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# Clinical Learning – Direct Patient Care Documentation

## Level 2 Clinical Courses

CHAMBERLAIN UNIVERSITY

Student Name:

D#:

Date:

Course:

Session and Year:

### DIRECTIONS

This Direct Patient Care Documentation must be completed for one patient whom you are providing direct care in a clinical learning setting. All information within this packet must be handwritten, (with the exception of the reflection journal) reviewed with your faculty on your assigned clinical day and submitted within 24 hours (or as directed by course coordinator). If additional space is needed, please use the back of each page.

- **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, Labs and Healthcare Provider Orders:** Document your initial and ongoing assessment findings, lab results with why they were drawn specifically for your patient and healthcare provider orders with why they were specifically ordered for your patient.

- **ATI® Active Learning Templates Required:**

- **Nursing Skill:** Select one nursing skill from the healthcare orders table and complete one Active Learning Template: Nursing Skill. The selected nursing skill should be one in which you have not previously completed a template for this session.
- **Medications:** List medications below and complete one Active Learning Template: Medication for each medication classification in which you have not previously completed a template.

Time Due	Drug/Classification	Clinical Significance
	Azithromycin (Antibiotic)	

- **Nursing Diagnosis:**

Identify three nursing diagnoses for your patient and list them by priority below. Complete one concept map for your top nursing diagnosis listed below.

- 1.
- 2.
- 3.

- **Reflection Journal**

Complete a reflection journal and submit to your faculty 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. The reflection journal is required to be a typed, Word document, Times New Roman 12-point font. Minimum of one page and no more than three pages.



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Initial Assessment Findings and Time			
<b>Vital signs:</b>			
T:	P:	Resp:	SpO <sub>2</sub> :
BP:	Height:	Weight:	Apical HR:
<b>Pain scale used with rationale:</b>			
P (Palliative, Provocative) What makes the pain better/worse?			
Q (Quality) How is the pain described?			
R (Radiation) Does the pain travel or spread anywhere else? If so, where?			
S (Severity) What is the intensity of the pain?			
T (Temporal) Is the pain constant or does it come and go?			
<b>Head and Neck</b> (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea):			
<b>Respiratory</b> (lung sounds, breathing effort, accessory muscles):			
<b>Cardiovascular</b> (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):			
<b>Abdomen</b> (inspection, bowel sounds, palpation, contour):			
Bowel incontinence:			
Bowel plan:		Last BM:	
<b>Neurological</b> (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):			
<b>Musculoskeletal</b> (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):			
<b>Genitourinary</b> (burning with urination, frequency, color of urine):			
Urinary incontinence:		Toileting plan:	
<b>Pelvic</b> (female: LMP):			
<b>Rectal</b> (bleeding, hemorrhoids):			
<b>Integumentary</b> (rashes, lesions, wounds, etc.):			
<b>Specialty assessment</b> (mental health exam, fetal heart rate, etc.):			
<b>Abuse screen</b> (physical, elderly, child, sexual, etc.):			
<b>IV access</b> (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change):			

Ongoing Assessment Findings and Time			
<b>Vital signs:</b>			
T:	P:	Resp:	SpO <sub>2</sub> :
BP:	Height:	Weight:	Apical HR:
<b>Pain scale used with rationale:</b>			
P (Palliative, Provocative) What makes the pain better/worse?			
Q (Quality) How is the pain described?			
R (Radiation) Does the pain travel or spread anywhere else? If so, where?			
S (Severity) What is the intensity of the pain?			
T (Temporal) Is the pain constant, or does it come and go?			
<b>Head and Neck</b> (inspect and palpate scalp, hair and skull, facial expression/symmetry, trachea):			
<b>Respiratory</b> (lung sounds, breathing effort, accessory muscles):			
<b>Cardiovascular</b> (jugular vein, carotid arteries, cardiac sounds, cardiac rhythm):			
<b>Abdomen</b> (inspection, bowel sounds, palpation, contour):			
Bowel incontinence:			
Bowel plan:		Last BM:	
<b>Neurological</b> (mental status, cranial nerves, sensory, motor, deep tendon reflexes, pupils):			
<b>Musculoskeletal</b> (ROM, dorsalis pedis and post-tibial pulses, muscle strength of upper and lower extremities):			
<b>Genitourinary</b> (burning with urination, frequency, color of urine):			
Urinary incontinence:		Toileting plan:	
<b>Pelvic</b> (female: LMP):			
<b>Rectal</b> (bleeding, hemorrhoids):			
<b>Integumentary</b> (rashes, lesions, wounds, etc.):			
<b>Specialty assessment</b> (mental health exam, fetal heart rate, etc.):			
<b>Abuse screen</b> (physical, elderly, child, sexual, etc.):			
<b>IV access</b> (type/size, site, reason for IV access, type of fluid/rate, reason for type of IV fluid, assessment of IV site, last dressing change):			

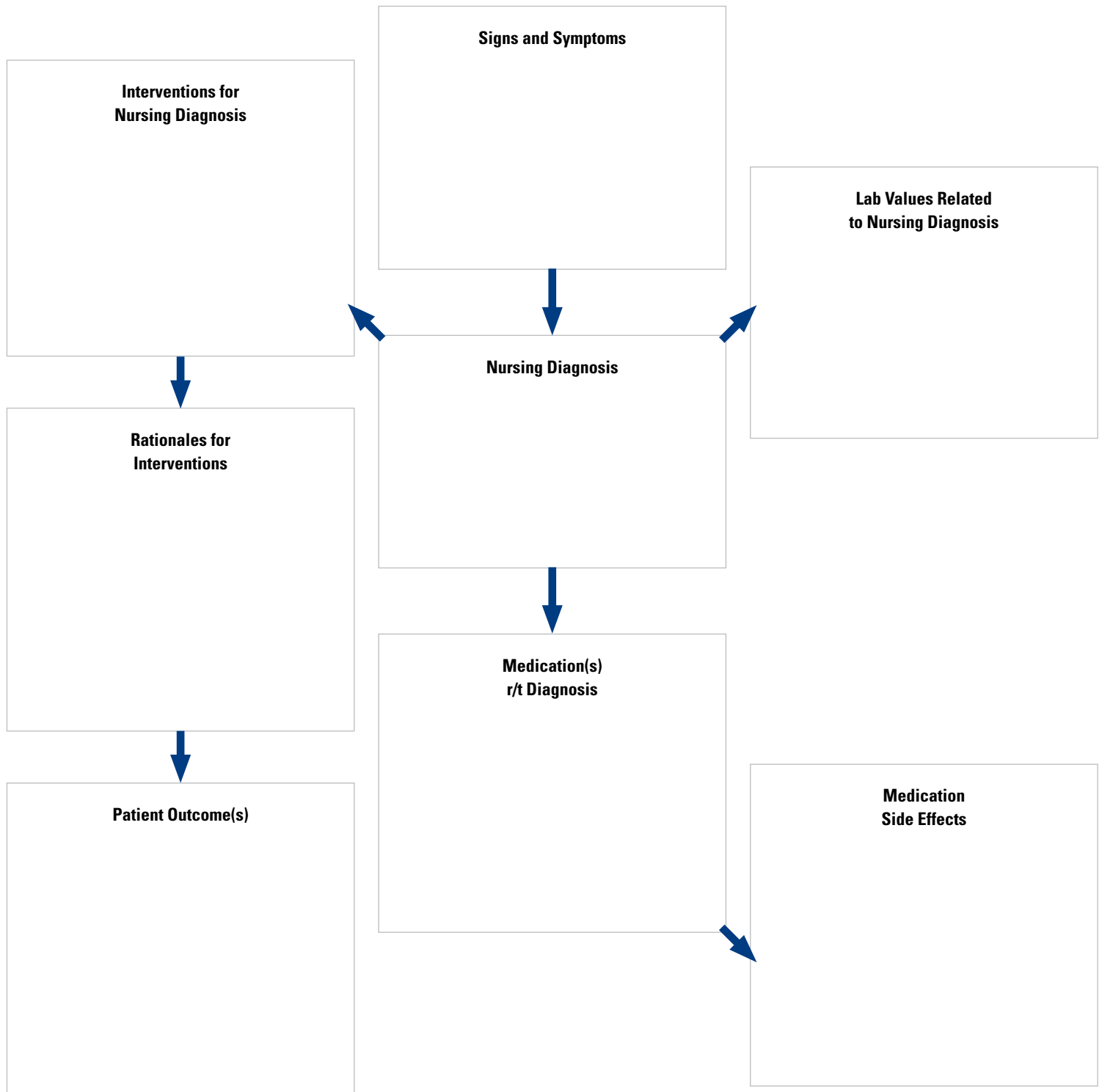


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## CONCEPT MAP





# Clinical Learning – Direct Patient Care Documentation

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## PURPOSE OF MEDICATION

### Active Learning Template – Medication

Student Name:

Medication:

Review Module Chapter:

Category Class:

#### Expected Pharmacological Action

#### Therapeutic Use

#### Complications

#### Medication Administration

#### Contraindications/Precautions

#### Nursing Interventions

#### Interactions

#### Client Education

#### Evaluation of Medication Effectiveness



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## Active Learning Template – Nursing Skill

Student Name:

Skill Name:

Review Module Chapter:

### Description of Skill

#### Indications

#### Outcomes/Evaluation

#### Potential Complications

#### Considerations

#### Nursing Interventions (pre, intra, post)

#### Client Education

#### Nursing Interventions



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