Student Name: ________________________ D#: ________________ Date: 2/19/2025

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.

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I-SBAR	
I – Introduce Yourself	Your Name: D#: Your Title: Student Nurse Reason for being there: N/A
S – Situation	Patient: D.M. Age: 74 Gender/Identity: F Height/Weight: 149.9 cm and 41.2 kg Allergies: Gabapentin, Gabapentin-naproxen Cmpd kit, Ziprasidone, Ziprasidone HCl 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: 2/18/2025 Attending Physician: N/A Patient Chief Complaint/Primary Medical Diagnosis and Clinical Significance: Parkinson's disease with dyskinesia without fluctuating manifestations Pathophysiology of Primary Medical Diagnosis: Parkinson's disease (PD) with dyskinesia results from the loss of dopamine-producing neurons, disrupting the basal ganglia's balance and leading to motor symptoms.
B – Background	**Include clinical significance with each:** Past Medical History: Tremore from Parkinson's Disease, hypertension, dyslipidemia, orthostatic hypertension, anxiety, depression, degeneration of cervical intervertebral disc Past Surgical History: Colonscopy, appendectomy, cesarean section, hysterectomy, lumbar epidural, total right knee arthroplasty Immunizations Received: Influenza (11/05/24), pneumococcal (11/05/24), sars-cov-2 (08/30/21, 02/25/21, 01/07/21), zoster (11/05/24), RSV (11/05/24) Social History/Socioeconomic Factors: No smoking or tobacco, no alcohol use, no drugs (CBD use). Support received from family, friends, and community. Stable domestic situation and housing.

A – Assessment

Vital Signs:

B/P	HR	RR	TEMP	$SP0_2$	PAIN
133/76 mmHg	95 bpm	16 cpm	98.5 F	99%	0
132/76 mmHg	64 bpm	14 cpm	97.9 F	99%	0

Fall Risk: Moderate fall risk

Accu-check: 102

IV Site: no IV

IV Fluids: N/A

Lab/Test Results: WBC – 7.6 10*3/uL; RBC – 3.93 10*6/uL; Hgb – 12 g/dL; Hct – 36.7%; Plt - 286 10*3/uL; AST – 25 U/L; ALT – 15 U/L; Glu – 102 mg/dL; BUN - 24 mg/dL; Na - 138 mEq; K – 4.3 mEq; Cl - 102 mEq/L; Creat – 0.84 mg/dL; CO2 – 29.6 mEq; Ca –9.1 mg/dL; Phos – 2.8 mg/dL; Mag. – 2.09 mg/dL; T. Pro – 6.2 g/dL; Alb – 3.3 g/dL; Chol – 215 mg/dL; Trig – 134 mg/dL

I and O	No data
Isolation	Isolation Precautions: Y ☐ N ☒ Contact Air ☐ Droplet ☐
RESPIRATORY	Lungs sounds heard bilaterally. Non-labored respirations. No accessory muscle use. Symmetrical chest wall expansion
CARDIOVASCULAR	S1 & S2 heard. Pulses equal and normal bilaterally. No edema.
NEUROLOGICAL	Alert and Oriented x4. Coherent speech. Sensation to light touch grossly intact. Tremors present, Upper and lower extremities 4/5 bilaterally. PERRLA
GI/GU	Abdomen soft, non-distended, no tenderness on palpation, bowel sounds present in all quadrants, last BM 2/18, clear and yellow urine
INTEGUMENTARY	Skin matches ethnicity. Skin warm and dry. No rashes or lesions. General bruising.
PSYCHOLOGICAL FAMILY – SUPPORT	Support received from family.

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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

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Initial Assessment Findings & Time

Vital signs: 1111

T: 98.5 F	P: 95 bpm	Resp: 16 cpm	Sp0$_2$: 99%
BP: 133/76 mmHg	Height: 149.9 cm	Weight: 41.2 kg	Apical HR: 95 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):
Lungs sounds heard bilaterally. Non-labored respirations. No accessory muscle use. Symmetrical chest wall expansion

Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):
S1 & S2 heard. Pulses equal and normal bilaterally. No edema.

Abdomen (inspection, bowel sounds, palpation, contour):

Bowel incontinence: Continent

Bowel plan: Self-toileting with supervision | Last BM: 2/18

Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):
Alert and Oriented x4. Coherent speech. Sensation to light touch grossly intact. Tremors present. PERRLA.

Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):
No gross deformities, moves all four extremities, Upper and lower extremities 4/5 bilaterally

Genitourinary (burning with urination, frequency, color of urine):
Clear and yellow urine

Urinary incontinence: Continent | Toileting plan: Self-toileting

Pelvic (female: LMP): No Data

Rectal (bleeding, hemorrhoids): No Data

Integumentary (rashes, lesions, wounds, etc.): Skin matches ethnicity. Skin warm and dry. No rashes or lesions.

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):
no IV

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: 1500

T: 97.9 F	P: 64 bpm	Resp: 14 cpm	Sp0$_2$: 99%
BP: 132/76 mmHg	Height: 149.9 cm	Weight: 41.2 kg	Apical HR: 64 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):
Lungs sounds heard bilaterally. Non-labored respirations. No accessory muscle use. Symmetrical chest wall expansion

Cardiovascular (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):
S1 & S2 heard. Pulses equal and normal bilaterally. No edema.

Abdomen (inspection, bowel sounds, palpation, contour):

Bowel incontinence: Continent

Bowel plan: Self-toileting with supervision | Last BM: : 2/18

Neurological (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):
Alert and Oriented x4. Coherent speech. Sensation to light touch grossly intact. Tremors present. PERRLA

Musculoskeletal (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):
No gross deformities, moves all four extremities, Upper and lower extremities 4/5 bilaterally

Genitourinary (burning with urination, frequency, color of urine):
Clear and yellow urine

Urinary incontinence: Continent | Toileting plan: Self-toileting

Pelvic (female: LMP): No Data

Rectal (bleeding, hemorrhoids): No Data

Integumentary (rashes, lesions, wounds, etc.): Skin matches ethnicity. Skin warm and dry. No rashes or lesions.

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):
no IV

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