



Student Name: _____ D#: _____ Date: 2/11/2025

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.



I-SBAR						
I – Introduce Yourself	Your Name:					
	D#:					
S – Situation	Your Title: Student Nurse			Reason for being there: N/A		
	Patient: R. H.			Attending Physician: N/A		
B – Background	Age: 84			Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance:		
	Gender/Identity: M			Fracture of head and neck of femur		
A – Assessment	Height/Weight: 177 cm and 75 kg			Pathophysiology of Primary Medical Diagnosis:		
	Allergies: NKA			Hip fractures in the elderly happen mostly because of weak bones and falls. As people get older, their bones lose strength. This makes fractures more likely. Muscle weakness and less physical activity also play a big role. With age, balance gets worse, making falls more common. Poor nutrition, like low calcium and vitamin D, weakens bones even more. Some medical conditions, such as thyroid problems or nerve diseases, raise the risk. Certain medicines make things worse by causing dizziness or bone loss. Even a small fall can break a hip. In some cases, bones are so weak that they break just from standing or walking.		
I and O	Code Status: DNR			Past Surgical History: Abdominal paracentesis and orthopedic surgery (closed reduction percutaneous pinning of left femoral neck fracture)		
	Advance Directive (durable power of attorney, living will, other) and Clinical Significance: N/A			Past Medical History: DM type 2, Hypertension, Coronary artery disease, Heart failure with preserved ejection fraction, Obstructive sleep apnea with CPAP, Paroxysmal atrial fibrillation, Orthostatic hypotension, Pleural effusion, Thrombocytopenia, Acute on chronic respiratory failure, and Acute on chronic heart failure		
Isolation	Privacy Code: N/A			Social History/Socioeconomic Factors: No smoking or tobacco, occasional alcohol use twice a week, no drugs. Support received from significant other and children. Stable domestic situation and housing. Inadequate health literacy.		
	Date of Care/Time: 2/4/2025			Immunizations Received: No data		
RESPIRATORY	Vital Signs:					
	B/P	HR	RR	TEMP	SP0 ₂	PAIN
CARDIOVASCULAR	116/73 mmHg	66 bpm	18 cpm	98.5 F	95%	0
	97/62 mmHg	80 bpm	15 cpm	98.1 F	99%	0
NEUROLOGICAL	Fall Risk: Low to moderate fall risk		Accu-check: 98		Lab/Test Results: WBC - 9.24 10 ³ /uL;	
	IV Site: Right anterior forearm		IV Fluids:		RBC - 4.99 10 ⁶ /uL; Hgb - 12.8 g/dL; Hct - 41.1%; Plt - 178 10 ³ /uL;	
GI/GU	No data					
	Isolation Precautions: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Contact Air <input type="checkbox"/> Droplet <input type="checkbox"/>					
Decreased breath sounds. No accessory muscle use. Crackles present.						
S1 & S2 heard. Pulses equal and normal bilaterally. +2 lower extremity edema.						
Alert and Oriented x4. Coherent speech. No focal motor deficits. Sensation to light touch grossly intact. Lower extremities weak.						
Abdomen soft, non-tender, bowel sounds present in all quadrants, last BM 2/3, clear and yellow urine						



INTEGUMENTARY	Skin matches ethnicity. Skin warm and dry. No rashes or lesions. Abrasions on right knee and right lateral thigh.
PSYCHOLOGICAL FAMILY – SUPPORT	Support received from family.
SAFETY	Teaching needed: Quality in Safety Education Nurses (QSEN) Risk(s) Identified: Patient-Centered Care
R – REQUEST/ RECOMMENDATION	Hand off report to: N/A From: N/A



Initial Assessment Findings & Time			
Vital signs: 0700			
T: 98.5 F	P: 66 bpm	Resp: 18 cpm	SpO ₂ : 95%
BP: 116/73 mmHg	Height: 177 cm	Weight: 75 kg	Apical HR: 66 bpm
Intake: No data		Output: No data	
Pain scale used with rationale: 0			
O (Onset): Did your pain start suddenly or gradually get worse? N/A			
P (Palliative, Provocative) What makes the pain better/worse? N/A			
Q (Quality) How is the pain described? N/A			
R (Radiation) Does the pain travel or spread anywhere else? If so, where? N/A			
S (Severity) What is the intensity of the pain? N/A			
T (Temporal) Is the pain constant or does it come and go? N/A			
Head and neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): Soft, supple, symmetric, and normal ROM			
Respiratory (lung sounds, breathing effort, accessory muscles): Diminished bilaterally. No accessory muscle use. No ronchi or wheezes. Crackles present.			
Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): S1 & S2 heard. Pulses equal and normal bilaterally. +2 lower extremity edema.			
Abdomen (inspection, bowel sounds, palpation, contour): Bowel incontinence: Continent Bowel plan: Self-toileting with Assist Last BM: 2/3			
Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): Alert and Oriented x4. Coherent speech. PERRLA. No focal motor deficits. Sensation to touch grossly intact.			
Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): No gross deformities, lower extremities weak, moves all four extremities			
Genitourinary (burning with urination, frequency, color of urine): Clear and yellow urine Urinary incontinence: Continent Toileting plan: Straight catheterization for retained urine			
Pelvic (female: LMP): N/A			
Rectal (bleeding, hemorrhoids): No Data			
Integumentary (rashes, lesions, wounds, etc.): Skin matches ethnicity. Skin warm and dry. Abrasions right knee and right lateral thigh.			
Specialty assessment (mental health exam, fetal heart rate, etc.): No Data			
Abuse screen (physical, elderly, child, sexual, etc.): No abuse			
IV access (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change): Right anterior forearm			
Psychological/Psychosocial/Family Support/Religious/Cultural Dynamics: Support received from family			

Growth and Development: (Developmental stage according to Erikson and your assessment findings):
Integrity vs. Despair

Ongoing Assessment Findings & Time			
Vital signs: 1300			
T: 98.1 F	P: 80 bpm	Resp: 15 cpm	SpO ₂ : 99%
BP: 97/62 mmHg	Height: 177 cm	Weight: 75 kg	Apical HR: 80 bpm
Intake: No data		Output: No data	
Pain scale used with rationale: 0			
O (Onset): Did your pain start suddenly or gradually get worse? N/A			
P (Palliative, Provocative) What makes the pain better/worse? N/A			
Q (Quality) How is the pain described? N/A			
R (Radiation) Does the pain travel or spread anywhere else? If so, where? N/A			
S (Severity) What is the intensity of the pain? N/A			
T (Temporal) Is the pain constant or does it come and go? N/A			
Head and neck (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea): Soft, supple, symmetric, and normal ROM			
Respiratory (lung sounds, breathing effort, accessory muscles): Diminished bilaterally. No accessory muscle use. No ronchi or wheezes. Crackles present.			
Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm): S1 & S2 heard. Pulses equal and normal bilaterally. +2 lower extremity edema.			
Abdomen (inspection, bowel sounds, palpation, contour): Bowel incontinence: Continent Bowel plan: Self-toileting with Assist Last BM: : 2/3			
Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils): Alert and Oriented x4. Coherent speech. PERRLA. No focal motor			
Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities): No gross deformities, lower extremities weak, moves all four extremities			
Genitourinary (burning with urination, frequency, color of urine): Clear and yellow urine Urinary incontinence: Continent Toileting plan: Straight catheterization for retained urine			
Pelvic (female: LMP): N/A			
Rectal (bleeding, hemorrhoids): No Data			
Integumentary (rashes, lesions, wounds, etc.): 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			
Specialty assessment (mental health exam, fetal heart rate, etc.): No Data			
Abuse screen (physical, elderly, child, sexual, etc.): No abuse			
IV access (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change): Right anterior forearm			