Persistent, serious, permanent disability to patients that may lead to death.

Some steps to take after a medication error is made include:

1. Check your patient! This is the most important step. Are they having dyspnea? Hives? Check their vital signs. Monitor them closely. If you gave something intravenously, it may be worth having a bag of normal saline hanging so you can help flush it out of their system if necessary.
2. Admit your mistake. You need to tell someone what occurred. If you don't and something happens after you leave, the patient may face dire consequences as the medical team will not be able to figure out the cause. You will be in more trouble if you don't tell someone. You won't be the first to make an error, and you certainly won't be the last person.
3. Document the medication you gave in the chart. You will need to ask another nurse exactly how to document, as each institution has a different protocol.
4. Document what happened in the institution's tracking system. Each hospital has a different way of tracking errors so they can learn from them and try to prevent further mistakes. This isn't punitive, but it is extremely important. Find out where and how you should document by your educator.

Ways to reduce potential medication errors:

- Limit distractions.
- Perform independent double-checks.
- Double check drug names that sound alike.
- Consistently do medication reconciliations.

If you make a medication error during your clinical rotation, you will be expected to fill out a medication error form and give it your clinical instructor. This is not meant to be punitive. Many students who have done this in the past have found that these forms help them learn their medications inside and out. You need to learn how to learn from your mistakes, and this is meant to help you. However, if you make more than 3 medication errors, it is expected that your clinical instructor will direct you to set up a meeting with the faculty of record. They may either be handwritten or typed and are due on the next clinical day.

Reference:

Anderson, P. & Townsend, T. (2015). Preventing high-alert medication errors in hospital patients. *American Nurse Today, (10)*5, 18-23.

# Oakland University School of Nursing
# GRADE CONVERSION

***Note: 70% = 2.5***

| PERCENTAGE | GPA |
|---|---|
| 100.00 | 4.0 |
| 98.00 – 99.99 | 3.9 |
| 96.00 – 97.99 | 3.8 |
| 94.00 – 95.99 | 3.7 |
| 92.00 – 93.99 | 3.6 |
| 90.00 – 91.99 | 3.5 |
| 88.00 – 89.99 | 3.4 |
| 86.00 – 87.99 | 3.3 |
| 84.00 – 85.99 | 3.2 |
| 82.00 – 83.99 | 3.1 |
| 80.00 – 81.99 | 3.0 |
| 78.00 – 79.99 | 2.9 |
| 76.00 – 77.99 | 2.8 |
| 74.00 – 75.99 | 2.7 |
| 72.00 – 73.99 | 2.6 |
| 70.00 – 71.99 | 2.5 |
| 68.00 – 69.99 | 2.4 |
| 66.00 – 67.99 | 2.3 |
| 64.00 – 65.99 | 2.2 |
| 62.00 – 63.99 | 2.1 |
| 60.00 – 61.99 | 2.0 |
| 58.00 – 59.99 | 1.9 |
| 56.00 – 57.99 | 1.8 |
| 54.00 – 55.99 | 1.7 |
| 52.00 – 53.99 | 1.6 |
| 50.00 – 51.99 | 1.5 |
| 48.00 – 49.99 | 1.4 |
| 46.00 – 47.99 | 1.3 |
| 44.00 – 45.99 | 1.2 |
| 42.00 – 43.99 | 1.1 |
| 40.00 – 41.99 | 1.0 |

Approved Faculty Assembly 2/20/03
Updated WI 05