Student Name: Group: AM PM Unit: CICU MICU SICU ED Week: 2 3 5 6 7 Faculty: Kineman Ponder Smith Spradling Leavell	INSTRUCTIONS: 1. You will complete the daily clinical packet for each assigned patient. All areas must be addressed. 2. Packets will be turned in to your faculty at the end of each clinical day. 3. Packets that are not complete may result in Unsatisfactory Clinical Evaluations and may require further action. 4. Hourly documentation is required for the Shift Nursing Care and the Narrative Notes.

IM 7 Clinical Judgment Patient Packet

Rev 6/2024 DS

RECOGNIZING CUES DAY 1
Identify relevant and important information from different sources.

Diagnosis/Current Problem:	Code Status: Full DNR	Daily Weight
	Diet	I/O 24 hours
Medical History (Allergies):	Activity (Fall Risk/Safety)	
	O2 Therapy (Type and current FiO2)	
Patient Story: What happened and why is the patient here?	IV Site(s) (Dates placed and dressing changed)	
	Tubes (Drains, urinary or bowel catheters)	
	Therapies: RT/OT/PT(What are the recommendations?)	
PRIORITY Body System/Concept to Assess:		

Explain the pathophysiology of your patient's current problem in your own words. Describe the concept associated with the pathophysiology.

Pathophysiology of current problem	Concept and what you expect to see

Abnormal Applicable Lab Tests	Current Lab	Why is it high or low? What is the clinical significance of this?

ANALYZING CUES DAY 1
Organize and link the recognized cues to the patient's clinical presentation.

Question	What/why is this happening?	What is the worst possible outcome?
Do you see any trends in the patient's vital signs or lab values?		
What clinical data/assessments are needed to identify complications early?		
What nursing intervention(s) can prevent them from developing?		
If a complication develops, what nursing intervention(s) will be implemented?		

GENERATING SOLUTIONS DAY 1
Identifying expected outcomes and defining a set of interventions for the expected outcomes.

1. Prioritization: List the priority assessment findings you have collected based on the patient condition.

Most important assessment findings	What is the clinical significance?

2. Medical Management of Care: Identify 3 (three) orders related to the patient condition, rationale, and expected outcome.

Provider Order	Why is this ordered?	Expected Outcome
1.	1.	1.
2.	2.	2.
3.	3.	3.

3. Nursing Management of Care: Identify 3 (three) priority nursing goals (related to your primary body system/concept) for your shift that will help your patient, and the rationale and expected outcome for each intervention.

Priority Goal/Outcome:

What do you want to do (interventions)?	Why should this be done?	How will you know it was effective?
1.	1.	1.
2.	2.	2.
3.	3.	3.

Circle which nursing intervention(s) could be delegated to an unlicensed assistive personnel (UAP).
What should the RN monitor when delegating these interventions to a UAP?

4. Patient Centered Care: Psychosocial and Holistic Care: Answer the following questions.

What is the patient and/or family likely experiencing or feeling during this medical situation?	
How can you engage with the patient's/family's current experience and show compassion towards them?	
Identify the patients religious/cultural values or beliefs system. Explain how you would incorporate this into the nursing plan of care.	
List appropriate interventions or referrals for your patient/family related to their psychosocial needs at this time.	

5. Teaching Priorities & Discharge Teaching: Identify 2 (two) priority teaching topics related to the patients nursing interventions, and 1 (one) discharge topic, along with the rationale and the teaching style.

Education topics	Why is this relevant?	How will you present/teach the material?
1.	1.	1.
2.	2.	2.
DISCHARGE TEACHING 1.	DISCHARGE TEACHING 1.	DISCHARGE TEACHING 1.

Summarize the discharge or transfer plan from each of the departments for this patient. What is their recommendations and/or plan?		
Case Management	Physical, Occupational, Speech Therapy	Palliative Medicine or OTHER: _____
Is your patient stable enough to meet the discharge or transfer recommendations? If not, what needs to be done to get your patient stable enough?		

TAKE ACTION DAY 1

Performing the solution(s) that address the highest priorities (interventions, medications)

PHARMACOLOGY

List each medication (scheduled and PRNs given within 12 hours) that align with the primary body system/concept.

Time Due	Medication Name & Dose	Pharm Class	How does this work?	Side Effects	Nursing management

Identify and summarize 1 (one) Covenant nursing policy related to your nursing interventions. Explain how the policy aligns with evidence-based practice.		
Nursing Policy	Summary	EBP - Identify what the recommended guideline is?

Identify and summarize 1 (one) Covenant nursing policy related to one of the medications you identified. Explain how the policy aligns with evidence-based practice.		
Nursing Policy	Summary	EBP - Identify what the recommended guideline is?

Shift Nursing Care DAY 1	0700 1400	0800 1500	0900 1600	1000 1700	1100 1800	1200 1900	1300 2000	NOTES
Hourly Rounding Done (initial)								
Oral Care								
Repositioned (L, R, C)								
Assessment (Every 4 hours)								
Full Assessment Completed								
Neuro (LOC)								
Glasgow Coma Scale								
Edema								
Pulse Strength								
Braden Score								
Vital Signs								
Blood Pressure								
MAP								
Heart Rate								
Respiratory Rate								
O2 Saturations (SaO2)								
Temperature								
Pain (Verbal or Non-Verbal)								
Oxygen Delivery:								
FiO2								
Ventilator								
FiO2								
Setting AC SIMV PSV								
Rate								
Peep								
RAAS Score								
Medication Titrations - Current milligram or microgram receiving								
Sedative:								
Vasoconstrictor:								
Other:								
Intake								Shift Totals
Oral Intake								Total Intake:
Tube Feeding: Type:								Total Output:
IV (total all IVs)								End of Shift balance:
Flushes (Oral and IV)								
Other:								Does your patient have a positive or negative balance? What does this mean?
Output								
Foley (amount & color of urine)								
Chest tube (amount & drainage color)								
Other Drains:								
BM (Bristol Stool Chart)								
Other output: (emesis)								

ADDITIONAL TOOLS YOU MAY NEED

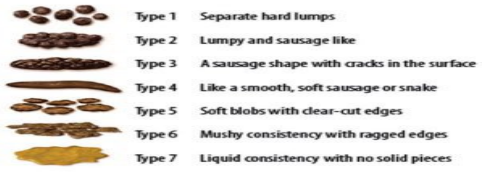
PHYSICAL ASSESSMENT
Each area must be addressed daily in narrative notes

General Info (time, why admitted, gen appearance)
Neurological-sensory (LOC, sensation, strength, coordination, speech, pupil assessment)
Cardiovascular (rhythm, rate, pulses, edema, heart sounds)
Respiratory (rhythm, rate, O2 sat, chest symmetry, breath sounds, signs of hypoxia, type of oxygen device present and patient response)
Comfort level (pain rating, location, how long)
Psychological/Social (affect, interaction with family, staff)
Gastrointestinal (last BM, appearance of abdomen, bowel sounds, reaction to palpation, soft/rigid, catheters or drains present, Bristol stool type, if observed)
Genitourinary-Reproductive (frequency, urgency, continence, color, clarity, odor, vaginal discharge, catheters/drains present)
Musculoskeletal (posture, hand grasp, toe wiggle, range of motion, mobility, deformities, gait)
Skin (color, temp, turgor, integrity)
Additional wounds, dressings, additional drains, all IV sites (location, output or drainage, site description, dressing soiled or clean, date of dressings)

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

SENSORY PERCEPTION	1. Completely limited	2. Very limited	3. Slightly limited	4. No impairment	
MOISTURE	1. Constantly moist	2. Very moist	3. Occasionally moist	4. Rarely moist	
ACTIVITY	1. Bedfast	2. Chairfast	3. Walks occasionally	4. Walks frequently	
MOBILITY	1. Completely immobile	2. Very limited	3. Slightly limited	4. No limitation	
NUTRITION	1. Very poor (NPO)	2. Probably inadequate	3. Adequate (Tube feed)	4. Excellent	
FRICTION & SHEAR	1. Problem (max assist)	2. Potential problem (min assist)	3. No apparent Problem		
SEVERE RISK 6-9	HIGH RISK 10-12	MODERATE 13-14	MILD RISK 15-18	NO RISK 19-23	TOTAL SCORE

BRISTOL STOOL



Nonverbal Pain Scale

FACIAL
0 = No grimace
1 = Occasional grimace
2 = Frequent grimace

ACTIVITY
0 = Still, normal position
1 = Increased movement
2 = Restless or withdrawing

GUARDING
0 = Still, normal position
1 = Tense
2 = Rigid, stiff

VITAL SIGNS
0 = Baseline
1 = SBP > 20 or HR > 20 from baseline
2 = SBP >30 or HR >25 from baseline

RESPIRATORY
0 = Baseline
1 = RR >10 over baseline
2 = RR >20 over baseline

Richmond Agitation Sedation Scale (RAAS)

4+ Combative - violent; danger to self/staff
3+ Very agitated - pulls lines/tubes, aggressive
2+ Agitated - frequent movement, fights vent
1+ Restless - anxious movement but not vigorous
0 Alert and calm
1- Drowsy - arousable to voice <10 seconds
2- Light sedation -eye contact to voice >10 sec
3- Moderate sedation - movement to voice
4- Deep sedation -response to painful stimuli only
5- Unarousable - no response to any stimuli

Narrative Notes DAY 1

You will document your full assessment, any changes in your patient and what you/nurse did,
any skills/tasks you performed, hourly patient updates, and who you reported the end of shift report to.
Use medical terminology for your documentation.
Date, time (military) and sign (credentials SN CSON) each time you document.
If you need additional narrative paper, ask the unit secretary for a narrative note (dark yellow/orange colored sheet)

Example: 8/12/24 0830 Report received from J.Doe RN. Assumed care of patient. A.Student, SN CSON ----------

EVALUATION DAY 1
Comparing observed outcomes against expected outcomes.

After implementing and performing your nursing management plan of care, review and interpret the clinical data at the end of your shift to determine if your patient's condition has improved, not changed, or declined.

Priority Data	Improved	No Change	Decline	What would you change or implement at this time?

Has your patient's overall status made an improvement, declined, or remained unchanged during your shift?
What other interventions must be considered by the nurse at this time to continue to help the patient improve?

Status of patient	
Additional Interventions	
Rationale for additional interventions	

END-OF-SHIFT SBAR DAY 1
AM students will give SBAR change of shift report to PM students
PM students will report to faculty

SITUATION

Initials/age/sex (give info verbally):
Date admitted:
Admitted from (home, nursing home, assisted living):
Code status:
Physician (attending):

BACKGROUND

Admitting diagnosis/Primary problem:

Date of surgery (if applicable):

Pertinent past medical history:

ASSESSMENT

Code status:

Abnormal V/S:

IV Site (lock/fluids/drips/when to change IV site):

Procedures done in the last 24 hours:

Abnormal assessments:

Current pain score: What has been done to manage this pain:

Safety needs/fall risk/skin risk:

RECOMMENDATION

Needed changes in the plan of care? (diet, activity, medications, consults)

What are you concerned about?

Discharge plans:

Pending labs/x-rays:

What does the next shift need to be aware of?

POST CLINICAL REFLECTION DAY 1

This exercise strengthens your clinical judgment skills.

Reflect on your clinical day and the decisions you made caring for this patient by answering the questions below.

Day 1 Reflection Questions	Student Nurse Reflection
What feelings did you experience in clinical today? Why?	
What did you already know and do well as you provided patient care today?	
What areas do you need to develop or improve?	
What did you learn today?	
How will you apply what was learned to improve your patient care?	

Day 2 Instructions:
- Review the chart for any changes and be prepared to receive report so you can ask questions for clarification, if needed.
- After reviewing the chart, answer and document all clinical packet items for day 2.
- Your completed clinical packet is due to your faculty by the end of today.
- Clinical packets that are not complete may result in an Unsatisfactory Clinical Evaluation and may require further action.

RECOGNIZING & ANALYZING CUES DAY 2

Identify relevant and important information from different sources. Organize and link the recognized cues to the patient's clinical

Updates on patient condition since last shift.

Abnormal Applicable Lab Tests	Current Lab	What is the clinical significance?

GENERATING SOLUTIONS DAY 2

Identifying expected outcomes and defining a set of interventions for the expected outcomes.

Day 2 Medical Management of Care: Identify new orders related to the patient current condition and provide the rationale, and expected outcome.

Provider Order	Rationale	Expected Outcome
1.	1.	1.
2.	2.	2.
3.	3.	3.

Day 2 Nursing Management of Care: Identify the priority nursing goal for your shift, 3 priority interventions that will help your patient meet the goal, and provide your rationale and expected outcome for each intervention.

Priority Goal/Outcome:

What do you want to do (interventions)?	Why should this be done?	How will you know it was effective?
1.	1.	1.
2.	2.	2.
3.	3.	3.

Circle which nursing intervention(s) could be delegated to an unlicensed assistive personnel (UAP).
What should the RN monitor when delegating these interventions to a UAP?

Day 2 Teaching Priorities & Discharge Teaching: Identify two priority teaching topics related to the patients nursing interventions, and one discharge topic, explain why you included this, and how you will teach the patient/family.

Education topics	Rationale	Teaching/Presentation style
1.	1.	1.
2.	2.	2.
DISCHARGE TEACHING 1.	DISCHARGE TEACHING 1.	DISCHARGE TEACHING 1.

Summarize any changes in the plan for discharge or transfer from each of the departments for this patient. Has the timeline changed?		
Case Management	Physical, Occupational, Speech Therapy	Palliative Medicine or OTHER: _____
Has there been any significant changes in your patient's condition that changed the recommendations? What is the estimated timeline for the patient to transfer or discharge?		

TAKE ACTION DAY 2

Performing the solution(s) that address the highest priorities (interventions, medications)

PHARMACOLOGY

Is your patient on the same medications as yesterday? Yes No

DISCONTINUED MEDICATIONS: List the name and the rationale for discontinuing the medication.

Name		Rationale	
Name		Rationale	
Name		Rationale	
Name		Rationale	
Name		Rationale	

NEW MEDICATIONS: List each new medication related to your primary body system/concept.

Time Due	Medication Name & Dose	Pharm Class	How does this work?	Side Effects	Nursing management

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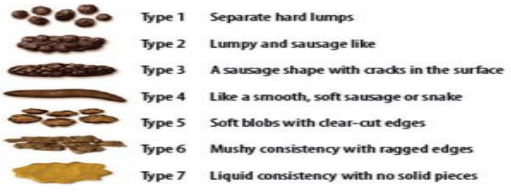

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What areas do you need to develop or improve?	
What did you learn today?	
How will you apply what was learned to improve your patient care?	