

Clinical Learning – Direct Patient Care Documentation

Student Name: _____ D#: _____ Date: 1/28/2025

Course: NR 325 _____ Session: _____ Year: _____

DIRECTIONS

This Direct Patient Care Documentation must be completed for one patient whom you are providing direct care in a clinical learning setting. Information within this packet can be handwritten or typed (with the exception of the reflection journal) and must be reviewed with your faculty on your assigned clinical day and submitted within 24 hours (or as directed by course leader). If additional space is needed, please use the back of each page. If any area within this packet was not performed, line out and place "N/A" in that section.

- **Grading:** Evaluated as Satisfactory, Unsatisfactory or Needs Improvement on the clinical learning evaluation. Satisfactory rating meets the following:
 - **Clinical Learning Competency:** Completes all clinical learning experiences and requirements successfully (PO 5).
 - **Performance Descriptor:** Completes all assignments related to the clinical learning experience within established guidelines.
- **I-SBAR:** Utilized for receiving report. Areas that indicate clinical significance are to be completed after patient report has been received. Students should deliver a hand-off report at the end of their shift to the bedside nurse.
- **Assessment Findings, Nursing Notes, Labs/Diagnostics, and Healthcare Provider Orders:** Complete according to your assigned patient.
- **Medication Information:** List and complete the information for each medication your patient is ordered.
- **Clinical Judgment Measurement Model (CJMM):** Complete reflecting on all the data/cues (Assessment, Labs/Diagnostics, Prescriptions/Orders and Patient Information) from your assigned patient.
- **Concept Map:** Complete reflecting on all the information and assessment findings gathered from your assigned patient.
- **Reflection Journal –** Complete a reflection journal and submit to your faculty (or as directed) within 24 hours of completing your clinical learning experience. Reflective journaling provides a format to share your knowledge, skills, experiences and personal reflection related to concepts and strategies learned throughout your program. What could you or did you delegate and to whom? Include ways you plan to care for yourself throughout your program. The reflection journal is required to be a typed Word document, Times New Roman 12-point font and minimum of one page and no more than three pages.

At least one time during the session, faculty will select one of the following questions for you to reflect on.

1. Describe how racial/health disparities, health equality/inequality, and social justice/injustice could apply to the clinical site/agency's community. Consider the population and determine why this may be occurring.
2. Transportation and housing are drivers of health and equity. Describe the steps you would take as a nurse to evaluate transportation and housing for your identified community population and what actions you could perform to identify resources.
3. How can nurses be change agents and advocate for their community? Provide at least two specific examples.

SBAR

I – Introduce Yourself	Your Name: D#: Your Title: Student Nurse Reason for being there: N/A					
S – Situation	Patient: L. M. Age: 72 Gender/Identity: F Height/Weight: 157.5 cm and 83.4 kg Allergies: Sulfa Antibiotics Code Status: Full Advance Directive (durable power of attorney, living will, other) and Clinical Significance: N/A Privacy Code: N/A Date of Care/Time: 1/28/2025			Attending Physician: N/A Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance: Right MCA ischemic stroke Pathophysiology of Primary Medical Diagnosis: Blood clot blocks the MCA, preventing blood flow to the brain, causing tissue damage due to a lack of oxygen and nutrients. Leads to neurological deficits like facial drooping and weakness of extremities.		
B – Background	<p>Include clinical significance with each:</p> Past Medical History: Rheumatoid arthritis, hypertension, GERD, pre-diabetes, dysphagia, hypothyroidism, hyperlipidemia Past Surgical History: Back surgery (date unknown); IR neurovascular thrombectomy (1/23/2025) Immunizations Received: Covid-19 – 1/7/21, 2/4/21, 10/26/21, 4/5/22, 12/14/22; PCV – 10/20/22; Influenza – 11/3/21, 10/20/22, 11/7/23, 12/20/24 Social History/Socioeconomic Factors: No smoking or tobacco, no alcohol, no drugs. Support received from significant other and children. Stable domestic situation and housing.					
A – Assessment	/ital Signs:					
A – Assessment	B/P	HR	RR	TEMP	SP0 ₂	PAIN
A – Assessment	122/70 mmHg	78 bpm	16 cpm	97.6 F	98%	0
A – Assessment	149/72 mmHg	86 bpm	17 cpm	97.9 F	97%	0
A – Assessment	Fall Risk: High fall risk		Accu-check: 122			
A – Assessment	IV Site: Right central line		IV Fluids: N/A		Lab/Test Results: WBC – 7.95 10 ³ /uL; RBC – 3.08 10 ⁶ /uL; Hgb – 9.7 g/dL; Hct – 28.4%; Plt - 249 10 ³ /uL; Chol – 166 mg/dL; Trig – 134 mg/dL; PT: 13.8s; APTT: 21.7s; AST - 16 U/L; ALT – 13 U/L; Glu – 122 mg/dL; BUN - 20 mg/dL; Na - 136 mEq; K – 4.3 mEq; Cl - 102 mEq/L; Creat – 1.11 mg/dL; CO ₂ – 26.7 mEq; Ca – 9.4 mg/dL; Phos. – 86 mg/dL; Mag. – 1.93 mg/dL; T. Pro – 5.5 g/dL; Alb. – 3 g/dL	
I and O	Urinary output of 800 mL					
Isolation	Isolation Precautions: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>			Contact Air <input type="checkbox"/>		Droplet <input type="checkbox"/>
RESPIRATORY	Clear bilaterally. No accessory muscle use. No ronchi, wheezes, or crackles.					
CARDIOVASCULAR	S1 & S2 heard. Pulses equal and normal bilaterally.					
NEUROLOGICAL	Alert and Oriented x4. Coherent speech. RUE 5/5, LUE 4/5, RLE 5/5, RLE 4/5. Left-sided facial droop					
GI/GU	Abdomen soft, non-tender, bowel sounds present in all quadrants, last BM 1/27, clear and yellow urine					
INTEGUMENTARY	Skin matches ethnicity. Skin warm and dry. Skin tears present at left distal leg, right posterior elbow, right abdomen, and right groin. General bruising found					
PSYCHOLOGICAL FAMILY – SUPPORT	Support received from significant other and children					

SAFETY	Teaching needed: Personal risk factors of stroke including: increased blood pressure, atrial fibrillation, increased cholesterol, diabetes, tobacco use & smoking, alcohol use, physical inactivity, and obesity. Quality in Safety Education Nurses (QSEN) Risk(s) Identified: Patient-Centered Care
R – REQUEST/ RECOMMENDATION	Hand off report to: N/A From: N/A

