

**Texas Concept-Based Curriculum
Ranger College AASN Program
RNSG 1161
LVN Bridge Transition Clinical
Fall 2017**

SEMESTER HOURS	1
CONTACT HOURS	LAB: 1
PREREQUISITES:	
COREQUISITES:	RNSG 1324, 1128, 1118, BIOL 2402

FACULTY INFORMATION

Vicki Calfa MSN, RN, PCCN
Office Address:
3201 Coggin Avenue Brownwood, TX 76801
Office Hours: Wednesday and Thursday
(email for appointment)
E-mail: vcalfa@rangercollege.edu

COURSE SCHEDULE

Lecture days: Monday
Lecture times: 3:00 to 3:50
Clinical Times: As assigned
Location: Early Campus

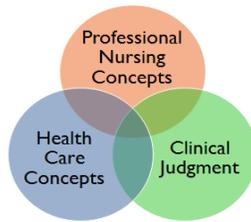
I. Texas Core Curriculum Statement of Purpose

Through the Texas Core Curriculum, students will gain a foundation of knowledge of human cultures and the physical and natural world, develop principles of personal and social responsibility for living in a diverse world, and advance intellectual and practical skills that are essential for all learning.

II. Course Description

A health-related work-based learning experience that enabled the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional. Nursing process is utilized in the care of individuals in acute and transitional care settings. Focus is on health promotion/disease prevention, basic pharmacological concepts, caring, ethical/legal aspects, and decision-making. Emphasis is on beginning assessment, psychomotor; and communication skills. Content includes applicable competencies in basic workplace skills.

III. Required Background or Prerequisites



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Students must meet all admission criteria for the nursing program. All corequisite courses must be completed with a C or better in order to progress. Must maintain current LVN licensure. Students must be concurrently enrolled or have previously completed: RNSG 1128, RNSG 1324, RNSG 1118.

IV. REQUIRED TEXTS AND MATERIALS

Required Textbooks & Equipment

ATI

ATI. (2016). *Fundamentals of nursing*. Assessment Technology Institute.

PEARSON

Callahan, B. (2015). *Clinical nursing skills a concept-based approach to learning* (2 ed., Vol. 3). Hoboken, New Jersey: Pearson Education, Inc. ISBN: 9780133351798.

Callahan, B. (2015). *Clinical nursing skills a concept-based approach to learning* (2nd ed.), Vol. 1 & 2). Hoboken, New Hersey: Pearson Education, INC. ISBN: 978-0132934-269, 978-0132934-275

FA DAVIS

Gasper, M. L., & Dillon, P. M. (2012). *Clinical simulation for nursing education - learner volume*. Philadelphia : F. A. Davis. ISBN: 9780803662711

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2016). *Davis's drug guide for nurses*.(15th ed.) Philadelphia: F. A. Davis Company. ISBN: 9780803657052

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's comprehensive handbook of laboratory and diagnostic tests with nursing implications*. (6th ed.) Philadelphia: F. A. Davis. ISBN: 9780803659438

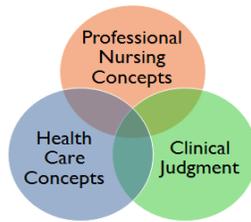
Yeager, D. (2015). EHR Tutor. Parma, OH

ELSEVIER

Giddens, J. F. (2017). *Concepts for Nursing Practice* (2 ed.). St. Louis: Elsevier Mosby. ISBN: 9780323374736

Jarvis, C. (2016). *Pocket Companion for physical examination and health assessment* (7 ed.). St. Louis: Elsevier. ISBN: 9780323265379

Required Textbooks & Equipment



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Students are responsible for materials placed on-line in Blackboard and individual emails sent by faculty. Please check your Ranger College email frequently. Students will be aware of and abide by the information contained in the Ranger College ADN Student Handbook which is available on-line in Blackboard.

Uniform - see *Clinical Attire* in Undergraduate Nursing Handbook.

Equipment - Bandage scissors, watch, stethoscope, and penlight

V. Course Purpose

The purpose of this course is to:

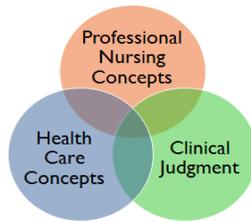
1. Demonstrate critical thinking, sound judgment, innovation, and problem-solving in a variety of health care settings.
2. Collaborate with interdisciplinary team members to continuously improve systems, enhance quality, and promote safety.
3. Apply data and informatics technology to organize and deliver optimal care based on science and professional standards.
4. Advocate effectively in delivering patient-centered, culturally appropriate care.
5. Incorporate understanding of health disparities and social determinants into professional and public policy actions.
6. Practice nursing according to ethical and professional standards.

VI. Learning Outcomes

Course Objectives

Upon completion of this course the student will:

1. Identify and adhere to Program Standards as outlined in Dept. of Nursing Handbook regarding: (1) honesty and ethical behavior, (2) accountability, (3) confidentiality, (4), professional conduct and courtesy, (5) safety, (6) responsibility within the academic institution and clinical agency, and (7) competency and growth.
2. Complete database with all subjective and objective data.
3. Identify and prioritize nursing diagnoses, goals and plans.
4. Evaluate process and outcomes based on goals/expected outcome and client's responses to the plan of care by utilizing SOAPIE. Modify Nursing Diagnosis/Goals/Expected Outcomes and Plan of care as necessary.
5. Make appropriate decisions and evidences critical thinking.



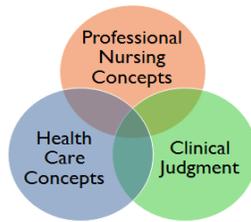
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6. Utilize adult care concepts in provision of nursing care to clients.
7. Provide care in a timely and organized manner.
8. Implement care in a safe manner for one or more clients.
9. Participate fully and responsibly in clinical.
10. Demonstrate professional dress and behavior in the clinical area.
11. Practice within a framework of professional, legal, and ethical standards.
12. Submit written work that is clear, comprehensive, organized and legible which follows APA format when citing sources within the body of written assignments and on reference list.
13. Appropriately communicate in the following manners: Verbal/Nonverbal/Interpersonal.
14. Demonstrate clear and complete documentation or reporting of client assessment, care, and responses in the medical record and to others on the health care team.
15. Safely calculate and administer medications.
16. Safely and effectively perform the following skills: (1) wound care, (2) NG tube management, (3) oropharyngeal suctioning, (4) IV access and management, and (5) urinary catheter management.

VII. Core Objectives

This course meets the following of the six Core Objectives established by Texas:

- ☒ **Critical Thinking Skills (CT)** – Creative thinking, innovation, inquiry, and analysis; evaluation and synthesis of information
- ☒ **Communication Skills (COM)** – effective development, interpretation and expression of ideas through written, oral, and visual communication
- ☒ **Empirical and Quantitative Skills (EQS)** – The manipulation and analysis of numerical data or observable facts resulting in informed conclusions
- ☒ **Teamwork (TW)** – The ability to consider different points of view and to work effectively with others to support a shared purpose or goal
- ☒ **Social Responsibility (SR)** – Intercultural competence, knowledge of civic responsibility, and the ability to engage effectively in regional, national, and global communities



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- ☒ **Personal Responsibility (PR)** – The ability to connect choices, actions, and consequences to ethical decision-making

VIII. Methods of Instruction

This course utilizes a variety of teaching methods, including assigned text readings, class lectures and discussions, PowerPoint presentations, information from nursing research databases and professional websites, video clips, small group discussions, case studies, and unscheduled but nulled quizzes (such as pre- and post-lecture tests). Discussion boards and ATI resources as described below will also be utilized.

Internet technology is utilized to provide additional sources of information, prepare and submit student assignments, provide ongoing student-faculty and student-student interaction and dialogue, and facilitate peer support. This technology can provide broader, current resources and research information; thus, students are required to access various websites and professional databases to complete certain lecture discussions and course assignments.

XI. Methods of Assessment

Clinical Success:

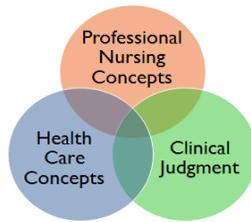
Students will be graded per assignments. Final course grade must be 75 or above and all COREQUISTIE COURSES (RNSG 1118, 1128, 1324) must have passing grades for advancement to the next level of the nursing program. Final course grades will not be rounded up.

The grading scale is listed below:

90-100	A
80-89	B
75-79	C Passing
74.99 and below	Failure

Grade calculation

Weekly clinical evaluation & simulations	40%
Preclinical assignment	10%
Weekly clinical paperwork	40%
Final Clinical Evaluation	<u>10%</u>
Total	100%



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Assignments

Clinical paperwork and responsibilities will be posted on Blackboard. Students will be responsible for submitting assignments on Blackboard by 2359 the Saturday after clinical. Late paperwork will receive a 5% deduction per each day late. **All Clinical paperwork must be submitted in order to pass the course.**

THE NURSING STUDENT IS ACCOUNTABLE TO LEARN AND PRACTICE ON A CONTINGENCY GRANTED BY THE TEXAS STATE BOARD OF NURSING WHILE THE INDIVIDUAL REMAINS A STUDENT WITHIN RANGER COLLEGE ASSOCIATE DEGREE NURSING PROGRAM. THE INSTRUCTORS, STAFF, AND PRECEPTORS WILL BE UTILIZED AS A RESOURCES TO VALIDATE THE STUDENT'S EXPERTISE. THE ULTIMATE GOAL IS THAT THE STUDENT WILL BE RESPONSIBLE TO GIVE INDEPENDENT, SAFE CARE UTILIZING HIS/HER OWN CRITICAL THINKING.

X. Course/Classroom Policies

Attendance/Tardiness

1. Clinical Participation:

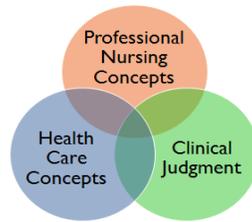
Strict attendance and active participation is expected for all clinical venues. Clinical participation is considered an independent student activity - NOT a group activity (unless otherwise indicated by your course instructor).

2. Missed Clinical/Assignments/Clinical Paper Work/Make-Up Policy:

A student not present at clinical is expected to follow-up with the clinical instructor. A student may be allowed to make-up a clinical etc. under the following circumstances:

- a. Absence is due to serious illness/hospitalization of the student or an immediate* family member. Documentation by a health care provider will be required at the time the student requests a make-up clinical/ simulation for the day of illness.
- b. Absence is due to a death in the immediate* family. Documentation will be required.
- c. An absence that the faculty and/or Department Head deems as unavoidable.

To be eligible for a make-up clinical/ simulation in the above circumstances, the student must notify their instructor 48 hrs prior to the absence, and all make-up work/clinicals for semester through simulation on the assigned day prior to the end of the course clinical evaluation.



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Faculty has the right to offer an alternative form clinical and/or to deduct up to 10 points from the grade or a letter grade.

*Immediate: Family member living in the same household or outside household totally dependent on the student for care such as a spouse, parent, child, sibling, grandparent or grandchild.

3. Academic Dishonesty

Nursing students are expected to maintain an environment of academic integrity. Actions involving scholastic dishonesty violate the professional code of ethics and are disruptive to the academic environment. Students found guilty of scholastic dishonesty are subject to disciplinary action, including dismissal from the Associate Degree Nursing Program and Ranger College in accordance with outlined criteria. Procedures for discipline due to academic dishonesty have been adopted as published in the Ranger College Student Handbook. Examples of scholastic dishonesty include, but are not limited to:

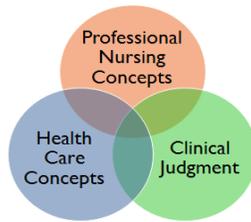
CHEATING: Copying from another student's test. Possessing or using, during a test, materials which are not authorized. Using, buying, stealing, transporting, or soliciting a test, draft of a test, test facsimile, answer key, care plans, or other written works.

PLAGIARISM: Using someone else's work in your academic assignments without appropriate acknowledgment.

COLLUSION: Collaborating with another person in preparing academic assignments without authorization.

CLINICAL LAB POLICIES

- Students are never to discuss events or scenarios occurring during lab clinical simulation experiences except during debriefing sessions. "What happens in clinical simulation during lab stays in clinical simulation during lab..." There is zero tolerance for academic dishonesty.
- Students are to dress for lab as if attending clinical. Scrubs, name badges and uniform policies are enforced.
- Faculty are responsible for supervising all students brought to the lab for training.



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- Universal Precautions are to be followed at all times as are all safety guidelines used in the clinical setting. Sharps and syringes are to be disposed of in appropriate containers. Anyone sustaining an injury must report it immediately to their instructor.
- Equipment may not be removed from the lab for practice nor are the labs to be used for practicing clinical skills unless supervised by faculty or staff.
- Students may be recorded during scenarios. Viewing of videos recorded during training are only permitted with faculty members. The videos are the property of the nursing program and students may not possess lab videos recordings.
- Coats, backpacks and other personal belongings are not to be in the lab during clinical simulation and should be secured as directed by the instructor.
- All electronic devices are forbidden during clinical experiences during lab. (Cell phones, pagers, any type of recording device, etc.).
- After a simulation take your personal belongings with you (i.e. papers, pens, stethoscopes, pen lights etc.).
- Food and drink are not permitted in the labs.
- If you have a latex allergy, inform your instructor before beginning simulation.
- Makeup days may not be available for students absent the day of simulation.

Standard Precautions

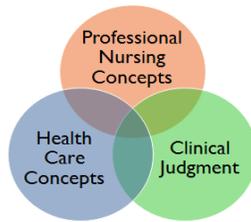
The Center for Disease Control and Prevention (CDC) Recommended Standard Precautions are outlined below. It is the student's responsibility to maintain compliance with these recommendations in all clinical settings.

Because the potential diseases in a patient's blood and body fluids cannot be known, blood and body fluid and substance precautions recommended by the CDC should be adhered to for all patients and for all specimens submitted to the laboratory. These precautions, called "standard precautions," should be followed regardless of any lack of evidence of the patient's infection status. Routinely use barrier protection to prevent skin and mucous membrane contamination with:

- a. secretions and excretions, except sweat, regardless of whether or not they contain visible blood
- b. body fluids of all patients and specimens
- c. non-intact skin
- d. mucous membranes

Hand Hygiene:

- a. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn and/or immediately prior to any client interaction or



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nursing intervention. Perform hand hygiene immediately after gloves are removed, between patient contacts and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross contamination of different body sites.

b. Use a plain (non-antimicrobial) soap for routine hand washing.

c. Use an antimicrobial agent or waterless antiseptic agent for specific circumstances (e.g., control of outbreaks or hyperendemic infections) as defined by the infection control program.

Gloves:

Wear gloves (clean non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another patient. Perform hand hygiene immediately to avoid transfer of microorganisms to other patients or environments.

Mask, Eye Protection, Face, and Shield:

Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose and mouth during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.

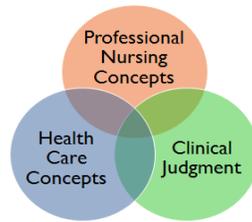
Gown:

Wear a gown (a clean nonsterile gown is adequate) to protect skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments.

Patient Care Equipment:

Handle used patient care equipment soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing and transfer of microorganisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed and single use items are properly discarded.

Environmental Control:



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Ensure that the hospital has adequate procedures for the routine care, cleaning and disinfection of environmental surfaces, beds, bed rails, bedside equipment and other frequently touched surfaces and that these procedures are being followed.

Linen:

Handle, transport, and process used linen soiled with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures and contamination of clothing and avoids transfer of microorganisms to other patients and environments.

Occupational Health and Blood-borne Pathogens:

- a. Take care to prevent injuries when using needles, scalpels and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments and when disposing of used needles. Never recap used needles or otherwise manipulate them with both hands and any other technique that involves directing the point of a needle toward any part of the body; rather, use either a one-handed scoop technique or a mechanical device designed for holding the needle sheath. Do not remove used needles from disposable syringes by hand and do not bend, break or otherwise manipulate used needles by hand. Place used disposable syringes and needles, scalpel blades and other sharp items in appropriate puncture-resistant containers located as close as practical to the area in which the items were used. Place reusable syringes and needles in a puncture resistant container for transport to the reprocessing area.
- b. Use mouthpieces, resuscitation bags or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable.

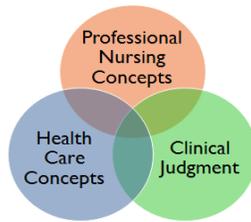
Patient Placement:

Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is not available, consult with infection control professionals regarding patient placement or other alternatives.

Student Occurrence:

Any student involved in a clinical occurrence (e.g. needle stick, patient or student fall/injury, medication error, etc.) must adhere to the following protocol for reporting the occurrence:

1. Notify the nurse responsible for the patient immediately.
2. Notify the clinical instructor, preceptor and/or faculty member as quickly as possible after the occurrence happens. The clinical instructor, preceptor & faculty will provide information on appropriate actions to be taken.
3. Notify the charge nurse.



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4. Be prepared with details necessary for filling out a report and to sign the report as a witness or the person responsible for the occurrence.
5. Meet any Ranger College or facility policy regarding occurrences.

Available Support Services

Library facilities are available at the main Ranger campus, the Brownwood campus (Heartland Mall), and the Brownwood Public Library. Reference materials are also available online as well.

ADA Statement

Ranger College provides a variety of services for students with learning and/or physical disabilities. Students are responsible for making initial contact with the Ranger College Counselor, Gabe Lewis (glewis@rangercollege.edu). It is advisable to make this contact before or immediately after the semester begins.

NON-DISCRIMINATION STATEMENT

Admission, employment, and program policies of Ranger College are non-discriminatory in regard to race, creed, color, sex, age, disability, and national origin.

SYLLABUS AND CALENDAR CHANGES

The course syllabus and calendar are subject to change. Students will be notified during scheduled class or via Ranger College email concerning any revisions to course syllabus.

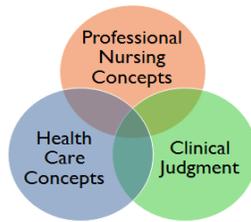
STUDENT EVALUATION OF COURSE

Students are strongly encouraged to participate in a course evaluation at the end of the semester. Areas of evaluation include:

- Gaining factual knowledge
- Developing specific skills, competencies, and points of view needed by professionals in nursing
- Developing competency in verbal and written communication
- Learning how to find and use resources for answering questions or solving problems
- Learning to analyze and critically evaluate ideas, arguments, and points of view

DROP/WITHDRAWAL FROM CLASS

Students wishing to drop/withdraw from the class must do so before the final drop/withdrawal date. If the student does not drop/withdraw before the official last date, he/she will receive the



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grade earned. A “C” or better is needed in all nursing courses to pass. For all nursing courses, a grade of C is designated as 75-79.99 %. Failure to pass the lecture course will result in a failing grade in any corresponding clinical component.

RECEIPT OF SYLLABUS FORM

All students must complete the attached “Receipt of Syllabus” form and return it to the course instructor.

XI. Course Outline/Schedule

Course Outline

Clinical Judgment

- Scenarios Applying the Nursing Process

Communication

- Interpersonal
- Inter-professional
SBAR
Electronic Healthcare Records
- Intra-personal

Health Promotion

- Injury Prevention
- Health Care Screening

Patient education

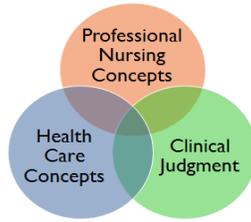
- Discharge Planning
- Formal (Examples related to Course Content)
- Informal Patient Teaching (Examples related to Course Content)

Professionalism

- Attributes of the Profession

Teamwork & Collaboration

- Interdisciplinary Plan of Care
- Group work



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- Chain of Command

Ethics & Legal Practice

- Nursing Practice Act
- Patient Confidentiality (HIPAA and Social Media)
- ANA Code of Ethics
- Patient Rights

Evidence-Based Practice*

Health Information Technology*

Patient-Centered Care

- Advocacy
- Prioritizing Individualized Care

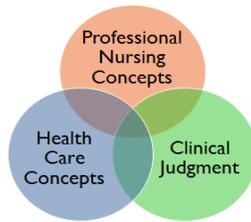
Safety

- Standard Precautions
- National Patient Safety Goals
- Environmental Safety & Medication Administration (Skills)

SYLLABUS SUBJECT TO CHANGE BASED ON CLINICAL EXPERIENCES

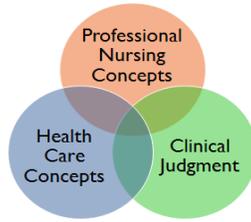
Course Outline

Week	Topics	Reading Material
Week 1 August 28th	1. Course Syllabus/Q&A 2. Syllabus form 3. Coping/Self Care	ATI: Achieve 1. Test Taking Skills 2. Preparing for Clinical Experiences
Week 2	LABOR DAY HOLIDAY	



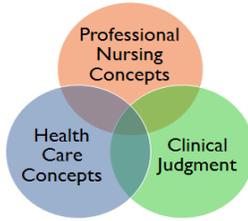
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September 4th		
Week 3	BRMC orientation	
September 11th	Ranger College Meeting	
Week 4	Self-Care	
September 18th		
Week 5	Health Promotion	
September 25th		
Week 6	Professionalism	
October 2nd		
Week 7	Communication- Interpersonal	
October 9th		
Week 8	Communication- Interprofessional	
October 16th		
Week 9	Ethics and Legal Practice	
October 23 rd		
Week 10	Health Information Technology	
October 30th		
Week 11	Safety	
November 6th		
Week 12	Patient Education	
November 13th		
Week 13	THANKSGIVING BREAK	
November 20th		
Week 14	Evidence based Practice	



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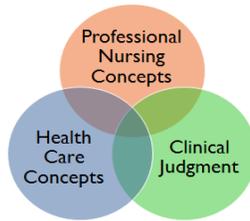
November 27th		
Week 15 December 4th	Patient Centered Care	
Week 16 December 11th	Clinical judgement	



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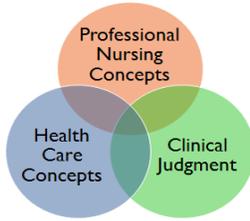
Ranger College Associate Degree Nursing Program
Weekly Clinical Evaluation – Transition

Component/Concept	3 points	2 points	1 point	0 points	points
Concept map (CM)	Submits CM that provides for safe, patient-centered care. Addresses all areas of nursing process. Includes 3 problems –highest priority, teaching an assigned concept. Includes more than 5 interventions for each problem with scientific rationale. Addresses reportable data, labs, and referrals.	Submits CM that provides for safe Pt. care. Addresses all areas of nursing process. Includes 2 problems based on assign concepts include 5 interventions for each problem.	Submits CM that doesn't address sufficient care needed for safe Pt. care. Includes 2 problems. Doesn't address all phases of the nursing process. Does not include at least 5 interventions. Problems are not related to assign concepts	Did not submit CM	
Safety	Intervenes to fix safety hazards in Pt. environment. Practices medical asepsis during care. Performs care ergonomically.	Recognizes safety hazards in Pts. environment. Practices medical asepsis during care.	Fails to identify safety hazards in Pts. environment. Inconsistent about practicing medical asepsis.	Creates hazards in Pts. environment. Contaminates Pts. environment.	
Clinical judgement Patient-centered care	Identifies & reports relevant & important assessment findings. Provides Pt-centered care for 1 geriatric Pt. implements at least 3 interventions from CM. reflects & critically	Identifies abnormal assessment findings appropriately but may tend to less pertinent data. Provides safe care for 1 geriatric Pt. implements at least 2 interventions from	Does not know what information to seek. Focuses on less relevant data. Provides care for 1 geriatric Pt. Implements 1 intervention from CM. reflections on clinical	Provides care for 1 geriatric Pt. with much prompting. Doesn't implement interventions from CM. even when prompted. Reflections are brief and not	



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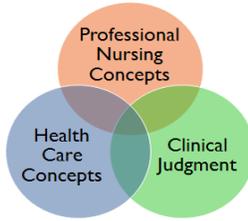
	evaluates nursing experiences indicating professional growth.	CM. reflects & evaluates clinical experiences.	experiences tends to state the obvious and need external evaluation.	used to improve performance.	
Informatics	Documents shift assessment with medical terminology in timely manner that reflects accurate status of Pt.	Documents shift assessment with lay terminology or terms such as "good" or "normal". Has to return to patient to collect more data to finish charting.	Documents shift assessment with lay terminology or terms such as "good" or "normal" that is incomplete and/or inaccurate.	Does not document shift assessment.	
Team work and Collaboration	Reports accurate Pt. status to peer or instructor using SBAR. Offers assistance to peer or PCTs without prompting.	Reports accurate Pt. status to peer or instructor. Offers assistance to peer or PCTs without prompting.	Reports inaccurate or incomplete Pt. status to peer or instructor using SBAR. Offers assistance to peer or PCTs with prompting.	Reports inaccurate or incomplete Pt. status to peer or instructor using SBAR. Does not offers assistance to peer or PCTs with prompting.	
Communication with Patients	Develops appropriate nurse-Pts. relationship. Allows Pt. opportunity to reminisce. Demonstrates interviewing skills. Gives clear instructions to Pt.	Introduces self to Pt. could be more effective in establishing rapport. Demonstrates basic interviewing skills. Gives clear instructions to Pt.	Fails to introduce self to Pt. Interviewing skills needs improvement as unable to collect complete information. Gives vague instructions to Pt.	Monopolizes conversation with Pt. or has difficulty communicating appropriately with Pt. explanations are confusing or contradictory.	
Patient education	Recognizes pertinent Pt. learning need. Teaches basic content to teach Pt.	Recognizes pertinent Pt. learning need. Identifies basic content to teach Pt.	Does not recognize pertinent Pt. learning need. Does not identify basic content to teach Pt.	Does not address learning needs at all.	



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Professional comporment	Identifies standards of practice implemented. Actively seeks learning experiences without prompting. Conduct self in professional manner in all aspects. Strong work ethics. Customer service orientation.	Identifies standards of practice implemented. Demonstrates integrity & accountability. Seeks learning experiences with prompting. Conduct self in professional manner in all aspects but one (i.e. on time, prepared, dress code, participate in post conference, customer-service).	Identifies repeated standards of practice implemented. Does not seek learning experiences. Valid complain from staff about care or behavior. Fail to exhibit professional behavior in several aspect.	Unable to identify standards of practice implemented. Does not seek learning experiences. Valid complain from Pt. about care or behavior. Demonstrate unprofessional behavior.	
Leadership & Management	Accurately identifies multiple skills that may be delegated in geriatric setting. Identify chain of command in setting.	Accurately identifies at least 2 skills that may be delegated in geriatric setting. Identify chain of command in setting.	Is not able to identify accurately what skills may be delegated in geriatric setting. Unable to accurately identify chain of command in setting.	Does not address delegation or chain of command at all.	
Quality improvement Evidence-Based Practice	Discuss how facility addresses QI or EBP related to concept of the day	Discuss how facility addresses QI or EBP related to concept of the day	Identifies how facility addresses QI or EBP related to concept of the day but doesn't discuss in post-conference.	Unable to discuss how facility addresses QI or EBP related to concept of the day.	
Total					

Student _____ Clinical Facility _____
 Faculty _____ Points/Pass or Fail _____ Date _____



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The previous page are expected behaviors that will be evaluated throughout the semester. A score of satisfactory (at least 23 points) must be obtained daily, less than 23 points or 0 in any area of daily evaluation may result in a written contract (area of concern and description of specific improvement is require; the purpose of the contract is to clarify the student status and future expectations). Failure to demonstrate improvement or 3 written contracts may result in clinical failure. Clinical is characterized as any environment to include skills lab, simulation, DCE, and any other community-based setting in which the student is observing, participating in any way, or providing care.

Student Comments:

Instructors Comments:

Student signature

Instructor signature



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RECEIPT OF SYLLABUS FORM

“I have received and understand the information in this syllabus. I agree to abide by the stated policies.”

PRINTED NAME: _____

DATE: _____

STUDENT SIGNATURE: _____