

STUDENT HANDBOOK

PART III

CLINICAL FORMS

Nursing Assessment and Documentation Guidelines.....	3
Process Recording.....	5
Teaching Plan.....	9
Data Collection Worksheet.....	10
Lab and Diagnostic Data Collection Worksheet.....	11
Medication Data Collection Worksheet	15
Generic Nursing Care Plan Form.....	17
Evaluation of Faculty, Theory.....	18
Evaluation of Faculty, Clinical.....	19
Hospital Evaluation.....	20
Skills Lab Evaluation.....	21

Nursing Assessment and Documentation Guide

Note: All assessments need to include pertinent current medical diagnosis, history, labs, diagnostic tests, medications, & risk factors that relate to the system being assessed.

Neuro/sensation

- Level of Consciousness
 - Awake, alert, and oriented x 3 (person, place, time), cooperative
 - Lethargic, stuporous, responds to verbal stimuli
 - Semi-comatose, responds only to painful stimuli
 - Comatose, does not respond
- Mood; Barriers to Orientation
- Glasgow Coma Scale: 15
 - Eye Opening Response: spontaneous, to voice, to pain, none
 - Verbal response: oriented, confused, inappropriate words, incomprehensible words, none (give examples)
 - Motor Response: obeys commands, localizes pain, withdraws to pain, flexion to pain, extension to pain, none
- Pupils: equality, size (pinpoint, dilated), reaction to light (brisk, sluggish, fixed)
PERRLA: Pupils equally round & react to light and accommodation
- Motor: grips, gait, movement: voluntary/involuntary (twitching, spasticity, flaccid)
- Sensation: pain (type, location, scale 1 to 10), touch, temperature (numbness, tingling)
- Eyes: vision, cataracts, false eye or other abnormality affecting pupil response; Ears: hearing
Documentation: appropriate, confused, laughing, inappropriate, combative, hostile, lethargic, flat affect, unresponsive to verbal/painful stimuli, nervous, anxious, frightened, irritable, restless, agitated, emotionally labile, down, uncooperative, pleasant, cheerful, manipulative, inability to follow commands, disoriented (describe), somnolent, difficulty concentrating

Respiratory

- Respiratory rate, rhythm, depth, ease
- Cough, frequency, productive/nonproductive; sputum (color, amount, viscosity)
- Chest Movement: symmetrical or asymmetrical, decreased, retraction
- Use of accessory muscles: abdominal, neck, nostrils
- Lung Sounds: Clear, diminished, absent, wheezes, crackles, rhonchi (location)
- Supportive Devices: O₂, spirometry, pulse oximetry, chest tube, trach
Documentation: respirations: rapid, regular, irregular, spontaneous, apnea, Cheyne-Stokes, Kussmauls, shallow, deep, even, SOB, dyspneic, labored, gurgling, gasping, panting, pursed lip, diaphragmatic or abdominal breathing, barrel chest

Circulation

- CMST: color: pallor, flushed, dusky, cyanotic, check mucous membrane; temperature: warm, dry, cold, clammy
- Capillary refill (<3 sec), clubbing, calf tenderness/redness/swelling
- Edema (dependent, pitting, slight, weeping), AE hose, SCD, JVD
- BP: assess trend
- Pulses: rate, equal, quality (present, absent, regular, irregular, weak, thready, strong, bounding)
- Heart Sounds: regular, irregular, S3, S4, murmurs, distant; Tele: EKG pattern

Exercise & Rest

- ROM (active, passive), limitations, extremity elevation
- Activity tolerance: assess change in VS and/or symptoms related to activity, (SOB, weakness, fatigue)
- Muscle strength/tone/mass: soft, flabby, wasting, atrophic, stiff, spasm, tremor, strong, weak (paresis), paralysis
- Body alignment/posture: kyphosis, lordosis, scoliosis
- Movement/coordination: assess ability to move, stand, & transfer (well coordinated)
- Ambulation: gait steady/unsteady; assistive devices (walker, cane, brace)
- Is patient on bedrest (turn q 2 hrs), BRP, chair, commode, ambulatory with assistance or independent?
- Safety: fall precautions, use of restraints, bed in low position, siderails up
- Performance of ADLs (hygiene: self, partial, complete, shower, shampoo, shave)
- Rest/sleep pattern: usual pattern, disruption by hospitalization, use of aids

Ingestion & Elimination

- Height & Weight, I & O (assess 24 hour trend)
- Diet: PO, snacks, tube feeding, TPN (type, how it is tolerated, % eaten)
- Anorexia, nausea, vomiting, heartburn, indigestion, belching, flatus, ability to chew & swallow, own teeth or dentures, condition of mouth & mucous membrane
- BM: usual pattern, last, color, consistency, use of laxatives or enemas, ostomies, constipation, diarrhea
- Urine: Amount, pattern (frequency, pain, burning, urgency, difficulty), color, clarity, continent, incontinent, urinal, BSC, BRP, foley, supra pubic, briefs
- Abdomen (soft, firm, flat, distended, tender, ascites, girth); bowel sounds (active, hypoactive, absent)

Fluid & Electrolytes

- Weight trends, I & O (assess 24 hour trend)
- Mucous membranes (dry, moist, color); report of thirst; skin turgor (elastic, tenting)
- Neck veins (flat, distended), peripheral veins (slow filling, full)
- Edema (dependent, pitting, slight, weeping)
- IV fluids (hypotonic, hypertonic, isotonic)

Endocrine/Protective

- General appearance/hygiene: well nourished, well developed, appears stated age, well groomed, unkempt, clean, showers/baths daily
- Temperature: assess trend
- Skin color: pink, pale, ruddy, dusky, grey, jaundiced, cyanotic, flushed, ashen, mottled; turgor (elastic, tenting)
- Skin temperature/hydration: warm, cool, cold, hot, dry, moist, clammy, diaphoretic
- Skin condition: intact, rash, flaking, rough, oily, hematoma, bruises, petechiae; hair, beard, scalp
- Wounds: location, size, drainage (color, amount & type), odor, closed, sutured, staples, steri-strips, open (dehiscence), undermining, tunneling, granulation, epithelialization, eschar, slough, surrounding skin (reddened-erythema, edematous, excoriation) dressing status (CDI), drains (type, location, describe drainage)
- Protective devices: mattress/bed, heel, elbow, foot cradle, eggcrate, other
- Therapeutic devices: heat, cold

Psychosocial (Self-Concept, Role Function, Interdependence)

- Anxiety, coping status, body image, role changes, sick role, support: family, social, spiritual

Teaching: Assessment of learning needs, barriers to learning, teaching methods, evaluation

OHLONE COLLEGE
NURSING 307
PROCESS RECORDING

What is a Process Recording?

A learning tool which aids a student to develop observation and communication skills. A nursing student/patient interaction is recorded verbatim (or as closely as possible). Included are descriptions of both the student nurse and patient's non-verbal behavior and evaluation of the nurse and patient's verbal and non-verbal communication. Instructor feedback will be provided when appropriate.

Purpose of Process Recording:

1. To guide the student in the development of self-awareness of impact of own behaviors—verbal and non-verbal, on a patient.
2. To encourage the student to explore a variety of strategies to accomplish stated communication goal.
3. To enable student to become more objective in the processing of patient messages.
4. To create opportunity for student to propose alternative responses to patient messages for faculty feedback.
5. To provide the student with a comparative record of own progress in development of communication skills.
6. To assist the teacher in gaining an understanding of the student's ability to communicate therapeutically with patients and families, and provide concrete examples and remediation.

How is a Process Recording Used?

Client's Name: Use initials only to maintain confidentiality.

Setting: State where the interaction occurs.

Examples:

- a. by duck pond at Ohlone College
- b. hospital room

Include some descriptive information about patient (i.e., age, sex, diagnosis) Include noise level, staff interruptions, proximity of other clients, etc.

Goal: State the objective or reason for the interaction. Goal must be specific and measurable.

Examples: The patient will

- a. verbalize his anxieties regarding being newly diagnosed with diabetes
- b. verbalize how her husband is reacting to her current hospitalization.
- c. verbalize concern regarding plans for discharge from hospital.
- d. verbalize his feeling regarding pending surgery.

Process Recordings are not for teaching, conducting assessments (i.e., pain), or psychotherapy.

Process Recordings are to help a patient express feelings and problem solve a current issue or concern.

Patient: Record patient's verbal communication verbatim. (word for word)

Nurse: Record nurse's verbal communication verbatim. (word for word)

Non-verbal Behavior:

Describe both the patient's and the nurse's non-verbal behavior.

Line up patient's non-verbal communication with patient's verbal communication.

Line up nurse's non-verbal communication with nurse's verbal communication.

Evaluation of Patient Communication:

- a. Evaluate both verbal and non-verbal communication. Are they congruent? i.e., do they match?
- b. State what you think is going on, i.e., patient's feelings.

Evaluation of Nurse Communication:

- a. Label technique as "Therapeutic" or "Non-therapeutic"
- b. Identify and state techniques used.
- c. If non-therapeutic techniques used, identify the therapeutic technique that should have been used and give an example of what you could have said. State alternative responses you could have made to facilitate interaction or to promote more open expression of thoughts and feelings by client.
- d. Evaluate both verbal and non-verbal communication. Are they congruent?
- e. Evaluation of Process Recording on back of form, evaluate whether goal was achieved with reasons.

Criteria for Satisfactory Process Recording

There is no "letter" grade attached to a Process Recording!

1. Goal is specific and limited to one topic area.
2. Conversation remains focused on the goal.
3. Each verbal comment made by the nurse and patient and all non-verbal behavior are evaluated (as described above). Note: A process recording may be satisfactory when a non-therapeutic technique is used by you, the nurse, if you identify it as non-therapeutic in your evaluation and give an example of what you could have said.
4. Communication is therapeutic, not social.
5. Technique of summarizing the patient's conversation is used.
6. An evaluation statement regarding whether the process recording goal was met, is included.

PROCESS RECORDING

Setting: State where the interaction occurs

Goal: State the objective or reason for the Interaction. Goal must be specific.

Nurse	Patient	Non-Verbal Behavior	Evaluation of Pt. Communication	Eval .of Nurse communication
Record nurse's verbal communication verbatim.	Record patient's verbal communication verbatim.	<ul style="list-style-type: none"> a. Describe both the patient's and the nurse's non-verbal behavior. b. Line up patient's non-verbal communication with patient's verbal communication. c. Line up nurse's non-verbal communication with nurse's verbal communication. 	<ul style="list-style-type: none"> a. Evaluate both verbal and non-verbal communication. Are they congruent? b. State what you think is going on. 	<ul style="list-style-type: none"> a. Evaluate both verbal and non-verbal communication. Are they congruent? b. Identify and state therapeutic techniques employed. c. Identify and state any non-therapeutic communication techniques employed. State the therapeutic technique that should have been used and give an example of what you could have said. d. On the back side of this form, comment on the following: was the objective of visit achieved, modified or discarded? Include reasons.

6099j/N101

Process Recording

Setting:

Goal:

NURSE	PATIENT	NON-VERBAL BEHAVIOR	EVAL OF PT. COMMUNICATION	EVAL. OF NURSE COMMUNICATION

6099j/N101

OHLONE COLLEGE
Teaching Plan

Student Name: _____

Patient's Initials _____ age _____

Occupation: _____

Diagnosis _____

Teaching time: Estimate: _____ Actual: _____

Assessment of Learning Needs	Teaching /Learning Nursing diagnosis	Related To: (causes)	Expected Outcomes	Nurse interventions	Evaluation/Modification
<p>Education and present knowledge level:</p> <p>Age: chronological and developmental</p> <p>Physiological status</p> <p>Emotional status:</p> <p>Family and support system:</p> <p>Misc. influencing factors:</p>	<p>Choose one of the following Nursing Dx.:</p> <p>A. Knowledge deficit of: (specify for teaching content)</p> <p>B. Growth and Development, altered in: (specify for teaching content)</p> <p>C. Health-seeking behaviors (specify for teaching content)</p> <p><u>D. Impaired Home Maintenance management (specify for teaching content)</u></p> <p>E. Ineffective management of therapeutic regime in:(specify for teaching content)</p>		<p>Pt. will:</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>as evident by (learner activities)</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p>(Teacher Activates)</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p>1.</p> <p>2.</p> <p>3.</p>

Student Name: _____

DATA COLLECTION/WORKSHEET

PT. Initials _____ Age _____ Rm. # _____ Dr./s _____ Adm. Date _____ Dates of Care _____

Current Med. Dx _____ Surgical Procedure & Date: _____

Social Hx: Language, Ethnicity, Supports, Allergies: _____ Diet: _____
Job, Economics:

Pertinent Health/Illness/Surgical or O.B. Hx:

Significance of Dx/Hospitalization on ADLs/Future:

Time	Medical Treatment Plan (Activity Status, IVs, Treatments)
Time	Current T/L Needs
Time	Possible D/C Needs

Lab/diagnostic test

Lab/Diagnostic Test	Date	Date	Date	Date	Date	Significance/Trend of Lab
Metabolic (Chemistry) Panel						
Na+ (135-143) mmol/L						
K+ (3.5-5.3) mmol/L						
CL- (96-110) mmol/L						
CO2 (24-31) mmol/L						
Glucose (70-110) mg/dl						
BUN (5-18) mg/dl						
Creatinine (0.5-1.3) mg/dl						
ALT (GPT) 10-60 IU/L						
AST (GOT) 10-42 IU/L						
Alk.Phos (20-125) IU/L						
Total Bili (0.1-1) mg/dL						
T.Protein (6-8) g/dL						
Albumin (3.5-5.3) g/dL						
Globulin (1-3,4) g/dL						
Ca ⁺⁺ (8.4-10.8) mg/dL						
Phosphorous (2.4-4.7 mg/dl)						
CBC w/AUTO DIFF						
WBC (4.5-11) thousand						
RBC (4.2-5.4) million						
HGB (12-16) gm/dl						
HCT (36-49) %						
Platelets (130-400) thousand						
MCV (800-1000) mm ³						
MCH (26-33)pg						
MCHC (32-36) gm/dL						
LYMPH (25-45) %						
MONO (2-6) %						
EOS (0-6) %						
NEUT (35-65) %						
Baso (0.1) %						
Arterial Blood Gas						
pH (7.35-7.45)						

pCO ₂ (35-45 mmHg)						
HCO ₃ (22-26 mmol/L)						
pO ₂ (80-100 mmHg)						
SaO ₂ >95%						
URINE CULTURE						
URINALYSIS						
Sp.Gravity (1.01-1.025)						
pH (5-8)						
Leuko, est. (neg)						
Nitrate (neg)						
Protein qual (neg)						
Glucose qual (neg)						
Keytone (neg)						
Blood (neg)						
Coagulation Panel						
PT (10.9-14.1 sec)						
PTT (30-45 sec)						
INR (2.0-3.0)						
Fibrinogen (150-450 mg/dl)						
Thyroid Panel						
FT ₄ (0.8-2.8 ng/dl)						
TSH (2-10 mU/L)						
Cardiac Isoenzyme Panel						
CPK (Male: 55-170 units/L) (Female: 30-135 units/L)						
CK-MB (0%)						
Myoglobin (<90 mcg/L)						
Troponin T (<0.2 ng/ml)						
Troponin I (<<0.03 ng/ml)						
CRP (<1.0 mg/dl or 10 mg/L)						
BNP (<100 pg/ml)						
Therapeutic Drug Levels						
Digoxin (0.8-2.0 ng/ml)						

Dilantin (10-20 mcg/ml)						
Phenobarbital (10-40 mcg/ml)						
Vancomycin: <Trough (5-15 mcg/ml) <Peak (20-40 mcg/ml)						
Gentamycin: < Trough (0.5-2.0 mcg/ml) <Peak (4-10 mcg/ml)						
DIAGNOSTIC TESTS						
CXR						
Endoscopy						
CT Scan						
MRI						
Ultrasound						
Cardiac Catheterization						
Cardiac Stress Test						
Echocardiogram						

Medication Sheets

MEDICATION TRADE/GENERIC	DOSE ROUTE FREQUENCY	CLASSIFICATION	Specific reason/s why patient is taking medication; therapeutic effect/s	<u>Priority</u> Nursing Actions (Assessments, Vital signs, Lab Test to check, etc). Write at least 5 <u>priority</u> nursing actions that you need to do or remember when giving this medication.

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (cause-directed actions)	Evaluation/ Modification

Assessments	Nursing Diagnosis (Issue of Nursing Care)	Related To (Causes)	Expected Outcomes (Short-term patient behavioral goals)	Nurse Interventions (cause-directed actions)	Evaluation/ Modification

ASSESS BLANK/N 10