PLNU forward

School of Nursing

NSG 331 Nursing of Families: Childbearing Process

3 Units

Fall 2015

Meeting days: Tuesday or Thursday	**Instructors: Shannon Barnett, BSN, RN** **Adjunct Professor of Nursing** **Mobile: 760-917-0579** **shannonbarnett@pointloma.edu**
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PLNU Mission
To Teach ~ To Shape ~ To Send

Point Loma Nazarene University exists to provide higher education in a vital Christian community where minds are engaged and challenged, character is modeled and formed, and service becomes an expression of faith. Being of Wesleyan heritage, we aspire to be a learning community where grace is foundational, truth is pursued, and holiness is a way of life.

SON Vision Statement

The School of Nursing at Point Loma Nazarene University embraces, as a covenant, the commitment to excellence within a dynamic Christian environment in which each one will engage in the sacred work of nursing. This sacred work involves symbolically removing one's shoes in service of others.

Take off your sandals for the place you are standing is holy ground. Exodus 3:5 NIV

SON Mission Statement

The School of Nursing at Point Loma Nazarene University exists to support the university Wesleyan mission and to provide an interdisciplinary learning program of excellence. Graduates of the SON are distinctly identified by grace, truth and holiness, serving others after the example of Christ, as they are sent to fulfill their calling as professional nurses.

So He got up from the meal, took off His outer clothing, and wrapped a towel around His waist. After that, He poured water into a basin and began to wash His disciple's feet, drying them with a towel that was wrapped around Him. John 13: 4-5 NIV

Now that I, your Lord and Teacher, have washed your feet, you also should wash one another's feet. I have set you an example that you should do as I have done for you. John 13: 14-15 NIV

Faculty reserves the right to make necessary schedule changes to this syllabus as the semester progresses.

Every attempt will be made to minimize the inconvenience to the student in the event of a change to the syllabus. Students will be notified of changes via eclass announcement section, with accompanying email notification, in a timely manner.

COURSE DESCRIPTIONS

Consists of opportunities for application of nursing theory as it relates to families throughout pregnancy, labor, delivery, and the postpartum period, including the care of the newborn. Graded Credit/No Credit.

PRE-REQUISITES: Current Junior standing in the nursing program

Note: A minimum grade of "C" must be achieved in all prerequisite courses for course eligibility

CO-REQUISITES: NSG 330

Note: A minimum grade of "C" must be achieved in all co-requisite courses in order to progress in the program.

CREDIT HOUR INFORMATION

In the interest of providing sufficient time to accomplish the stated Course Learning Outcomes, this class meets the PLNU credit hour policy for a 3 unit class delivered over15 weeks.

PROGRAM VALUES & COURSE LEARNING OUTCOMES

Upon completion of NSG 331 , the student will meet the following outcomes:

Inquiring Faithfully:

NSG 331 Course Learning Outcomes (CLOs)

1. Collaborates with patient, interdisciplinary care team and nursing faculty to advocate for patient and family (PLO 1.1; QSEN Patient-centered care).
2. Implement individualized evidence–based plan of care for the childbearing family (PLO 1. 3/1.4; BSN essential I-3; QSEN EBP; BSN essential III-6 BSN essential IX-1,3; QSEN EBP)
3. Evaluates the implementation of evidence-based practice care within the healthcare setting (PLO 1.3; QSEN EBP).
4. Examine own personal self-care practices in provision of sustained quality care (PLO1.5; BSN essential VIII-14)

Caring Faithfully:

NSG 331 Course Learning Outcomes (CLOs)

- Exemplify Christ's love through compassionate care for the childbearing family (PLO 2.1; BSN essential IX-21).
- Investigate community resources to advocate for optimal health care for patients, families and communities (PLO 2.2; BSN essential IX-10)
- Incorporate patient's health beliefs, culture, and health literacy into nursing plan of care (PLO 2.1; BSN essential IX-7; QSEN patient-centered care)
- Reflect on personal beliefs and values as related to professional nursing practice (PLO 2.3; BSN essential VIII-6, 3/4; QSEN patient-centered care)

Communicating Faithfully:

NSG 331 Course Learning Outcomes (CLOs)

1. Engage with information technologies to document and monitor patient care.
2. Formulate evidence-based health education to enhance patient/family understanding of health care practices (PLO 3.4 & PLO 3.5; BSN essential VII-2, 3, 5; QSEN teamwork and patient-centered care).
3. Apply therapeutic communication skills to deliver patient/family-centered care (PLO 3.2 & PLO 3.3; BSN essential I-4, VI-2; QSEN Informatics).
4. Evaluate the inter- and intra-professional communication to optimize patient outcomes (PLO 3.3; BSN essential VI-4).

Following Faithfully:

NSG 331 Course Learning Outcomes (CLOs)

1. Evaluates the role of the professional nurse in improving the design of practice (PLO 4.1).
2. Applies professional standards of care according to ethical, legal and Christian principles (PLO 4.2; BSN essential VIII-1, 2)
3. Commit to lifelong learning and continued professional development for nursing excellence (PLO 4.3; BSN essential VIII-13; BSN essential I-9)

Leading Faithfully:

NSG 331 Course Learning Outcomes (CLOs)

1. Create a safe and compassionate caring environment that results in high quality patient outcomes (PLO 5.1; BSN essential IX-11, 12).
2. Role model Christian nursing by integrating servant leadership into the care of diverse populations (PLO 5-2; BSN essential I-5; QSEN Patient-centered care).

LEARNING STRATEGIES**:** The following methods will be used as learning strategies for the clinical setting:

1. Guided clinical practice
2. Self study guides for each clinical area
3. Nursing care maps
4. Free writing or journal entries
5. Independent clinical experiences

METHODS OF EVALUATION**:** Students must meet a minimum of 75% of the standards listed on the *Clinical Evaluation Form* to receive "Credit". To receive credit for the course, all assignments must be completed as assigned – NO EXCEPTIONS.

ACADEMIC POLICIES

Make up for clinical hours is at the discretion of the faculty. All clinical (i.e. on-campus, skills lab, clinical sites) hours must be made up. It is the responsibility of the student to initiate communication regarding arrangements for make-up. Failure to makeup clinical hours will result in a "No Credit" for the clinical practicum and an incomplete for the co-requisite theory course.

ATTENDANCE AND PARTICIPATION

Make up for clinical hours is at the discretion of the faculty. All clinical (i.e. on-campus, skills lab, clinical sites) hours must be made up. It is the responsibility of the student to initiate communication regarding arrangements for make-up. Failure to make up clinical hours will result in a "no credit" for the clinical practicum and an incomplete for the co-requisite theory course.

- **Call the night before or the morning of clinical day to notify instructor of absence.** Type of makeup assignment is assigned at the discretion of the clinical instructor and **due 2 weeks after missed clinical day - NO EXCEPTIONS**
- **Have a valid Point Loma Nazarene University picture ID with them and DISPLAYED in order to engage in clinical practice.**
- **ALL** clinical requirements including compliance with immunizations, hospital required forms and background check information **must be completed and turned in** to faculty or School of Nursing as assigned prior to first clinical shift (on-campus, skills lab, clinical site) or as directed. Failure to do so will result in the inability to attend clinical session and **formal disciplinary action.**
- **Actively** participate in clinical conferences.
- Complete all assigned self-study guides by first day of on-site clinical. (Students are not permitted to care for clients if the self-study guides are not completed.)
- Make every effort to work collaboratively with assigned staff nurse and communicate any issues directly to instructor.
- Demonstrate the possession of medication information on assigned medications and on each medication given by the student. The information must highlight the effect on the fetus or breastfeeding newborn, and safety for use in pregnancy. Medications will be reviewed with the instructor or assigned RN before administering a medication to a patient. Pre-printed cards or medication grid provided by the professor may be used.

REQUIRED TEXTS & RECOMMENDED STUDY RESOURCES

Same as NSG 330 (Theory)

PORTFOLIO REQUIREMENT

At the conclusion of each course, students are expected to complete/update a LiveText® portfolio including self-evaluation of outcomes using the BSN Growth Portfolio template. The portfolio provides evidence supporting professional development and attainment of PLNU SON BSN graduate outcomes. For this course, the following assignment(s) are **required** to be submitted in LiveText®.

- *Guided Reflective Journals: Responsibility, Accountability, Respect/Dignity for others, Humility, Courage (see Activity 2)*

Students are strongly encouraged to submit additional coursework into LiveText® to demonstrate personal and professional growth.

REQUIRED LEARNING ACTIVITIES

Activity 1: Care Maps (see care map template in Canvas)
Number Due: 3 – due the week after you have cared for the patient

Student Learning Outcomes: On completion of the clinical day the student will:

1. Recognize changes in client status and identify possible interventions.
2. Perform thorough, accurate assessments in each the childbearing areas with corresponding documentation
3. Demonstrate the ability to anticipate the needs of the childbearing family and render appropriate care
4. Reflect on care given and redirect their actions as needed.
5. Display the ability to set forth a plan for completion of tasks.
6. Develop a plan for evaluating the effectiveness and outcomes of plan.
7. Interact in an ethical manner at all times and with all persons using Christian principles

GUIDELINES:

1. 3 concept maps due during the semester

2. Each completed Care Map must include:

☐ Patient Assessment (done weekly in clinical)
☐ Included in the body of the care map
☐ Pathophysiology of the disease/problem
☐ Main physiologic problem(s) including all relevant diagnostic findings (X-rays, labs, physical assessment findings, etc.)
☐ Main psychosocial problem (or potential problem)
☐ Nursing interventions (at least 3) with evaluation method for each
☐ Outcomes/Goals – at least 2 per intervention

3. Concept Maps will be reviewed weekly as turned in and returned to student with feedback.

☐ First two (2) concept maps – reviewed and graded as pass/fail. Those concept
☐ Final concept map (1) will be graded for a maximum of 15 points toward NSG 330
Maps that do not meet minimum standards or lack demonstration of learned knowledge will be returned for rewrite and resubmission.

DUE DATE: One week following the experience on which you've chosen to do the care map. Turn all clinical assignments in using course folders provided by the clinical instructor.

RESOURCES: See Canvas to obtain required forms and helpful guidelines for completing care maps.

Activity 2: Reflective Journaling
Number Due: 5 during semester

Student Learning Outcomes: The student will:

1. Submit a one-page (minimum) type-written, double-spaced reflection of the day's experience (submitted on Canvas).
2. Reflect on clinical experience as it related to their growth and development as a nurse and document this reflection.
3. Evaluate their own clinical performance to determine weaknesses and strengths.
4. Maintain a record of age(s) and diagnosis(es) of patient(s) cared for during the semester.
5. Evaluate their achievement of SON core competencies for the day.
6. Set goals for future clinical experiences.

GUIDELINES:

1. The student will complete 1 reflective journal on each of the following topics (total of 5 journals during the semester):

☐ Responsibility
☐ Accountability
☐ Respect/Dignity for others
☐ Humility
☐ Courage

2. There is no specified length for the journal but journal entry must be at least 300 words in length. Journal entries will be posted on Canvas in the Journals section of Nursing 331.

RESOURCES:
Clinical Journal Guidelines – found on Canvas

DUE DATE: Journals must be turned in one week after the experience written about. All journals should be complete by the students last clinical. You may not turn all journals in on the same day!

TOPIC: Clinical Orientation

Student Learning Outcomes:
Upon completion of the class session and discussion, the student will:

1. Verbalize familiarity with the clinical syllabus, required assignments and the schedule of a typical clinical day.
2. Prove completion of the clinical facility requirements, including paperwork (i.e. HIPAA, safety & confidentiality requirements).
3. Verbalize basics of Electronic Fetal Monitoring, including fetal heart rate baseline, accelerations, decelerations, and contraction pattern.
4. Demonstrate components of the physical assessment of the neonate & gestational age assessment.
5. Demonstrate the components of the physical assessment of the pregnant, laboring & postpartum woman.
6. Verbalize critical elements to assess in the breastfeeding process, including the benefits to mom and baby, common positions, LATCH assessment and common discomforts.
7. Review components of birth videos and types of births viewed.
8. Verbalize principles of infection control and demonstrate the ability to pass an infection control test.

RELATED STUDENT ACTIVITIES:

1. **Review Canvas site** for required documents and print/complete as directed.
2. **Complete Hospital requirements** as directed on Canvas site and print required forms to prove completion.
3. **Read, sign and turn in** "Critical Behaviors" form at back of syllabus (Appendix E).

Clinical Area	Objectives: At the end of the clinical experience, the student will be able to:	Assignment
ANTENATAL TESTING	1. Describe the role of the RN in antenatal testing and identify the educational requirements necessary to perform this role. 2. Recognize and define the differences between non-stress tests. Explain the possible importance of these tests 3. Describe the inter-relationship between the antenatal RN and perinatologist or OB. 4. Observe and describe the ultrasound procedure for antenatal testing. What role does the nurse have in ultrasound?	□ *Antenatal Testing Experience Worksheet* □ *Fetal Monitoring form*
TRIAGE	1. To observe and describe the role of the labor & delivery nurse in triaging pregnant and postpartum women. 2. To recognize and articulate the procedure for assessing the acuity of the clients, and their need for admission. 3. To observe the nurses role in reporting client status to the attending provider. Describe the interrelationship between the RN and the physician provider in triage and how it differs from that in the Antenatal Testing. 4. Describe common reasons for a client to seek care in the triage unit.	□ *Triage worksheet* □ *Fetal Monitoring form*
PERINATAL SPECIAL CARE UNIT	1. Articulate the role of the antepartum nurse caring for high-risk antenatal patients. 2. Complete physical and psychosocial assessments on assigned mother under the guidance of the preceptor nurse. 3. Correctly document in the medical record all care and teaching performed for the patient. 4. Participate in the care of the high-risk patient. This includes procedures, medication and IV management at the discretion of the preceptor nurse. 5. Under the direction of the staff nurse or instructor, participate in the discharge and discharge teaching of assigned patients, if indicated. 6. Under the direction of the staff nurse, participate in the transfer to LDR or OR of assigned patient. 7. Be able to articulate and define the most common reasons for admission to the antepartum unit, including:	□ *PSCU worksheet* □ *Weekly H&P & Journal* □ *Fetal Heart Monitoring form*

	a. Preterm Labor (PTL) b. Pregnancy Induced Hypertension (PIH) c. Diabetes, Gestational Diabetes d. Trauma e. Multiple gestations	
LABOR AND DELIVERY	1. Assess the patient's contraction pattern, both manually and via the electronic monitoring system. 2. Begin to identify fetal heart patterns using the fetal monitor. 3. Identify when a fetal monitoring strip warrants calling the physician. 4. Participate in the maternal & infant recovery assessments under the guidance of the LDR nurse. Become familiar with the LDR environment and clinical charting. The staff nurse may assume responsibility for supervision of these activities. 5. Under the supervision of the LDR nurse, chart vital signs, IV's, catheterizations/voids, and position changes. **THE STAFF NURSE OR INSTRUCTOR MUST BE PRESENT** when IVs are changed or when narcotics are given. The student is **NOT** to call a physician or take orders from a physician.	□ □ *Weekly H&P and Journal each day* □ □ *Fetal Heart Monitoring Form each day*
POSTPARTUM	1. Complete physical and psychosocial assessments on his/her assigned mothers and/or babies twice per shift. 2. Correctly document in the medical record all care and teaching performed on patient (mothers and babies). **The first assessment will be documented no later than 90 minutes after the start of the shift**. 3. Be responsible for the total care of his/her patients (mothers and babies). This includes procedures, medications and IV management. 4. Under the direction of the staff nurse, participate in the discharge and discharge teaching of assigned patients, if indicated. 5. Manage at least two complex patients or two Mother-Baby couplets in a safe and timely manner by last clinical shift in postpartum. 6. Communicate effectively with staff nurse all assessments, with attention to abnormal findings, in a timely manner. 7. Prioritize client needs and assessments according to client acuity. Be able to	□ □ *Weekly H&P* □ *Fill out well newborn column on newborn assessment grid*

	articulate rationale for decisions made in the care of the client.	
NICU (Neonatal Intensive Care Unit)	1. Perform a gestational age assessment on a high-risk neonate. Compare and contrast these findings with those of a normal newborn. 2. Discuss the role of the NICU nurse at a high-risk delivery. If possible, attend a high-risk delivery with a NICU nurse. Compare and contrast the role of the NICU nurse with the labor and delivery nurse. 3. If possible, observe the discharge of a high-risk infant. Discuss the aspects of discharge teaching that differs from that of the normal newborn. Discuss the rationale for these differences. 4. Provide care to a minimum of 1 high risk infant in a safe and timely manner. Chart assessment findings under the supervision of the preceptor RN. 5. Safely give medications **only with the supervision of the preceptor RN** and be able to articulate the needs for the medications and their effect on the infant.	□ *Perform an assessment on one high-risk neonate. Fill out the NICU column on Newborn Assessment Grid* □ *Complete NICU worksheet* □ *Weekly H&P*
Operating Room/Post Anesthesia Care Unit	1. Articulate the role of the Scrub nurse and the Circulating nurse. Articulate the comparison and contrast their roles. 2. Observe and describe the inter-relationship and team-work of all of the professionals in the Operating room (surgical suite). 3. Recognize and describe asepsis and sterile techniques before, during, and after surgery. Also describe the areas that are sterile or clean. Observe and describe scrubbing techniques and appropriate Operating Room attire. 4. Provide care to a minimum of 1 recovering client (mother /baby couplet if possible) in a safe and timely manner. This should include assessments and medications as appropriate and **with the RN present** to assist. 5. Articulate how the needs of a post surgical client differ from that of a client who did not undergo a surgical birth. 6. Prioritize the needs of the postsurgical client. 7. Articulate the requirements for discharge to the postpartum unit.	□ *Operating Room worksheet*
Women's Acute Care Unit (WACU)	1. Articulate the role of the nurse caring for patients in the WACU. 2. Complete physical and psychosocial assessments on assigned woman under the guidance of the preceptor nurse.	□ *WACU worksheet*

	3. Correctly document in the medical record all care and teaching performed for the patient. 4. Participate in the care of the high-risk patient. This includes procedures, medication and IV management at the discretion of the preceptor nurse. 5. Under the direction of the staff nurse or instructor, participate in the discharge and discharge teaching of assigned patients, if indicated. 6. Under the direction of the staff nurse, participate in the transfer to/from OR/PACU of assigned patient. 7. Be able to articulate and define the most common reasons for admission to the WACU, including: a. Pre/Post Op Hysterectomy b. Pre/Post Op Mastectomy (Include types) c. OBGYN Oncology	

5 Reflective journals on different topic: You can choose any area on any given day to complete your reflective journal

□ Forgiveness
□ Responsibility
□ Accountability
□ Humility
□ Respect/Dignity for others
□ Courage

3 Care Maps

□
□
□

APPENDICES

APPENDIX A

ADDITIONAL POSTPARTUM INFORMATION

CALL YOUR INSTRUCTOR & NOTIFY NURSE IF:

Baby	**Mother**
• Baby Temperature: below 97.7 (36.5 C) OR above 99.4 (37.5 C) • Respirations: below 35 OR above 60 • Pulse: below 110 OR above 160 • Glucose: below 40 mg/dl OR above 150 mg/dl • Has not voided or stooled on your shift • Bleeding at circumcision • Bilirubin above 11 mg/dl	• Mom's fundus above the umbilicus or deviated after voiding, boggy fundus, large amount of lochia or passing clots, saturating 1 peripad in less than 2 hours • Palpable bladder, no void in past 4 hours, inability to void • Abdominal distention, inability to pass gas 24-36hrs past cesarean section • Maternal temp. >100.4 F (38.0), pulse >110, BP 140/90, RR <14

ASSESSMENTS MUST BE DONE AND CHARTED EVERY 4 HOURS ON BOTH MOTHER AND BABY. FOR A MOTHER WHO IS A NEW ADMISSION ASSESSMENTS ARE DONE EVERY 2 HOURS. THE FIRST THREE TIMES A NEW POSTPARTUM PATIENT VOIDS IT MUST BE MEASURED AND RECORDED.

Students are required to have Absolute Compliance with the Following:

A. Students are responsible for assessing their assigned patients and documenting their assessments at the start of their shift, prior to patient discharge, and 1 hour before the end of their shift**.** The Point Loma Instructor may or may not be present for these assessments.

B. Check with the Point Loma instructor or nurse preceptor prior to attempting new procedures and have one of them observe you. Remember to record the date you performed the new procedure in your *Student Skill Book.*

C. The Point Loma *instructor or preceptor nurse **MUST** be present* when the student is giving **any medication**. The *student is **NOT** to call a physician or take orders from a physician.*

APPENDIX B

Sharp Mary Birch Hospital for Women and Newborns
3003 Health Center Drive
San Diego, CA 92123

Naval Medical Center San Diego
34800 Bob Wilson Drive
San Diego, CA 92134

APPENDIX C

NSG 331 EVALUATION

DATE:

STUDENT'S NAME: _____

INSTRUCTOR'S NAME:

SEMESTER/YEAR:

CLINICAL FACILITY: Sharp Mary Birch Hospital for Women

Student adheres to ANA Standards of Practice with interpretive statements (found in PLNU Department of Nursing Student Faculty Handbook) YES NO

1. Completed 100% of the clinical time. YES NO
2. Make-up time arranged and completed YES NO
   N/A
   Description of make-up work: _____
   Date completed: _____
3. Portfolio Reviewed YES NO

CLINICAL COURSE GRADE: CREDIT NO CREDIT

INCOMPLETE

Student is to complete the evaluation, date it, and return it to the clinical instructor at least 1 week prior to the last clinical day. Student to mark with a check (√) and faculty will mark with an "χ"

I. <u>INQUIRING FAITHFULLY</u>: the student will demonstrate knowledge, skill and behavior of the evidence-based practice of nursing which integrates growth in reasoning, analysis, decision-making and the application of theory with the goal of advocating for others and/or self. This includes holistic nursing skills in the nursing process.

	Meets expected standards	Needs improvement to meet expected standards
1. Collaborates with patient, interdisciplinary care team and nursing faculty to advocate for patient and family (PLO 1.1; QSEN Patient-centered care).		
2. Integrates research and evidence-based practice into patient care planning and implementation (PLO 1.2; QSEN EBP).		
3. Evaluates the implementation of evidence-based practice care within the healthcare setting (PLO 1.3; QSEN EBP).		
4. Adapts family-centered care to the body, mind, emotion, spirit and social/cultural preferences within the patient and family environment (PLO 1.4; QSEN Patient-centered care)		
5. Appraises learning, including personal strengths and limitations, for personal growth and learning (PLO 1.5).		

Examples:

II. <u>CARING FAITHFULLY</u>: The student will embrace a calling to the ministry of compassionate care for all people in response to God's grace, which aims to foster optimal health and bring comfort in suffering and death.

	Meets expected standards	Needs improvement to meet expected standards
1. Investigate community resources to advocate for optimal health care for patients, families and communities (PLO 2.2; BSN essential IX-10)		
2. Incorporate patient's health beliefs, culture, and health literacy into plan of nursing care (PLO 2.1; BSN essential IX-7; QSEN patient-centered care)		
3. Reflect on personal beliefs and values as related to professional nursing practice (PLO 2.3; BSN essential VIII-6, 3/4; QSEN patient-centered care)		

Examples:

III. <u>COMMUNICATING FAITHFULLY</u>: The student will actively engage in the dynamic interactive process that is intrapersonal and interpersonal with the goal of advocating for others and/or self. This includes effective, culturally appropriate communication which conveys information, thoughts, actions and feelings through the use of verbal and nonverbal skills.

	Meets expected standards	Needs improvement to meet expected standards
1. Engage with information technologies to document and monitor patient care.		
2. Formulate evidence-based health education to enhance patient/family understanding of health care practices (PLO 3.4 & PLO 3.5; BSN essential VII-2, 3, 5; QSEN teamwork and patient-centered care).		
3. Apply therapeutic communication skills to deliver patient/family-centered care (PLO 3.2 & PLO 3.3; BSN essential I-4, VI-2; QSEN Informatics).		

Examples:

IV. <u>FOLLOWING FAITHFULLY</u>: Defined as claiming the challenge from Florence Nightingale that nursing is a "divine imposed duty of ordinary work". The nursing student will integrate the ordinary work by complying with and adhering to regulatory and professional standards (e.g. ANA Code of Ethics, the California Board of Registered Nursing, Scope of Nursing Practice, SON Handbook). This includes taking responsibility for all actions and treating others with respect and dignity.

	Meets expected standards	Needs improvement to meet expected standards
1. Evaluates the role of the professional nurse in improving the design of practice (PLO 4.1).		
2. Applies professional standards of care according to ethical, legal and Christian principles (PLO 4.2; BSN essential VIII-1, 2)		
3. Commit to lifelong learning and continued professional development for nursing excellence (PLO 4.3; BSN essential VIII-13; BSN essential I-9)		

Examples:

V. <u>LEADING FAITHFULLY</u>: The student will incorporate a foundational relationship with Christ and others and embrace a willingness to serve others in the midst of life-circumstances (e.g. illness, injustice, poverty). The student will role-model the need for "Sabbath Rest" as a means of personal renewal, and true care of the self so that service to others is optimally achieved. The student will incorporate the characteristics of a servant leader including: humility, courage, forgiveness, and discernment.

	Meets expected standards	Needs improvement to meet expected standards
1. Create a safe and compassionate caring environment that results in high quality patient outcome (PLO 5.1; BSN essential IX-11, 12).		
2. Role model Christian nursing by integrating servant leadership into the care of diverse populations (PLO 5-2; BSN essential I-5; QSEN Patient-centered care).		

Examples:

Student's Comments
Student's Strengths:

Areas for Improvement: (Include any ideas you have to facilitate your own growth)

Faculty Comments:
Student's Strengths:

Areas for Improvement:

Signatures: Student _____ Date:

Faculty _____ Date:

APPENDIX D

TECHNICAL SKILLS & SAFETY MEASURES

	Meets Expected Standards	Needs Improvement to Meet Expected Standards	Not able to perform- N/A
1. MEDICATIONS			
A. Narcotic administration			
B. Non-narcotic administration			
C. Injections: Adult/Infant			
2. Intravenous (Main line and IVPB's)			
A. Assessment and management			
B. Changing IV Bags			
C. Removal and disposal			
3. CATHETERS (Foley, straight)			
A. Insertion			
B. Removal			
C. Charting of I & O			
4. Assessment of labor contractions			
5. Monitoring and assessment of the fetal heart rate.			
6. MATERNAL ASSESSMENT (Complete)			
A. Fundus			
B. Lochia/Episiotomy			
C. Breasts/Nipples			
D. High risk (DTR/Clonus)			
7. NEONATAL (ADMISSIONS AND ASSESSMENT)			
8. WOUND CARE (Staples removed)			
9. CHARTING			
A. Timely			
B. Accurate			
C. Complete			

APPENDIX E

CRITICAL BEHAVIORS THAT IMMEDIATELY RESULT IN PROBATION OR POSSIBLE FAILURE OF THE COURSE:

1. Falsifying a client record.
2. Blatant disregard of client confidentiality.
3. Denying responsibility for one's own deviation from standard practice.
4. Actions that place the client in jeopardy.
5. Actions that place the student or colleague in jeopardy.
6. Abusive behavior toward clients.
7. Ignoring the need for essential information before intervening.

Grading scale for performance:

Meets Expected Standard
Needs Improvement to Meet Expected Standard
N/A - Not Applicable.

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Student Signature: _____ Date:

Faculty Signature: _____ Date:

APPENDIX F

ACTUAL AND POTENTIAL INCIDENT REPORTING

The following procedure is to be followed by the Faculty at the time of any actual or potential critical incidents or medication errors. This is a confidential survey that is intended to be used for patient/student safety and tracking purposes. The following is a list of occasions that may require reporting, including but not limited to:

Medication related incidents such as:

1. Administration of the wrong medication.
2. Administering medication to the wrong patient.
3. Administering the wrong drip rate or dose.
4. Administering the medication at the wrong time or omitting a dose by mistake.
5. Unsafe medication administration.
6. "Near miss" – medication error was stopped prior to administration by RN or Instructor.

Patient related incidents such as:

1. Incomplete, inaccurate or incorrect charting.
2. Inappropriate actions resulting in actual or potential danger to patient well-being.
3. Demonstration of inadequate knowledge base to carry out safe clinical practice (inadequate preparation for clinical).
4. Patient fall or injury.
5. Other behaviors which warrant the concern of the nursing instructor or clinical staff.

Student related incidents such as:

1. Any injury requiring medical treatment that occurs during clinical hours.
2. Fall, with or without loss of consciousness or injury.
3. Needle-stick (please see **Infection Control - Blood and Body Fluid Exposure** policy)
4. Blood or Body fluid exposure (please see **Infection Control - Blood and Body Fluid Exposure** policy)

STUDENT Procedure:

1. The student will complete the incident report as soon as possible after incident or near miss, and after notifying clinical instructor of event requiring report (within 48 hours unless otherwise arranged by clinical instructor).
2. The student will access the **SON Incident Report** form in the SON resource folder and follow the link provided (see below).

(https://eclass.pointloma.edu/> School of Nursing Resource Site >SON Documents>Misc. Forms)

3. The survey must be completed in one sitting, once started it must be finished. Please be aware that any information pertaining to the event needs to be collected prior to beginning the survey.
4. Once report is complete, student to notify faculty of record for the course in which the incident took place.

Consequences, if any, of such reports shall be determined by the level team faculty in the School of Nursing.

FACULTY Procedure:

1. Once notified of an incident requiring the completion of the **SON Incident Report**, direct student to complete report form located in eclass under the SON resource form (see above for student procedure and possible occasions requiring completion of a report).
2. If possible, assist the student in completing the form while together at the hospital, or arrange for the student to complete the form within 48 hours (unless otherwise unable).
3. Once the student has completed the form, enter Qualtrics via the link provided here to review the students report. https://pointloma.us.qualtrics.com/ControlPanel/
4. If there are any necessary updates or clarifications to be made, type up a Word document with your clarifications indicating the date and time of completion.
5. Contact the ASAC Chairperson, or other designee in the SON, to notify them of the students completion of the Incident Report and give comments or clarifications to them for attachment to the report and placement into the student Shared Folder.

APPENDIX G

INFECTION CONTROL - BLOOD/BODY FLUID EXPOSURE

Purpose: This policy is established because of the particular concern for exposure to Hepatitis B, Hepatitis C, or HIV in the clinical setting.

For: ***Any person (faculty or student) exposed*** to blood/body fluids by puncture, laceration, bites, contact through eye, nose, or mouth, or contact with pre-existing breaks in the skin. The ***source person*** is the person whose blood/body fluids have come in contact with the exposed person as previously listed.

I. **Immediate First Aid** (Responsibility of the Exposed Person)

A. Squeeze the wound/cut to make it bleed and wash with soap and water. *(Please note the CDC does not recommend this)*.
B. Rinse mouth, eye, or nose with large volumes of clean water or saline.
C. If sutures are required or other medical intervention, the exposed person should receive immediate attention by the agency's urgent care/emergency services (student or insurance company will be billed for expenses).

II. **Report of Incident** (Responsibility of the Exposed Person)

A. Contact Instructor and Supervisor/Preceptor/Primary Nurse
B. Complete Agency Incident Report ***AND*** School of Nursing Incident Report (via eclass link) as soon as possible.
C. Seek professional first-aid follow-up via the urgent care/emergency department **within one hour of the incident.**
D. Contact personal health care provider.

III. **Instructor's Responsibility**

A. Assist in completing Agency Incident Form ***AND*** School of Nursing Incident Report. Place a copy in the student's file.
B. Notify Employee Health/Quality Assurance Personnel in Agency and Human Resources at Point Loma Nazarene University (619-849-2534).
C. Notify SON Dean and Human Resources department to initiate Workman's Comp process.

POINT LOMA NAZARENE UNIVERSITY

IN CASE OF WORK RELATED INJURY

DURING REGULAR WORK HOURS:	
Go to or contact: PLNU Wellness Center 1ST floor Nicholson Commons Extension 2574	If the Wellness Center is closed, contact Human Resources Mieras Hall, Top Floor Extension 2203 or 2240

AFTER HOURS & WEEKENDS:	IF INJURY IS SEVERE OR LIFE THREATENING:
Call Shelter Island Medical Group 1370 Rosecrans Street 619-223-2668 (On Call 24 hrs) *notify Human Resources the following work day x2203.	Contact Public Safety Extension 2525

***Please note, for any work related injury you must contact one of these parties immediately.

D. Assure the student's access to professional first-aid treatment.
E. Obtain information on the Agency's policy for Blood/Body/Fluid Exposure treatment.
F. Document events related to the incident. Relevant information that should be included (CDC, 1998a):
   1. date and time of exposure;
   2. details of the procedure being performed, including where and how the exposure occurred, and if the exposure was related to a sharp device, the type of device and how and when in the course of handling the device the exposure occurred;
   3. details of the exposure, including the type and amount of fluid or material and the severity of the exposure, (e.g., for a percutaneous exposure, depth of injury and whether fluid was injected; or for a skin or mucous-membrane exposure, the estimated volume of material and duration of contact and the condition of the skin [e.g., chapped, abraded, or intact]).
G. Initiate follow-up contact with Clinical Agency Health/Quality Assurance personnel within 72 hours.
H. **Urgent Care Protocol:** If there is a clinical agency policy in place for such an incident, adhere to it. Otherwise, if there isn't one, the School of Nursing procedure is to:
   a. Obtain consent from the source person to have blood withdrawn for testing purposes. If the source person refuses to consent to a lab draw, ***an emergency care physician must submit a report within 24 hours*** and provide an evaluation of the source person within 72 hours. Notify the source person's primary physician who ***must*** respond to the urgent care agency/ED, or to the exposed person's primary physician within three weeks. If the source person refuses to consent to a blood draw, any blood that has been drawn for a diagnostic study can be used (if available). Urgent Care/ED personnel are to notify the person who has been exposed as soon as possible of the test results as to whether or not the source person is positive for HIV. *Note*: the CDC recommends an FDA approved test kit that can be used in a situation where enzyme immunoassy (EIA) for HIV, cannot be completed within 24-48 hours.
   b. Obtain consent from the exposed person to have blood drawn for baseline information.
   c. Obtain a history of incident and a report of the examination of exposed areas of the exposed person.
   d. Provide counseling and options of prophylactic procedures to the exposed person.
   e. Obtain follow-up information about the blood/body fluids of the source person from the Employee Health/Quality Assurance Personnel, and the attending physician.

IV. **Treatment** - The recommended procedure for:

A. **Hepatitis B**
   1. Immune Globulin (0.06 ml/kg) within 24 hours if the exposed person has not completed the vaccination series, then follow the accelerated schedule for Hep B vaccine.
   2. If the person has not been vaccinated, give Hep B on an accelerated schedule starting immediately, followed in one, and two months later. Check blood titers one month after 3rd dose of vaccine. Give a booster shot in 12 months.

B. **Hepatitis C**
   1. Draw serum. Give HCV Ab now, then at 3, 6, 12 months.
   2. Refer the exposed person to their primary physician if serum is positive.

C. **HIV** (Clinical Agency)
   1. Determine the extent of the exposure, in conjunction with the CDC guidelines (CDC, 1998b). Follow-up care should be in conjunction with the CDC guidelines for management of exposures for postexposure prophylaxis (CDC, 1998b).
   2. In the event that treatment is required:
   3. Provide and document counseling for the exposed person.
   4. Testing for HIV for the exposed person is as follows: baseline, six weeks, three, six, and twelve months post exposure.
   5. ***Treatment should be given within 1-2 hours of exposure***. Alert the exposed person to the possible side effect from the drugs.
   6. A prescription of at least four days of antiretroviral medication should be provided to the exposed person.
   7. Document that the exposed person knows personal responsibility for follow-up care.
   8. Submit confidential report to OSHA.
   9. The recommended protocol should follow the most current Communicable Disease Control recommendations for prophylaxis. Current recommendations may be obtained through a free 24-hour hotline, through San Francisco General Hospital, San Francisco, CA (CDC, 1998c). The National Clinicians' Post Exposure Prophylaxis Hotline (PEPLine) is for clinicians in need of advice on how to best treat healthcare workers accidentally exposed to blood-borne disease **— 1-888-448-4911**

References:

Center for Disease Control. (2006). Updated Public health service guidelines for the management of health-care worker exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis, June 29, 2001. http://www.thebody.com/cdc/pdfs/rr5011.pdf

Center for Disease Control. (1998b). Public health service guidelines for the management of health-care worker exposures to HIV and recommendations for postexposure prophylaxis, figure 1, May 15, 1998. http://www.thebody.com/cdc/pep/figure1.html.

Center for Disease Control. (1998c). National hotline opens for advice on occupational HIV exposure prophylaxis, November 19, 1997. Http://www.thebody.com/cdc/pepline.html.