Clinical Goals/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 2 Clinical Goals: (Head-to-Toe Assessment/Clinical Bingo)

1. Demonstrate effective communication and professionalism while providing patient care. Be respectful to all staff members.
2. *Bring any issue to instructor immediately to be addressed in real time.*
3. **Perform head-to-toe assessment using minimum prompts from observing instructor**. (Please review head-to-toe assessment thoroughly in preparation for clinical this week.)
4. **Clinical Bingo Students** – Review Clinical Bingo (Under Clinical Resources) prior to clinical attendance (no need to print). Your instructor will give you an individual card to use for the day. As you provide care throughout the day, attempt to mark off as many items as possible. (Please use a dry erase marker on the laminated cards.) *Practice a head-to-toe assessment with your partner so you will be able to document in EHR Tutor.*
5. Continue to assist with vital signs, both manual BP and using BP machines, on other patients as needed by healthcare team(0800 and 1100). **Be sure to report any vital sign measurement outside of normal ranges to the nurse. If you cannot find the nurse, report measurements outside of normal limits to your instructor.**
6. 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).**
7. Assist with as many activities of daily living as possible. Activities of daily living include assistance with bathing, showering, brushing teeth, hair care, assisting with meals, assist with ambulation, emptying trash, straightening up rooms, refilling water pitchers, measuring intake and output, emptying urine collection devices and reporting output to the nurse/nurse aide for documentation. *While doing any of the above, if you note abnormal findings, you need to report it to the nurse or your instructor. Ex: After 5 hours on shift, patient has only 100 mL of dark brown urine in catheter bag.
8. Answer call lights. You may not know how to address the patient's need, but you can find someone who does. (Instructor, nurse, nurse aide, PCT)
9. "If you have time to *lean*, you have time to *clean*"
    - Trash, linens, trays, answer call lights, toileting, ambulation etc.
10. Seek out one patient on oxygen therapy. Note the oxygen device in use, flow rate of the oxygen, and any assessment data associated with the use of oxygen (respiratory rate, depth of respirations, oxygen saturation). Be prepared to discuss this observation in post-clinical conference.

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11. Observe the diet ordered for one of your patients. The ordered diet is commonly listed on a slip of paper on the patient's meal tray. What percentage of the meal did the patient eat? Did you note any assessment parameters related to diet? Be prepared to discuss this observation in post-clinical conference.
12. Throughout care make efforts to think of how care affects patient outcomes (i.e. how well is your patient progressing toward recovery?). As you perform baths, assist with ambulation, and speak with patients consider aspects of physical assessment. What is the patient's mental status, emotional status, nutritional status? What needs do you feel are priorities for each patient you see?

*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.

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)**
- **SBAR to oncoming nurse**

Be prepared to share Plus/Delta and Information on Numbers 7-9 above during Post-Clinical Discussion. Then select examples from Safety and Infection Control listed below.

Week 2: Post Clinical Discussion

Look at the elements below and think about if you observed an example of one or more during the clinical day.

Safety and Infection Control

Protecting clients and health care personnel from health and environmental hazards.

- Assess client for allergies and intervene as needed
- Assess client care environment
- Promote staff safety
- Protect client from injury
- Properly identify client when providing care

Clinical Goals/Post Clinical Discussion Prompts

- Use ergonomic principles when providing care
- Educate client on safety issues
- Facilitate appropriate and safe use of equipment
- Follow security plan and procedures (e.g., newborn security, violence, controlled access)
- Apply principles of infection prevention (e.g., hand hygiene, aseptic technique, isolation, sterile technique, universal/standard enhanced barrier precautions)
- Educate client and staff regarding infection prevention measures
- Follow requirements when using restraints