CSON Module 1 NCLEX Test Plan

Post Clinical Discussion Prompts

Pre-Clinical: Bring a watch, stethoscope, pen light, hospital vital signs sheet, physical assessment check off sheet, documentation with check sheet, narrative documentation form, history and physical form, pen, a clipboard or folder to keep papers, and an Excellent Attitude. It is best to eat before coming to clinical so you don't feel weak.

You are not *just* a student. You are a valuable member of the interdisciplinary healthcare team and what you say and do matters to your patients. Take pride in your efforts and make the most of each opportunity to learn and serve.

Week 4 Clinical Goals: (Medication Administration Observation)

1. Demonstrate effective communication and professionalism while providing patient care.
2. *Bring any issue to instructor immediately to be addressed in real time.*
3. **Med Admin Observation** – Your primary goal this week is to observe medication administration. **You may NOT give any medications** or participate in the medication preparation process.
4. After listening to report, get 0700 vital signs and report to aide/nurse for documentation. We will take 1100 vitals and report those before lunch. **Be sure to report any vital sign measurement outside of normal ranges immediately to the nurse. If you cannot find the nurse, report to your instructor.**
5. Medication debrief – Please bring a blank medication work up sheet. You will write up two of the medications you observe a nurse administer during med pass. You may not write up the same medications as your partner. Your instructor will review/discuss your medication write up with you.
6. Partner check-off physical assessment – you and your partner will each do a head-to-toe assessment on a patient and check each other off.
7. Perform blood glucose checks (AccuCheks) starting at 1045. **Be sure to report blood glucose values to nurses quickly. If you get a low or high blood glucose (less than 70 mg/dL or greater than 300 mg/dL let your nurse know immediately).**
8. Answer call lights. If you cannot help the patient yourself, find someone who can.
9. Once the above expectations are met, help with activities of daily living. However, if a patient needs immediate assistance, do not ignore their need for the sake of med observation.
   Ex: A patient needs help to the bedside commode. Please help. Once they are safely back in bed/chair, catch back up with your nurse.
10. "If you have time to *lean*, you have time to *clean*"
    *Trash, linens, trays, answer call lights, toileting, ambulation etc.
11. Observe and prepare to speak in post-clinical about patient education experiences you observed. What went well during the education interaction? What did not go well? What barriers to learning were present?
12. Observe for skin breakdown/risk for skin breakdown in each patient interaction. Complete a Braden Scale for one patient. Be prepared to discuss these observations in post-clinical.

*Note – do not give food or water to patients until a member of the healthcare team has confirmed the patient is not NPO. Report all vital signs measurements to nurse or CNA for documentation.

Post Clinical Discussion Prompts

Module 1 students will not give any medications in the inpatient setting.

Documentation that is Required in EHR Tutor before Friday at 2359: (documentation can begin in the clinical setting if ALL of the above are completed)

- **Head-to-toe assessment findings**
- **0800 and 1200 vital signs**
- **Intake and Output**
- **Patient Care (bathing, linen changes, etc.)**
- **Patient Health History (refer to the form on LMS to find information needed)**
- **Physical Assessment Narrative (chart in the notes section and follow the format from the template posted on LMS)**
- **Braden Scale**
- **SBAR to oncoming nurse**

Week 4: Post Clinical Discussion: ***Be prepared to share Plus/Delta and information on numbers 9-10 above during post-clinical discussion. Then select examples from Pharmacological and Parenteral Therapies, and Basic Care and Comfort listed below.***

Look at the elements below and think about observed examples of one or more during the clinical day.

Pharmacological and Parenteral Therapies

Providing care related to the administration of medications and parenteral therapies.

- Perform calculations needed for medication administration
- Evaluate client response to medication
- Educate client about medications
- Prepare and administer medications using rights of medication administration
- Review pertinent data prior to medication administration (e.g., contraindications, lab results, allergies, potential interactions)
- Participate in medication reconciliation process
- Titrate dosage of medication based on assessment and ordered parameters
- Dispose of medications safely
- Handle and maintain medication in a safe and controlled environment
- Evaluate appropriateness and accuracy of medication order for client
- Handle and administer high-risk medications safely
- Administer medications for pain management
- Handle and administer controlled substances within regulatory guidelines

Basic Care and Comfort

Post Clinical Discussion Prompts

Providing comfort and assistance in the performance of activities of daily living.

- Assist client to compensate for a physical or sensory impairment (e.g., assistive
- devices, positioning)
- Assess and manage client with an alteration in bowel and bladder elimination
- Perform irrigations (e.g., of bladder, ear, eye)
- Perform skin assessment and implement measures to maintain skin integrity
- Apply, maintain, or remove orthopedic devices
- Implement measures to promote circulation (e.g., active or passive range of motion, positioning and mobilization)
- Assess client for pain and intervene as appropriate
- Recognize complementary therapies and identify potential benefits and contraindications (e.g., aromatherapy, acupressure, supplements)
- Provide non-pharmacological comfort measures
- Evaluate the client's nutritional status and intervene as needed
- Provide client nutrition through tube feedings
- Evaluate client intake and output and intervene as needed
- Assess client performance of activities of daily living and assist when needed
- Perform post-mortem care
- Assess client sleep/rest pattern and intervene as needed