TTUHSC School of Nursing NURS3610 Experiential Learning I Clinical Appraisal Form

STUDENT NAME _	DATE	
FACULTY NAME_		

Instructions:

To complete this graded assignment, the student will select a patient for the clinical appraisal with clinical faculty observation on a scheduled clinical day. During the clinical visit, the student will provide clinical faculty with a report on the selected patient. The student will complete a focused assessment, medication administration, and documentation utilizing the information presented in didactic and clinical courses throughout the semester.

The student may utilize clinical resources during the appraisal. The clinical appraisal assignment may be completed in parts on multiple clinical days or all at once. The expected behaviors faculty will be grading are listed under each category. Become familiar with the information within this tool. Students are required to sign the clinical appraisal form after evaluation.

If a student does not earn 75% or greater on the clinical appraisal tool, the student will need to complete an individual remediation program outlined by the site coordinator(s) and/or the retention counselor. Additionally, one repeat appraisal at the clinical site will be scheduled. The score entered in the gradebook will be an average of the first and second attempts.

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Experiential Learning I Clinical Appraisal Tool

Expected Behavior	Possible Points	Date(s) & Faculty Comments		
Student Learning Outcome: Provide client-centered care for individuals, families, and communities				
Initiate care contract with client	5			
- AIDET – introduce self & purpose of care				
- Patient identifiers/Allergy				
- Asks about status & care				
Complete focused physical assessment in a	20			
manner that reflects client-centered care				
(spirituality, culture, and situation)				
- Neuro: LOC/PERRLA				
- Skin				
- Cardiac:				
o Aortic, pulmonic tricuspid, mitral				
 Peripheral pulses (radial, pedal) 				
o Capillary refill				
 Skin turgor 				
- Respiratory:				
 All fields: 4 anterior/6 posterior/lateral 				
- Abdominal				
 Inspection, Auscultation, Palpation 				
o Las BM, Void				
- Lower extremity				
o Edema				
o Skin				
- Drains/Tubes assessment				
o IV - Clean, dry, intact, flush IV if needed				
o Assess IVF				
 Foley Catheter 				
- Specific to pt diagnoses				
Student Learning Outcome: Employ evidence-based practice by integrating current research with				
clinical expertise and client values to provide optimal client care				
Perform dosage calculation(s) correctly	5			
- Complete dosage calculation prior to med				
admin				
- Calculate IV meds without the assistance of				
IV pumps				
For medication(s) administered: Verbalize to	20			
faculty indications, action, related				
contraindications/precautions, adverse				
reactions/side effects, appropriate				
route/dosage, nursing considerations for				
implementation (assessment/evaluation)				

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- For each med student will discuss:			
0	 Drug, dose, route 		
0	Indication/action		
0	Contraindications/precautions/nursing		
	considerations		
0	Adverse reactions/side effects		
0	For IV med – dilution, compatibility, rate		
	of administration (duration needs to be		
	from drug reference)		
	nt Learning Outcome: Utilize informatics		
inforn	nation, make decisions, and communicate	more effec	ctively
Docum	Document assessment findings and		
interv	entions		
- Cor	nplete documentation in electronic health		
record: assessment and interventions			
Utilize Micromedex or other scholarly source to		10	
verify	medications and other diagnostic		
information as appropriate; use IV drug			
referei	nce if administering an IV medication.		
- Stu	udent can use facility resource. Needs to be		
kn	owledgeable about meds being		
	ministered		
Stude	nt Learning Outcome: Provide safe care t	o individua	ls, families and communities through
indivi	dual performance and system effectiveness		
Admir	nister medication(s) according to	25	
institu	tional policy (injectable or intravenous		
route preferable for the appraisal)			
- Principles of safe med administration:			
 Pt identifiers & allergies 			
o Med rights x 5			
Med check #1			
○ Med check #2			
0	Med check #3		
TOTA	AL POINTS	100	Faculty Signature:
			Student Signature:
ORIF	CTIVES MET	Yes/No	If remediation is required, outline plan
(D)		1 55/110	below.

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Remediation Plan:

If narrative documentation is preferred/required, document assessment and/or medication administration here: