Clinical-Licensed Vocational Nurse (LVN) Training: Intermediate (4-0-16)

I. INTRODUCTION/COURSE DESCRIPTION

VNSG 1461 CLINICAL - LICENSED VOCATIONAL NURSE (LVN) TRAINING: INTERMEDIATE (4-0-16). This course is a health-related work-based learning experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional.

With emphasis on clinical reasoning, nursing process and evidence-based practice, the student develops skills in the role of the vocational nurse as provider of patient-centered care, patient safety advocate, member of the health care team, and member of the profession. Clinical learning experiences provide opportunities for students to apply medical-surgical theory and concepts and advanced nursing skills necessary to practice safe care of the middle aged and elderly client experiencing common healthcare problems. Skills: P

Prerequisites: VNSG 1304, VNSG 1400, VNSG 1115, VNSG 1423, VNSG 1160. Co requisite: VNSG 1509 and VNSG 2331. Course Type: W

II. REQUIRED TEXTBOOKS/ INSTRUCTIONAL MATERIALS


Learning activities are included in the clinical foci.
III. INSTRUCTIONAL METHODOLOGY

Instructional methods for this course have been developed to facilitate the student to meet the course and behavioral objectives as stated in the syllabus, clinical evaluation tool and clinical foci. Learning activities will take place in a variety of settings, including (but not limited to) on-campus skills lab, inpatient and outpatient healthcare facilities, community settings and clinically focused classroom seminars. Under the supervision of faculty, students will have the opportunity to develop the behaviors and skills necessary to assume the roles of the licensed vocational nurse: provider of care, coordination of care and member of a profession.

Students are responsible for being prepared for all of the VNSG 1461 learning activities. Preparation will include the ability to apply relevant content from prerequisite and corequisite courses VNSG 1509 and VNSG 2331 in order to meet all of the course objectives.

Learning activities are listed in the clinical foci and include modeling, discussion, role playing, interviews, written assignments, projects, client teaching, audio-visuals, development of concept maps, simulation, computer assignments, Computer Assisted Instruction, case studies, reading assignments from periodicals and textbooks, and critical thinking exercises. Additional learning activities may be assigned by the course faculty.

Learning activities may include lecture, discussion, role-playing, writing papers, computer-assisted instruction (CAI), demonstrations, research, videos, computer simulations, and critical thinking exercises.

Each week, an attempt will be made by the faculty, to make patient assignments correlate with the didactic topics taught in VNSG 1509.

Students are responsible for reading all assigned materials, participating in all learning activities, and answering all objectives. The instructor may not cover each individual objective in class, but will cover the essence of the material. The student is responsible for all material presented in the class regardless to whether it is in the text or not.

Throughout the syllabus, objectives may be highlighted with a “C” or “S”. “C” denotes objectives that meet Differentiated Essential Competencies. “S” denotes objectives that meet SCANS competencies. A list with definitions of SCANS competencies can be found on the Austin Community College Website at http://www.austincc.edu/mkt/scans.php.

IV. COURSE RATIONALE

The levels of the program have a logical progression in introducing the student to the roles of the Vocational Nurse. VNSG 1461 provides a supervised clinical practicum. Courses in other levels will build upon these clinical learning experiences. VNSG 1461 is a prerequisite to VNSG 1510 and 2462.
The Austin Community College Vocational Nursing Program curriculum is based on a conceptual framework, which is derived from the faculty’s stated philosophy. The faculty believes that humans are a composite of mind, body, and spirit, and that health is a state of internal and external homeostasis existing on a continuum throughout the life span. These beliefs are central to curriculum development and are the core of the conceptual model. The conceptual framework provides the foundation for instruction throughout the program. A conceptual model has been designed to explicate the components of the conceptual framework.

Curriculum threads are specific concepts that are integrated throughout the curriculum to strengthen the students’ development. They reflect areas of increased knowledge, skills, and attitudes of students as they progress in the program. These threads create cohesive learning experiences. The threads integrated in VNSG 1461 include:

1. Critical Thinking and the Nursing Process
2. Caring Behaviors
3. Therapeutic Communication
4. Therapeutic Nursing Interventions
5. Roles of the Vocational Nurse
6. Growth and Development
7. Nutrition
8. Diversity

V. COURSE OBJECTIVES

Underlined phrases indicate the threads present in this course.

A. The student, upon completion of VNSG 1461, will have had the opportunity to apply the theory, concepts, and skills involving specialized materials, tools, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with the occupation and the business/industry and will demonstrate legal and ethical behavior, safety practices, interpersonal and teamwork skills, and appropriate written and verbal communication skills using the terminology of the occupation and the business/industry. The student will develop beginning skills in the roles of a vocational nurse as a provider and coordinator of care and member of a profession by achieving the following objectives: (C)

1. Administer safe, organized nursing care to the middle-aged and elderly client based on critical thinking skills and the nursing process: assessment, nursing diagnosing, planning, intervention and evaluation.

   a. Assessment (C)
   1) Describe the client’s medical diagnoses to include definition, etiology, pathophysiology, signs/symptoms.
   2) List areas of assessment to be assessed when caring for assigned client. (S
3.1)  
3) Demonstrate beginning assessment skills when gathering data about assigned clients.  
4) Demonstrate assessment of client in relation to growth and development and diversity.  
5) Assess nutritional status and needs of the client.  

b. Nursing Diagnosis (C)  
1) Choose basic nursing diagnoses for the middle-aged and elderly client from approved NANDA list.  

c. Planning (C, S 1.1)  
1) Identify basic client outcomes/goals appropriate for nursing diagnoses.  
2) Prioritize client needs. (S)  
3) Plan basic care to assist in meeting client outcomes/goals.  

d. Implementation (C, S 3.2)  
1) Implement a basic plan of care appropriate for middle-aged and elderly clients based on identified nursing diagnoses, outcomes and goals.  
2) Demonstrate competence in performing nursing skills presented in VNSG 1423 and 2331. (S 7.5, 8.1, 8.4)  

e. Evaluation (C,S)  
1) Evaluate the nursing process in terms of its effectiveness in meeting client outcomes/goals.  
2) Collaborating with a Registered Nurse to make necessary adjustments in the nursing process. (S 2.1 )  
3) Document concise, relevant information on the client’s record. (C, S 6.2)  
4) Utilize therapeutic communication skills to facilitate effective interactions with diverse middle-aged and elderly client, peers, faculty, and health team members. (C. S 2.2)  
5) Demonstrate caring behaviors during interactions with clients and their families. (C, S)  
6) Provide culturally sensitive care.  
7) Maintain confidentiality of all client information. (C, S 8.5)  
8) Manage time effectively during the administration of client care. ( C, S 1).  
9) Demonstrate personal development by assuming responsibility for: (C, S 8.1)  
   a. exhibiting professional legal and ethical clinical behaviors (C, S)  
   b. preparing and submitting written assignments by specified date and time (S 6.2, 8.1)  
   c. participating in pre/post conferences by sharing information with the clinical group (S 6.5, 6.6)  
   d. respecting the dignity and worth of humans and their inherent
e. demonstrating acceptance of constructive criticism (C, S)

f. adhering to program and clinical policies according to the VNG Student Handbook

PROGRAM STUDENT LEARNING OUTCOMES: Upon completion of the Certificate in Vocational Nursing program, the student will be able to:

1. Practice within the nurse’s legal scope of practice, in accordance with policies and procedures of the practice setting while demonstrating responsibility for continued competence, reflection, self-analysis and self care.

2. Demonstrate responsibility and accountability for the quality of nursing care provided to patients and their families

3. Contribute to activities that promote the development and practice of vocational nursing

4. Use clinical reasoning in the nursing process, and established evidence-based policies as the basis for decision making in nursing practice

5. Demonstrate ability to determine the physical and mental health status, needs and preferences of culturally, ethnically and socially diverse patients and their families based on interpretation of health related data

6. Report data to assist in the identification of problems and formulations of goals/outcomes and patient centered plans of care in collaboration with patients, their family and the interdisciplinary healthcare team and report alterations in responses to therapeutic interventions in comparison to expected outcomes

7. Provide safe, compassionate, basic nursing care within legal, ethical and regulatory parameters and in consideration of patient factors, to assigned patients with predictable health care needs through a supervised, directed scope of practice

8. Implement teaching plans for patients and their families with common health problems and well defined health learning needs while coordinating human, information and material resources in a cost effective manner

9. Demonstrate knowledge of the Texas Nursing Practice Act and Texas Board of Nursing Rules that emphasize safety, as well as all federal, state and local government and accreditation organization safety requirements and standards and comply with all mandatory reporting requirements

10. Implement measures, goals and outcomes to promote quality and a safe environment that reduces risks for patients, self and others

11. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices

12. Accept and make assignments that take into consideration patient safety and organizational policy

13. Communicate and collaborate with patients, their families and the interdisciplinary health care team in a timely manner to assist in the planning, delivery and coordination of patient centered care to assigned patients in a way that promotes optimal health.
14. Participate as an advocate in activities that focus on improving health care for patient and their families and identify patient needs for referral to resource that facilitate continuity of care and ensure confidentiality.

15. Communicate patient data using technology to support decision making to improve patient care.

16. Assign and supervise nursing care to LVNs or unlicensed personnel for whom the nurse is responsible based on analysis of patient or unit needs.

VI. COURSE EVALUATION: TESTING AND GRADING POLICIES

Satisfactory performance in all clinical experiences is required and is graded by the clinical instructor on a pass/fail basis. The student must:

A. Arrive for all clinical experiences on time, in appropriate uniform and with adequate preparation.

B. Satisfactorily complete all clinical assignments (including, but not limited to, care plans) and submit at specified time.

C. Satisfactorily meet criteria as stated in the VNSG 1461 Clinical Evaluation Tool.

D. Submit ONE (1) nursing care plan that is graded as satisfactory by the clinical instructor according to the Vocational Nursing Care Plan Grading Criteria. A satisfactory or passing care plan is one that receives a score of “42” or greater out of 50.

Students are required to turn in all assigned paperwork on the designated day according to the clinical timeline distributed during course orientation and posted on the Blackboard Course site. The clinical instructor will notify the student when s/he has passed the required care plan and can modify required paperwork. Failure to turn in work and/or unsatisfactory completion of work will be indicated as a “1” (one) on the Clinical Evaluation Tool for that week under the appropriate components of the nursing process.

E. Students are required to bring their “Clinical Nursing Skill Checklist/Experience Log” to clinical/post conference as instructed by their clinical instructor. Failure to do so may be reflected on the clinical evaluation tool under appropriate section. In addition, students are to bring this checklist/log to final clinical evaluation for the semester; failure to do so will result in an “I” until it is updated.

VII. COURSE POLICIES

A. Attendance

Nursing is a practice discipline. Attendance at scheduled classroom, clinical, and laboratory experiences reflects accountability and is required for professional growth. Students must be
present in order to meet the learning objectives of the classroom and/or clinical experience.

Clinical:

1. Clinical attendance is required in order to meet clinical objectives.

2. A maximum of 4 absences per semester are allowed. **Students who exceed the maximum number of allowed clinical absences will be withdrawn from the program. There are NO excused absences.**

3. **There is NO makeup for clinical absences.**

4. The student will receive a verbal warning at 3 absences, a written warning at 4 absences, and will be withdrawn from the program on the 5th absence unless the official date for withdrawal has passed at which time the student will be given an unsatisfactory grade of “U.”

5. Tardy is defined by the VNG Program as “arriving late or leaving early from the assigned clinical experiences.” Students leaving clinical early in excess of 45 minutes of the designated time will be counted absent. Students leaving clinical early, but less than 45 minutes of the designated time, will be counted tardy. **Three tardies count as an absence.**

It is the student’s responsibility to keep track of his/her absences and to follow through with the instructor.

6. Any absence due to illness of three consecutive days or more requires a release signed by the physician stating the student can return to clinical without any restrictions on activities.*

7. Any injury that could jeopardize the safety of the student and/or the client requires a release signed by the physician stating the student may return to clinical without any restrictions on activities.*

*Please refer to the “Non Discrimination” statement in the VNG Student Handbook.

8. If a student is absent on the day assignments are made or absent on a clinical day, the student must contact the instructor for assignments prior to reporting to the clinical setting.

9. Students who have or have been exposed to a contagious illness may not be allowed in certain areas of certain clinical facilities. The student must check with the clinical instructor to determine those requirements in these situations:
   a. diarrhea
   b. fever
   c. respiratory infections
d. open lesions on hands, face

10. If the student will be absent for clinical, s/he must notify the clinical facility first, then the instructor no later than one hour before the designated time to begin clinical activities.

11. Students who plan to attend clinical but cannot arrive at the designated time must call and inform the instructor no later than 15 minutes after the designated time and must be on the unit no later than 45 minutes after the designated time. Failure to follow the outlined procedure will result in the student being directed to leave the unit and will be counted absent for the clinical period.

12. Students who arrive in the clinical area without preparing necessary and requested written work for the clinical assignment will be dismissed from the clinical area and counted absent for the clinical day.

13. Clinical times vary according to the instructor & hospital. These times may vary from the times published in the Course Schedule.

14. Students are encouraged to limit telephone calls and pages to the instructors to matters that cannot be handled during class, clinical, and/or instructors’ office hours.

B. During the course of the clinical experience for VNSG 1461 students are expected to visit the hospital Wednesday afternoons prior to the first day of care and obtain information about the assigned client(s).

Throughout the semester students are expected to maintain the professional standards listed below. Remember, students are a representative of Austin Community College Vocational Nursing program and a guest of the clinical facility. Please review clinical policies in your Student Handbook. Please note *your ACC student photo ID or hospital ID and VNG patch are required on lab coats and uniforms.

1. Students may only go to the floor to gather information about their assigned client(s) at times specified by the clinical instructor.

2. Clinical uniforms OR a buttoned, white lab coat over professional attire should be worn. Shorts, short skirts, tank tops, jeans, and open-toed sandals are NOT considered professional attire.

3. Children are not allowed in the clinical areas at any time.

4. Relinquish the chart immediately if needed by hospital personnel.

5. You are not to remove or photocopy ANY PORTION of the chart from the hospital. Any
printed information must be shredded prior to leaving the floor.

6. Do not write patients’ names or any identifiable information (medical record numbers, age, room numbers, etc.) on ANY of your notes.

7. Your instructor will give you instructions as to whom you should report to upon arrival at the clinical facility.

8. Your instructor is available via pager to answer any questions. Please refrain from asking staff questions about your assignment.

9. **YOU ARE NOT TO PROVIDE ANY TYPE OF PATIENT CARE WITHOUT YOUR INSTRUCTOR PRESENT.** Do not visit with or contact your client at this time. You are at the hospital strictly to gather information from the chart. ACC liability insurance DOES NOT COVER students for any action taken when an instructor is not present in the hospital.

**FAILURE TO ABIDE BY THESE RULES AND/OR CLINICAL POLICIES IN THE VOCATIONAL NURSING STUDENT HANDBOOK MAY RESULT IN IMMEDIATE PROBATION OR ADMINISTRATIVE WITHDRAWAL FROM THE PROGRAM.**

C. Withdrawal, Incompletes, Academic Freedom and Student Discipline

See VNSG Student Handbook.

**Adding, Dropping, or Withdrawing from a Course** Adding, dropping, or withdrawing from a course may affect financial aid, veterans’ benefits, international student status, or academic standing. See an advisor, counselor, or your instructor before making changes.

**Adding or dropping a course (schedule changes):** Students may add or drop a course before open registration ends or during the session’s official schedule change (add/drops) period. See the course schedule for information on add/drops procedures, deadlines, and tuition refunds.

**Withdrawing from a course:** It is the responsibility of each student to ensure that his or her name is removed from the roll should he or she decide to withdraw from the class. The instructor does, however, reserve the right to drop a student should he or she feel it is necessary. If a student decides to withdraw, he or she should also verify that the withdrawal is submitted before the Final Withdrawal Date. The student is also strongly encouraged to retain their copy of the withdrawal form for their records. Students who enroll for the third or subsequent time in a course taken since Fall, 2002, may be charged a higher tuition rate, for that course. Students may withdraw from one or more courses prior to the withdrawal deadline by submitting a request form to Admissions and Records. Withdrawal deadlines are published in the academic calendar. Withdrawal courses appear on the student’s record with a grade of W. Until a student is officially withdrawn, the student remains on the class roll and may receive a grade of F for the course. Students are responsible for understanding the impact withdrawing from a course may have on their financial aid, veterans’ benefits, international student status,
and academic standing. Students are urged to consult with their instructor or an advisor before making schedule changes.

**Per state law,** students enrolling for the first time in fall 2007 or later at any Texas college or university may not withdraw (receive a W) from more than six courses during their undergraduate college career. Some exemptions for good cause could allow a student to withdraw from a course without having it count toward this limit. Students are encouraged to carefully select courses; contact an advisor or counselor for assistance.

**Incompletes:** An instructor may award a grade of “I” (Incomplete) if a student was unable to complete all of the objectives for the passing grade in a course. An incomplete grade cannot be carried beyond the established date in the following semester. The completion date is determined by the instructor but may not be later than the final deadline for withdrawal in the subsequent semester.

**Scholastic Dishonesty:** Acts prohibited by the college for which discipline may be administered include scholastic dishonesty, including but not limited to cheating on an exam or quiz; plagiarizing; and unauthorized collaboration with another in preparing outside work. Academic work submitted by students shall be the result of their thought, research or self-expression. Students engaging in scholastic dishonesty will be withdrawn from the Vocational Nursing Program and not be eligible for readmission to the Vocational Nursing Program. See the Student Standards of Conduct and Disciplinary Process and other policies at [http://www.austincc.edu/current/needtoknow](http://www.austincc.edu/current/needtoknow)

**Academic Freedom:** Each student is strongly encouraged to participate in class. In any classroom situation that includes discussion and critical thinking, there are bound to be differing viewpoints. Students may not only disagree with each other at times, but the students and instructor may also find that they have disparate views on sensitive and volatile topics. It is my hope that these differences will enhance the class and create an atmosphere where students and instructors alike will be encouraged to think and learn. Therefore, be assured that your grade will not be adversely affected by any beliefs or ideas expressed in class or assignments. Rather, we will respect the views of others when expressed in classroom discussions.

**Statement on Students with Disabilities:** Each ACC campus offers support services for students with documented physical or psychological disabilities. Students with disabilities must request reasonable accommodations through the Office for Students with Disabilities on the campus where they expect to take the majority of their classes. Students are encouraged to do this three weeks before the start of each semester. Students who have received approval for accommodations from OSD for this course must provide the instructor with the ‘Notice of Approved Accommodations’ from OSD before accommodations will be provided. Arrangements for academic accommodations can only be made after the instructor receives the ‘Notice of
Approved Accommodations’ from the student. Students with approved accommodations are encouraged to submit the ‘Notice of Approved Accommodations’ to the instructor at the beginning of the semester because a reasonable amount of time may be needed to prepare and arrange for the accommodations. Additional information about the Office for Students with Disabilities is available at http://www.austincc.edu/support/osd/

**Safety Statement:** Austin Community College is committed to providing a safe and healthy environment for study and work. You are expected to learn and comply with ACC environmental, health and safety procedures and agree to follow ACC safety policies. Additional information on these can be found at http://www.austincc.edu/ehs. Because some health and safety circumstances are beyond our control, we ask that you become familiar with the Emergency Procedures poster and Campus Safety Plan map in each classroom. Additional information about emergency procedures and how to sign up for ACC Emergency Alerts to be notified in the event of a serious emergency can be found at http://www.austincc.edu/emergency/. Please note, you are expected to conduct yourself professionally with respect and courtesy to all. Anyone who thoughtlessly or intentionally jeopardizes the health or safety of another individual will be dismissed from the day’s activity, may be withdrawn from the class, and/or barred from attending future activities. You are expected to conduct yourself professionally with respect and courtesy to all. Anyone who thoughtlessly or intentionally jeopardizes the health or safety of another individual will be immediately dismissed from the day’s activity, may be withdrawn from the class, and/or barred from attending future activities.

**Use of ACC email:** All College e-mail communication to students will be sent solely to the student’s ACCmail account, with the expectation that such communications will be read in a timely fashion. ACC will send important information and will notify you of any college related emergencies using this account. Students should only expect to receive email communication from their instructor using this account. Likewise, students should use their ACCmail account when communicating with instructors and staff. Instructions for activating an ACCmail account can be found at http://www.austincc.edu/accmail/index.php.

**Student and Instructional Services:** ACC strives to provide exemplary support to its students and offers a broad variety of opportunities and services. Information on these services and support systems is available at: http://www.austincc.edu/s4/

Links to many student services and other information can be found at: http://www.austincc.edu/current/. ACC Learning Labs provide free tutoring services to all ACC students currently enrolled in the course to be tutored. The tutor schedule for each Learning Lab may be found at: http://www.autincc.edu/tutor/students/tutoring.php.

For help setting up your ACCeID, ACC Gmail, or ACC Blackboard, see a Learning Lab Technician at any ACC Learning Lab.
VIII. ENTRY BEHAVIORS

A. Successful completion of BIO 1714, HPRS 1206, HPRS 2300, and VNSG 1160, 1115, 1304, 1400, 1423.

B. Required Pharmacology Examination
A score of 95% or greater is required to pass the Pharmacology Exam. Students will be provided a calculator and the test may be administered using computerized testing. The student will be given a maximum of three attempts to pass the examination. If the student does not score at least 95% by the third attempt, the student will be withdrawn from this course and all co-requisite courses (VNSG 1509 and VNSG 2331) for failure to progress and complete course requirements. An absence on a scheduled pharmacology examination day will result in a zero, “0,” for that attempt.

IX. ENROUTE BEHAVIORS

Specific behavioral objectives are listed in the clinical evaluation tool.

X. EXIT BEHAVIORS

Student must complete all the behavioral objectives to satisfactorily pass clinical.

XI. HOW TO REACH FACULTY

Faculty Name:
Office:
Phone(s):
Mobile:
Email:

Faculty Name:
Office:
Phone(s):

Email:

Conferences/Appointment can be arranged with your faculty by email or by phone. Any additional faculty to be announced.

XII. CALENDAR

Schedule and location for the course is posted on the VNG website: http://www.austincc.edu/health/vng/resources.php under the Current Students Semester 2 Class Links.
XII. STUDENT AND INSTRUCTIONAL SERVICES

Information related to student and instructional services available at ACC can be found in the VNG Student Handbook and http://www.austincc.edu/s4/. 
Nursing Care Plan Grading Criteria

Satisfactory (S) = The written nursing care plan is satisfactory when:
• It contains complete and appropriate information for the assigned client based on the student’s level in the program.
• It reflects increasing knowledge as the student progresses in the program.
• The overall score is 42 points or more.

Unsatisfactory (U) = The written nursing care plan is unsatisfactory when:
• It contains incomplete and/or inappropriate information for the assigned client based on the student’s level in the program.
• It does not reflect the knowledge expected of a student at this level in the program.
• The overall score is less than 42 points.

Note: Care plans are to be submitted to the clinical instructor each week on the first full class day following the clinical experience.

EXPLANATIONS OF INFORMATION ON NURSING CARE PLAN:

• Vital Signs – Scheduled times for taking and recording client vital signs
• Neuro Vital Signs – Scheduled times for taking and recording client neuro vital signs
• Diet/Special Feedings – Prescribed types of diet and/or type of special feedings
• IV – Type and rate of intravenous solution ordered by physician
• Elimination Considerations – Prescribed types of urinary catheters, need for enemas, bowel and bladder training, etc.
• Respiratory -- Treatments and O₂ therapy
• Activity – Identify activities appropriate for the client
• Precautions – highlight type used for your client.
• Focused Assessment Data – What will be assessed on the client based on the patient situation and textbook research relative to the medical diagnosis
**DEFINITIONS** – of each current medical diagnosis(es)

- **S** = Define(s) and discuss(es) current medical diagnosis(es), including anatomy and pathophysiology.
- **U** = Fails to define and/or discuss current medical diagnosis(es); does not include appropriate anatomy and pathophysiology.

**ETIOLOGY** – of each current medical diagnosis(es)

- **S** = Lists known causes of each medical diagnosis and includes specific cause(s) for the disease developing in the assigned client if known.
- **U** = Fails to list all or most of the known causes of each medical diagnoses and/or fails to list specific cause(s) for the disease process developing in the assigned client.

**SIGNS & SYMPTOMS**

- **S** = Lists signs and symptoms generally related to each medical diagnosis as stated in class and/or texts.
- **U** = Fails to list most of the signs and symptoms generally related to the medical diagnosis(es) as stated in class and/or texts and/or specifically for the client.

**TREATMENT**

- **S** = Discusses treatment medically and surgically
- **U** = Fails to identify treatment modalities and indicate what this client is experiencing.

**ASSESSMENT/DATA COLLECTION**

- **S** = Data is collected in each assessment category of the nursing care plan. Physical and psychosocial assessment data is accurate and complete and reflects students’ progression in the program.
- **U** = Data is incomplete, incorrect, or lacking.

**MEDICATION PROFILE & DIAGNOSTICS**

- **Medications** – List of all prescribed medications written as ordered. The form is completely filled out under the headings of Therapeutic Classification & Action, Rationale for this patient, Nursing Implications inclusive of Assessment, Teaching and Labs, along with Side Effects which are life threatening & most common.

- **Lab Values** – The form provided is completely filled out with appropriate information concerning specified client. Other labs may be important and are expected if significant
to Medical Diagnosis or client’s history.

- **Diagnostic Procedures** – Name of diagnostic procedure, purpose of this test for this client, what education does the client need for the test, are there any special considerations for preparation and post care and what is the client’s diagnostic results.

II. **NURSING DIAGNOSIS**

- **S** = Nursing diagnoses are located from data collection and describes both current client problems/needs as well as those needs/problems the client may have a high risk for developing. The nursing diagnosis is written according to NANDA standards (Problems, Etiology, Signs and Symptoms). The “related to” of the nursing diagnoses will delineate problems to which nursing interventions are effective. Nursing diagnoses identify supportive data and are appropriate for the client.
- **U** = Nursing diagnoses are incomplete; are not in NANDA format or are inappropriate for assigned client.

III. **PLANNING**

A. **Goals** (short-term and long-term)

- **S** = Goals are stated in positive client terms. They are measurable, include deadline for attainment, and are realistic and attainable for the client. There is one long-term goal for each nursing care plan and at least one short-term goal for each nursing diagnosis.
- **U** = Written goals are not written in positive client terms. Goals are unrealistic for the client. Goals are not measurable. The long-term goal(s) and/or short-term goal(s) with outcomes are omitted from the nursing care plan.

B. **Priorities of Nursing Diagnosis**

- **S** = Nursing diagnoses are numerically rated for each day according to ABCs and/or Maslow’s Hierarchy of Needs, the client situation and the degree of nursing intervention required.
- **U** = Nursing diagnoses are not numerically rated for each day. ABCs, Maslow’s Hierarchy of Needs, the client situation and the degree of nursing intervention are not considered while judging priorities of nursing diagnoses.

IV. **IMPLEMENTATION – NURSING INTERVENTION/RATIONALE**

- **S** = Nursing interventions are appropriate, complete (include details of actions), and are directed toward meeting the short-term goal. Rationales for each intervention are scientifically based and reflect information gained from texts and course material presented in pre-requisite and concurrent courses.
• **U** = Interventions are incorrect, inappropriate, lack details and/or omitted. Rationales are inappropriate for selected intervention, not scientifically based, and/or omitted.

V. **EVALUATION** – The short-term goal is the criterion for evaluation. An evaluation statement is written for each diagnosis.

• **S** = The evaluation includes the correct resolution category* and supporting data used to choose the category as well as interventions to be taken to resolve client’s problem.

• **U** = The short-term goal is not used as criterion for evaluation. The evaluation statement does not include a resolution category, incorrectly identifies a category and/or fails to support the category selected with reassessment data.

*RESOLUTION CATEGORIES*
Goal Attained
Goal Partially Attained
Goal Not Attained

**GRADING SCALE**
The care plan grade (S or U) is the sum of the component points.

**S** = 42 points or greater (84%)

**U** = less than 42 points

**COMPONENTS OF THE NURSING CARE PLAN**

I. **ASSESSMENT/DATA COLLECTION**  17 points

II. **NURSING DIAGNOSIS**  8 points

III. **PLANNING:**
A. **SHORT TERM GOAL**  6 points
B. **LONG TERM GOAL**  1 point

IV. **IMPLEMENTATION:**
A. **INTERVENTION**  7 points
B. **RATIONALE**  6 points

V. **EVALUATION**  5 points

**TOTAL**  50 points

Nursing care plans are to be submitted on the day and at the time designated by the clinical instructor. A nursing care plan received after the designated time will not be graded and will be indicated as a “1” on the Clinical Evaluation Tool for Nursing Process.
VNSG 1461 Nursing Care Plan Grading Criteria Sheet

Assessment/Data Collection: (17 points)
Includes assessment data pertinent to diagnosis, complete pathophysiology, labs & diagnostics with explanations of values relevant to disease process, medications included (classifications, rationale, SE’s, nursing implications)

Comments:

Nursing Diagnosis: (8 points)
Top 3 nursing diagnoses stated according to NANDA format, based on patient data collection (appropriate to the assigned patient), appropriate “related to” phrase, demonstrates understanding of the physiology and cause, manifestations, & potentials to be considered; prioritized according to Maslow’s Hierarchy of Needs

Comments:

Planning: (7 points)

a. Short Term Goal (6 points)
Establishes 1 appropriate short term goal for each diagnosis, with at least 3 measurable and/or timed outcome criteria for each short term goal.
Realistic for patient and relevant to the nursing diagnosis/problem

b. Long Term Goal (1 point)
Establishes 1 appropriate and realistic long term goal for the client
including an overview of the total client condition

Comments:

Implementation: (13 points)

a. Interventions (7 points)
Relevant to planning and nursing diagnosis; anticipates potential needs of the patient, coordinates use of ancillary depts.; realistic, practical, specific, individualized; use of meds, teaching, & assessment included

b. Rationale (6 points)
Able to justify the impact of the nursing interventions on the patient’s nursing diagnosis based on scientific principles; appropriate reference is provided/cited for each intervention

Comments:

Evaluation: (5 points)
Determines effectiveness of nursing care provided and if goals/OC were obtained; objective and subjective data provided to support conclusions; decision to continue or discontinue current plan is stated.

Comments:
## Careplan Circumstantial Requirements if Patient/s are Discharged

### 1 patient: Long Careplan version

<table>
<thead>
<tr>
<th>Situation</th>
<th>Paperwork Requirement</th>
</tr>
</thead>
</table>
| 1. Client is discharged Thursday early enough so student has at least one hour to gather data from chart. | **Original Client:** Complete careplan.  
**New Client:** Instructor attempts to assign client with similar diagnosis OR stable client consistent with VNSG 1509 theory.  
- Page 1  
- Pathophysiology page  
- Scheduled medications  
- Abnormal labs/diagnostics |
| 2. Client is discharged at the end of Thursday or is gone before the student arrives Friday morning. | **Original Client:** Complete careplan.  
**New Client:** Instructor attempts to assign client with similar diagnosis OR stable client consistent with VNSG 1509 theory. Student is given preparation time to prep and complete the “Focused Assessment” box on page 1 of the syllabus. **Student must go to instructor to discuss plan of care prior to any client contact.**  
The following items will be due on Tuesday:  
- Page 1  
- Pathophysiology page  
- Scheduled medications  
- Abnormal labs/diagnostics |

### Careplan Circumstantial Requirements

<table>
<thead>
<tr>
<th>Situation</th>
<th>Paperwork Requirement</th>
</tr>
</thead>
</table>
| 1. Pt./s d/c’d Thurs early enough so student has at least 1 hour to gather data from chart | **Original 2 patients:**  
2 completed concept maps  
Long version meds  
Long version labs/diagnostics  
**New patient/s:**  
Concept map page 1 top half (all except nsg dx/plan boxes)  
Page 2- “Assess For”  
Page 2-Med diagnosis |
| 2. Pt. d/c’d at end of Thurs or is gone before student arrives Fri. am | **Original 2 patients:**  
2 completed concept maps  
Long version meds  
Long version labs/diagnostics  
**New patient/s:**  
Page 2- “Assess For” |

**After student passes 1 required careplan, the student will be issued one “Give me a break!” ticket that can be redeemed to allow them NOT to turn in Tuesday paperwork on one occasion. (It will not apply to the Tuesday following summative & the student will still have to present required paperwork on the unit prior to care each day as indicated in clinical timeline).**

***After student successfully passes the 1 required careplan and demonstrates consistency, the instructor may also adjust paperwork requirements.**
Infection Control – Standard Precautions

Students may be exposed to various diseases during class and/or clinical. The following guidelines for student and patient safety have been established in accordance with the Center for Disease Control (CDC) standard precaution guidelines and with all clinical policies.

Any student who is exposed to blood or body fluids in the classroom or laboratory, at a clinical site should inform the Department Head immediately in order to receive appropriate counseling and guidance.

A. Clinical Site Guidelines

1. Body fluids precautions should be used on EVERY patient, not just those known or suspected to be infectious.
2. Examples of types of procedures requiring precautions (not intended to be a complete list):
   - nasogastric tube insertion
   - intubation
   - open wound exposure or care
   - suctioning
   - vaginal deliveries
   - surgery
   - intravenous catheterization
   - intramuscular or subcutaneous injection
   - vital signs
   - changing linens
   - emptying catheter bags
3. Students should keep all open cuts, sores or lesions covered with adhesive bandages while in healing stage.
4. Students should refrain from direct patient contact when the student has exudative lesions or weeping dermatitis.
5. Thorough hand-washing should be accomplished both before and after each patient contact.
6. Gloves should not be considered as a substitute for thorough hand-washing.
7. Gloves should be worn during any exposure to body fluids; during circumstances where the threat of significant exposure exists, goggles, mask, and gown should also be worn.
8. Needles and syringes should not be recapped after use, and should be placed in “sharps” containers immediately after use; remove/holders on “sharps” containers should be used to assist in the removal of needles from vacutainer holders.
9. Students should check with personnel from the clinical site before cleaning or discarding linens, dressings, containers or equipment soiled with body fluids.