

The Robert T. White School of Practical Nursing (RTW)

CLINICAL MAP PAPERWORK GUIDELINES (CL 1000)

Students are expected to complete the forms according to their level of expertise and the course being taught at the time of each clinical experience.

Separate Clinical Map packages are prepared for the Adult client (form series 2000) and the OB-Pediatric client (form series 3000). Each package may be found at <http://accrtw.org/rtw>; *Student Services*.

The purpose of the Clinical Map paperwork package is to assist the student in molding together theory content with subjective/objective data collected during clinical experiences and meeting the course objectives. Although the Licensed Practical Nurse contributes data but does not develop the Plan of Care (POC), correlating the components of data collection with a diagram can assist the practical nursing student understand the relationship between client data and problems (recent and remote); prescribed medications, diagnostic testing, laboratory test results and medical treatment to the individual aspects/application of the associated nursing process. (Appropriate medical terminology/acronyms appropriate to the student's level of academia are to be used)

In order to best help evaluate students' understanding of the application of the nursing process, students are to ***paraphrase*** rationales and nursing interventions. While citation to text material is encouraged for reference and to help the student learn, students are ***not*** to copy-right material. For every client assigned, the student will complete 1 paperwork package in its entirety based on the 'Clinical Map Concept' (Form CL 2000/Adults and/or CL 3000/OB-Pediatrics) and the following guidelines. Evaluation of the student's work will be based on satisfactory or unsatisfactory evaluation as determined by the RTW Faculty/Instructional Personnel member supervising the student in the clinical area, and it is subject to review and recommendations by the Program Coordinator (PC) and/or their designee.

Students are to submit a 1 page journal ***directly*** to the individual delegated as responsible for the course and are ***not*** to be given to the clinical Instructor. Journals are to include the student name, date, clinical site and name of Instructor. Students are encouraged to share their feelings during each of their clinical experiences and identify each of their strengths and weakness and how the course content was applied. Additionally, students are encouraged to include any problems

and/or concerns that they may have regarding these experiences as journal content is considered confidential and **only** shared when necessary. Student journals are subject to review by the Program Coordinator.

For students completing a clinical rotation during weekdays, the package and journal will be due at the beginning of the class scheduled 2 days following the clinical experience. For students completing a clinical rotation on the weekends, the package and journal will be due at the beginning of class on the scheduled class day following the experience. Late or extraordinarily incomplete paperwork packages will merit an unsatisfactory.

For clinical experiences lasting less than 8 hours, the Clinical Map paperwork is to be prepared in a condensed form for the purpose of reference to be used during group post-conference conducted for each clinical experience. The condensed forms will be due at the end of the post-conference and a grade of satisfactory or unsatisfactory will be awarded based on the efforts and compliance of the student in meeting the clinical experience expectations. Student journals for these experiences will be due according to the pre-set schedule for Clinical Map paperwork packages as stated above.

Students assigned as Team Leaders in a clinical experience will not be required to complete a Clinical Map package but rather a Team Leader report (CL 5004). This exception is applicable **only** to second level students in LSP II and III. Team Leader are *not* to be assigned in first level courses and is not applicable to Preceptorship.

At no time nor under circumstance is any student permitted to leave the clinical area with copies of documentation deemed as property of the clinical site and/or in any way identifies the client.

CLINICAL MAP EVALUATION SHEET (CL 2010-Adults and/or CL 3010 – OB/ Pediatrics)

A condensed Evaluation Sheet is to be completed by the student and the Instructor jointly. The student will be responsible for completing the upper portion areas including; course identification, clinical date, site, Instructor name, student name/initials, client's initials and client's primary diagnosis. Reference to any client is to be limited to initials and age and is **not** to include medical identification numbers or any other means of identifying the client(s) to those not participating in their care. **At no time or under any conditions,** is client(s) confidentiality to be compromised.

Excerpts from course syllabi objectives are combined and generalized as applicable to the current course(s) of study; this includes objectives for Team Leading in second level courses. Students are encouraged to review the course objectives prior to clinical experiences.

Specific for OB-Pediatrics clinical rotations:

Excerpts of clinical objectives are taken specifically from the course syllabus. Students are to indicate if the client is the Mom, Neonate/Infant or Child.

The Instructor is expected to provide feedback to the student regarding their completion of the Clinical Map Package by entering comments in the appropriate area(s). After Instructor evaluation of the student's paperwork package, the Instructor is to forward the package to the Faculty/RTW personnel member delegated as responsible for the course no later the time-frame stipulated in the RTW Policy and Procedure Manual. The Course Delegate will review the Instructor comments throughout the package and may make additional comments that they feel necessary to enhance student learning. Course Delegates responsible for courses will then forward the package to the Program Coordinator for review *within 2 days of receipt. The Program Coordinator is to return the package to the Course Delegate who will be responsible for forwarding the package to the student.

Upon receipt of the package, the student is to review and then acknowledge reading the Instructor's evaluation feedback **only after** the clinical experience is completed and **only after** the evaluated clinical paperwork is returned to the student. Only, the signed evaluation sheet is to then be returned to the Course Delegate for placement in the student's course file.

CLINICAL MAP CLIENT DATA SHEET
(CL 2011-Adults and/or CL 3011; 12; 13 – OB/ Pediatrics)

The primary diagnosis is to be limited to 1 disorder and identified from the client's current medical chart. The student is then asked to provide a brief, but descriptive, definition of the diagnosis using their own words and **not** text book definitions. Students are **not** expected to take the definition to the cellular level but rather provide a more generalized characterization of the disease/disorder.

A client's medical-surgical (med-surg) history (hx) is to include **all** identified disease processes/disorders pertinent to the client. A descriptive definition of past med-surg hx is **not** to be included.

Should a client not be subject to any allergic reaction(s), the student is to mark NKA (no known allergies) 1 time in the section. However, should a client actually be subject to allergic reaction(s), the causative substance and the associated reaction are to be recorded. If after checking the chart/asking the client or their significant others no information can be obtained as to a reaction, the student is to record "unable to verify" and provide a brief explanation.

Listing of **ALL** current medications is to include reported medications taken at home as well those prescribed while currently being treated. Routes/frequency etc. are **not** to be recorded in this section. The trade name or generic name of the medication may be used independently of

each other in this section; student may list one or the other and is not required to use both in this section.

Specific to 3010- OB /Pediatric client(s)

“Resources needed”, the student is to investigate if the Primary Care Provider (PCP) has prescribed referrals to outside resources. The type of the resource may be generalized or listed by name. e.g. financial or “Family Services”. Should a student identify a need for referrals but find that none has been prescribed, the student should complete this section and discuss the issue with their clinical Instructor; clinical site staff is to be advised.

CLINICAL MAP NURSING INTERVENTIONS SHEET (CL 2012-Adults and/or CL 3014 – OB/ Pediatrics)

Prior to the completion of the course content regarding Communication, Documentation and Nursing Process presented in 101- Foundations of Nursing Theory and Practice; first level students may elect to complete this sheet but **will not** be evaluated as satisfactory or unsatisfactory for their efforts. Instructors are to review the student's efforts and provide feedback, but are **not** to consider the work as part of their evaluation of the package. **Only** after completion of the course subject as stated above, will students be expected to complete this sheet for evaluation by the Instructor.

After the data collection process is completed for a client, the student is to consider and apply the 3 remaining steps of the Nursing Process by identifying Nursing Diagnosis and associated nursing interventions and evaluations, according to client(s) priority needs. Three areas of specific client needs, psychosocial, safety and reinforced teaching, have been pre-determined in order to assist the student in becoming familiar with addressing the holistic needs of those assigned to their care. The student is to select 2 additional Nursing Diagnoses for the Adult and 1 for the OB/Pediatric client using independent thinking. The 3 pre-determined needs are **not** to be duplicated for either type of client.

Requirements for completion of this sheet are;

- list 6 Adult and 4 OB-Pediatric Nursing Diagnoses (Nrsg Dx) in stated NANDA (North American Nursing Diagnosis Association) terminology.
- identify the source(s) used in the data collection process (subjective/objective) to determine applicable Nrsg Dx.
- list priority needs as a Nrsg. Dx. including the related to r/t component followed by the/a relative cause which creates the need.
- identify specific nursing interventions appropriate for implementation in addressing the client need shown in the Nrs. Dx.(remember: nursing interventions are actions taken by a nurse that are not prescribed/or that need to be prescribed by a PCP).

- identify the rationale *specific to the nursing intervention*. (*why* the nurse should initiate an intervention/action).
- evaluate the *nursing interventions* implemented by the nurse. Evaluation is to be measurable and based on actual findings which may or may not indicate that the actions of the nurse were successful. Measurable is meant as something that is can be quantifiable through demonstration, description or detection.

CLINICAL MAP MEDICATION SHEET
(CL 2013-Adults and/or CL 3015 – OB/ Pediatrics)

Prior to completion of 102 - Pharmacology in Nursing, students may complete this portion but **will not** be evaluated as satisfactory or unsatisfactory for their efforts. Instructors are to review the student's efforts and provide feedback, but are **not** to consider the work as part of their evaluation of the package. **Only** after completion of the course subject as stated above, will students be expected to complete this sheet for grading evaluation by the Instructor.

Requirements for completion of this sheet are;

- select 4 **major** medications for each client with 1 additional medication prescribed on an as needed (prn) basis **only** for the Adult; this does not include the “OB Mom”. Medications should include those that are **especially important** for the client based on primary diagnosis and/or med-surg history.
- select **only** medications as shown on the Client Map Data Sheet. Medications listed here are to be shown using ‘trade’ and ‘generic’ name.
- reference the medication by classification. Classification means just that, the pharmacological classification assigned to of medication as determined by the pharmaceutical industry.
- use approved medical terminology/acronyms when listing dose, frequency and/or route.
- identify the intended actions of the medication; the reason it is prescribed as related to (r/t) the client’s primary diagnosis and/or med-surg history.
- list nursing interventions appropriate for a client receiving this particular medication/classification of medication. **Note: “give medication as ordered” is not acceptable as a nursing intervention.**
- provide the rationale for the specific nursing intervention identified as appropriate. The rationale is to be directed to the nursing intervention and **not** the medication itself.

CLINICAL MAP Prescribed/Expected DIAGNOSTIC TESTS/PROCEDURES SHEET
(CL 2014-Adults and/or CL 3016 – OB/ Pediatrics)

Requirements for completion of this sheet are;

- list a minimum of 4 diagnostic tests or procedures that have been prescribed by the PCP and rationales *related to the client's primary diagnosis/med-surg history*; why were they prescribed.
- list appropriate nursing *interventions* and associated *rationales specific to nursing care* of the client(s) under-going these tests/procedures.

Should diagnostic tests/procedures not be prescribed for the client, the student is to list a minimum of 2 diagnostic tests/procedures that would be applicable and ones they might *expect* the PCP to prescribe (R χ). The rationale for the expected R χ would continue to be the student's concept as to *why* a test/procedure would be appropriate for *the client*.

CLINICAL MAP Prescribed/Expected TREATMENTS SHEET
(CL 2015-Adults and/or CL 3017 – OB/ Pediatrics)

Requirements for completion of this sheet are;

- list a minimum of 4 treatments that have been prescribed by the PCP and rationales *related to the client's primary diagnosis/med-surg history*; why were they prescribed.
- list appropriate nursing *interventions* and associated *rationales specific to nursing care* of the client(s) under-going these treatments.

Should treatments not be prescribed for the client, the student is to list a minimum of 2 treatments that would be applicable and ones they might *expect* the PCP to prescribe (R χ). The rationale for the expected R χ would continue to be the student's concept as to *why* a treatment would be appropriate for *the client*.

CLINICAL MAP Prescribed/Expected LABORATORY DATA SHEET
(CL 2016-Adults and/or CL 3018 – OB/ Pediatrics)

Prior to the completion of the course content regarding Laboratory Diagnostic Testing presented in 200-Nursing Care of Patients Throughout the Life Span II, first level students may complete this portion but *will not* be evaluated as satisfactory or unsatisfactory for their efforts. Instructors are to review the student's efforts and provide feedback, but are *not* to consider the work as part of their grading evaluation of the package. *Only* after completion of the course subject as stated above, will students be expected to complete this sheet for grading evaluation by the Instructor.

Requirements for completion of this sheet are;

- review the client's chart for recent laboratory tests prescribed noting the acceptable range for each according to clinical site parameters as well as the client's resulting value in a minimum of 4 **significant** laboratory tests.
- provide a simple but appropriate rationale for the PCP's Rx according to the client's primary diagnosis, med-surg history and/or clinical presentation. Simple rationale may include, but is not limited to, a disease process, medication or procedure: e.g. diabetes mellitus (DM), on Coumadin therapy, or recent gallbladder surgery. When a student records a rationale that is referenced by a diagnosed disease or disorder, that disease or disorder should be **listed** on the Client Data sheet.
- address the laboratory tests shown on the form. The student may report a value not listed but **only** if that laboratory result is **exceptionally abnormal and seriously comprises** the client. The blank spaces provided may be used under these circumstances.

Should laboratory testing not be prescribed for the client, the student is to list a minimum of 4 laboratory tests that would be applicable and ones they might **expect** the PCP to prescribe.

Specific to 3018- OB /Pediatric client(s)

For all pediatric clients the student is to identify and address the last 3 laboratory tests; stool, sputum and PKU.

CLINICAL MAP NARRATIVE CHARTING SHEET (CL 2017-Adults and/or CL 3019 – OB/ Pediatrics)

Under NO circumstances is any first level student to enter a narrative and/or narrative note in a client's chart without the explicit approval directly from the Clinical Instructor. All entries are to be in strict compliance with state/federal laws and the facility's' policies and procedures.

Second level student may ONLY enter the 1 line narrative entry without the approval of the Team Leader and/or Instructor. All other entries must be pre-approved.

Each narrative entry is to be timed, using military time, dated and signed appropriately by the student. Signature is to be written as: first initial, last name followed by RTW SPN. Should an entry not use the space provide on an entire line, the end of the entry is to be separated from the signature by a drawn line. A drawn line is **not** to follow a student's signature. A **minimum** of 3 entries are to be recorded per 8 hour clinical experience.

While students are **highly** encouraged to prepare their own narratives, **limited** suggestions may be requested from team members/Team Leaders and/or Instructor. Finalized narratives are to be written in accordance to Team Leader/Instructor suggested revisions. **All** drafts and/or finalized

narratives are to be written on the form provided; separate or loose sheets of paper will **not** be accepted.

Any time client care is provided, a complete foci assessment narrative entry should be documented. This includes but is not limited to dressing changes; administering pain medication. The action, findings, client tolerance and results are to be documented. E.g. Client ambulated to the bathroom with assist; Were they steady? Did they use any assistive devices? How many needed to assist? Voided § difficulty? All needs addressed in documentation.

The data collected is to be recorded in a condensed yet comprehensive, logical and sequential (systematic) order; head-to-toe, addressing **all** body systems paying particular attention to the client's primary diagnosis, presenting clinical condition and any medical devices/appliances in place. E.g. indwelling urinary catheters, dressing, and colostomies.

Requirements for completion of this sheet are;

- record a 1 line entry at the beginning of a shift indicating that the student has seen the client and that the client is safe and not in distress requiring immediate attention.
- **independently** prepare an early shift narrative draft for review by the clinical Instructor and/or the *Team Leader, if applicable, which is to include all subjective and objective information obtained in the head-to-toe data collection process; psychological and physical aspects, client safety and re-enforcement of education needs are to be included.

*For second level students functioning under the direction of an adjunct Team Leader (a student who assists the Instructor but has no authoritative responsibility), the student is to present the narrative draft for review at a minimum 2 hours into the shift to the Team Leader. The Team Leader will independently review the narrative noting suggestions, discuss the suggestions with the Instructor and then present their comments to the student individually. The student will then prepare a re-written narrative accordingly, without improvisation.

- make all necessary narrative corrections appropriately, use correct spelling, avoid unnecessary adjectives, and insert appropriate punctuation in and between body systems.
- use approved medical terminology and/or abbreviations. Approved abbreviations may be subject to facility rules and regulations.
- indicate late/out of time sequence entries by circling the time or as stipulated by the facility.
- record a focus assessment entry before ending the shift or leaving the clinical area.

Any time there is a change in a client's condition and/or new clinical manifestation presents, the student is required to immediately report and then document their findings to the Instructor, the Team Leader if applicable and the staff nurse covering that client. There are to be no exceptions.

Students are asked to keep in mind that various Instructors were trained differently in relation to narrative documentation and that various facilities have different narrative formats. However for consistency, students and Instructors are asked to follow directions given during presentation of Communication and Documentation lecture in 101- Foundations of Nursing Theory and Practice and presentation of Clinical Maps review for each class which Instructors are encouraged to attend.

CL 1000

dln 11/11 (Curr appr)