MICHIGAN STATE UNIVERSITY
COLLEGE OF NURSING

NURSING 410
Practicum in Community Health Nursing

COURSE SYLLABUS
FALL, 2000

Course Chairperson:
Grace J. Kreulen, PhD, RN
Course Number: NUR 410

Course Tiles: PRACTICUM IN COMMUNITY HEALTH NURSING

Course Placement: Level III

Credit Hours: 3 (0-9)

Course Description:
Clinical experience in community health nursing which focuses on the application of public health and nursing principles in the care of individuals, families and aggregates in a variety of settings. Emphasis is on levels of prevention and health promotion. Utilizes the epidemiological method to support community health nursing diagnoses in the development of a plan for implementing change.

Course Objectives:
1. Apply strategies for assessment, planning, intervention and evaluation that are appropriate to client characteristics.

2. Provide epidemiological data to support community health diagnoses.

3. Apply established research findings as a basis for making judgments in community health nursing programs.

4. Coordinate appropriate community resources in the care of the individual, group or community client.

5. Accept individual responsibility and accountability in community health nursing practice.

6. Describe the impact of major legal, social, cultural, political and economic issues on the client focus.

7. Demonstrate the professional role characterized by critical thinking, self-directed learning, and effective communication and leadership skills.

8. Demonstrate an understanding of the uniqueness of self and client in community health nursing practice.

Course Chairperson:
Grace J. Kreulen
Assistant Professor
Office: A203 Life Sciences Building
Course Faculty:
All course faculty have mailboxes in the second floor mailroom in the College of Nursing (A206). Individual faculty will provide students with additional information about office hours and telephone numbers during the first week of clinical. Faculty by clinical site are:

Section 1:  Elaine McParlane  
Barry-Eaton County Health Dept., Charlotte  
Mondays

Section 2:  Jacqueline Wright  
Walnut Street School and 20th Precinct Community Center, Lansing  
Wednesdays

Section 3:  Pam Groner  
Ingham County Health Department and CLCCA Lansing School District, Lansing  
Mondays

Section 4:  Grace Kreulen  
Wexford Community School, Lansing  
Wednesdays

Instructional Model:
Nine (9) hours per week will be spent in a clinical practice setting. The specific hours spent in a clinical practice setting may vary by the clinical site. All students will participate in clinical nursing practice and clinical conferences/seminars each week. The overall purpose of the clinical conferences/seminars is to assist students to integrate theoretical concepts and clinical experiences. Approaches include discussion of the clinical issues, clinical case studies, and student presentations. The format will vary to fit the topic and setting.

Clinical instructors will provide students with information about specific assignments that will be required for a given setting during the first weeks of clinical. All students are expected to meet the course and College of Nursing basic clinical expectations.

Nur 410 Basic Clinical Expectations:
1. Nursing care delivery. Provide community health nursing services to clients (individuals/families and aggregates/populations) throughout the semester. (See below: CHN practice foci)

2. Clinical conferences/seminars. Conferences will occur each clinical day for the purpose of enhancing student learning. During conferences students are expected to: share and discuss clinical activities and encounters, bring clinical issues for group discussion and problem solving, discuss learning needs, and share knowledge/skills important to community health nursing practice. Each student will be required to prepare and facilitate one content-specific/case-based seminar.
3. **Documentation.** Complete community health nursing services documentation in client folders on the day of clinical or by the end of the clinical week. This includes all documentation for individual/family and aggregate/population activities. The format for documentation will be specified by your clinical faculty, and will vary depending on the unit of service, referral source and clinical site requirements.

   **Correspondence.** At times it is important to communicate in writing to agencies, other health professionals, clients, etc. All correspondence must be reviewed by faculty prior to transmittal. A copy is to be placed in the appropriate documentation folder. This pertains to all forms of written correspondence, including email.

4. **Theory application.** Complete 6 core and 2 optional theory application assignments and submit to clinical faculty within two weeks of the time the theory is covered in NUR 409. Selection of optional assignments or alterations in submission times should be discussed with clinical faculty.

5. **Nursing research articles annotation.** Prepare 2 brief annotations of nursing research articles relevant to community health nursing practice and submit by midterm to clinical faculty. The articles chosen for annotation must relate to community health issues encountered during clinical experience and be published in peer-reviewed research journals within the last 5 years. The annotations should: 1) identify the article and source using APA format, 2) identify the community health issue addressed, 3) critique the research question and findings, and 4) indicate specific relevance to personal community health nursing practice. A copy of the article is to be submitted attached to the annotation.

6. **Folders.** Personal folders are to be turned in for each week of clinical to clinical faculty and are to include (typed, in this order, clipped together by category, with most recent work on top):

   - *Course and personal NUR 410 objectives*
   - *Clinical calendars:* Weekly clinical calendars are to be maintained as requested by clinical faculty and included in personal folders.
   - *Critical reflections Journal:* Weekly dated on your experiences that briefly address the following questions:
     1. What did I learn this week? (progress toward meeting course and personal objectives/ how applied knowledge, theory and research to practice)
     2. What questions were raised by this week’s experiences?
     3. What thoughts and feelings do I have about this week’s experiences?
   - *Assignments:* Including theory application assignments (assignment sheet and work) and annotations annotated nursing research articles.
   - *Any other material* when requested by your clinical faculty, such as midterm and endterm evaluations.

   All submitted work is to be typed unless other arrangements are made with clinical faculty.

7. **Clinical preparation and professional behavior.** Demonstration of professional behavior is expected in NUR 410. Students are expected to be active and assertive learners throughout the semester, in order to maximize personal learning experiences. Using the clinical faculty
as a resource person, students are expected to seek out and structure their own learning experiences, to approach their instructor and appropriate others for consultation regarding specific interventions with clients, and to verbalize a plan of action which is based on theoretically sound rationale and appropriate to the client situation. Specific preparation and professional behavior that is expected at all times includes:

- Appropriate attire, including MSU name tag.
- Prepared for each clinical day, including reading, searches, assignments, skill practice—whatever needed to be informed and competent.
- Accountable for time management and communicating scheduled activities, on time.
- Active participant in all clinical conferences and meetings.
- Demonstrate the following qualities as ‘initiate and carryout’ each clinical day:
  1. assertive and appropriate in expressing own thoughts, feelings, needs and concerns
  2. create and direct own learning experiences in collaboration with faculty
  3. highly involved in group clinical activities
  4. actively evaluates own experiences

Community health nursing (CHN) practice foci:

   Students will work together in groups or individually to assess, diagnose, plan and implement a specific population-focused health program that meets an identified need of a specified population group in the community. Weekly documentation of all population-focused activities is to be recorded on the appropriate form and maintained in an appropriately-labeled folder. A final population-focused report is to be submitted which summarizes the processes and outcomes of care using a community nursing process format (See Population-focused care report guidelines.)
   This experience is designed to provide an opportunity to develop personal knowledge and skill in providing health care to a group in the community, e.g. group work with parents, adolescents, school aged children, senior citizens; planning a community event such as a health fair; participating in a health promotion project such as passage of a clean air referendum or development of an exercise course. All population focused care must address a health need identified by the community and use a collaborative, partnership approach to the provision of care. Students are expected to work with individuals in the community and empower them with the knowledge, attitudes and skills necessary to meet their identified health needs.

2. Family-focused care: Improving the health status of families and individuals in the community. Each student is expected to provide family-focused care to a caseload of clients in their homes. Care delivered to individuals will be provided within the context of their family, and families will be considered within the context of their community. Continuity of care will be emphasized. Caseloads are obtained from community-based primary care providers and from school nurses. Protocols from the referring agency will be followed re. care delivery, documentation and feedback. Students are expected to work to empower families with the knowledge and skills necessary to meet the identified health needs.

3. Community-focused health planning: Attending community health planning meetings as a participant observer (optional). Students may desire to attend one or two community-level health planning meetings to enhance their exposure to community health. Examples include the local
smoking cessation coalition, fitness council or a health/social agency board meeting; and a State Department of Community Health or legislative session related to a health area of interest. Clinical faculty and course chair can assist in identification of an appropriate experience. Approval must be received from the clinical faculty prior to attendance. The experience should be documented in the weekly folder with a special journal entry that includes:

1) a description of the community health group (type, membership, relationship to the community) and meeting focus.
2) a description of the focal population served and approaches used to address identified needs.
3) an evaluation of what was learned from this experience.

Information about additional optional community health nursing learning opportunities that become available during the semester will be made available to students by posting on the 410 bulletin board and from clinical faculty.

**Attendance Policies:**

**Attendance at all clinical experiences is required.** A student who cannot attend a clinical experience is expected to notify their clinical instructor prior to the clinical experience so that alternate plans can be made. Any unexcused absence may be cause for student withdrawal from the course. Absences are excused at the discretion of the clinical instructor.

Clinical instructors will provide students with information by the first day of clinical for how to notify the instructor of an anticipated absence from a clinical experience. A student who misses a clinical experience may be required to provide appropriate written documentation of the reason for his absence to his/her clinical instructor; i.e., a written excuse from a health care provider may be required for incidents of illness/injury. Students with unexcused absences or excessive amounts of absence from clinical who are in jeopardy of failing to meet course objectives will be referred to the Student Affairs Office (refer to College of Nursing undergraduate student handbook).

Any student who is not prepared to provide safe nursing care at a given clinical experience for any reason (including previous absence from clinical experiences and incomplete documentation of immunization and CPR status) will be sent home from that clinical experience.

**Bad Weather Procedures:**

Clinical instructors will provide students with information the first day of clinical regarding procedures for the event of severe inclement weather.

**Required Texts:**


**Grading And Evaluation:**

The standard University numerical grading system will be used to assign course grades. A student must obtain a course grade of ≥ 2.0 in order to pass the course. A 0.0 grade will be given for either unsafe or dishonest behavior.
The following scale will be used for grade determination:

<table>
<thead>
<tr>
<th>Percent</th>
<th>Grade Point</th>
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<tbody>
<tr>
<td>100 - 95</td>
<td>4.0</td>
</tr>
<tr>
<td>94 - 88</td>
<td>3.5</td>
</tr>
<tr>
<td>87 - 80</td>
<td>3.0</td>
</tr>
<tr>
<td>79 - 75</td>
<td>2.5</td>
</tr>
<tr>
<td>74 - 70</td>
<td>2.0</td>
</tr>
<tr>
<td>69 - 65</td>
<td>1.5</td>
</tr>
<tr>
<td>64 - 60</td>
<td>1.0</td>
</tr>
</tbody>
</table>

There will be a mid and end semester conference with the instructor. A progress report will be prepared at mid-semester identifying strengths and weaknesses in performance using the clinical evaluation form; no grade will be given at mid-semester. The final clinical grade will reflect progress over the semester and will encompass all clinical attributes. Each student will be expected to submit a completed self-evaluation prior to mid and end semester conferences.

**Student Progress:**

Any student who has a concern about his/her progress in clinical or his/her course grade is responsible for approaching his/her clinical instructor to discuss the concern. Students who believe they may be experiencing academic difficulties are urged to consult promptly with course faculty in order to obtain faculty guidance in proposed remedial activities (refer also to the College of Nursing undergraduate student handbook).

Throughout the semester, a student is expected to apply promptly all feedback (verbal and written) from his/her clinical instructor to future performance in clinical. Failure to apply instructor feedback will be reflected in the student’s course grade.

A student who has a concern related to the course is expected to approach his/her clinical instructor to discuss the situation. Resolution of a concern on an informal basis between the student and instructor is encouraged. However, if the concern is not resolved at this level, the student should contact the Nursing 410 course chairperson to discuss the situation. The student should be prepared to discuss a proposed solution to the concern, during the meeting with the course chairperson. A joint meeting between the clinical instructor, student, the Student Affairs representative, and the Nursing 410 course chairperson may be required. If the situation is still not successfully resolved following consultation with the course chairperson, the student should then contact the College of Nursing Student Affairs office for further guidance (refer to the College of Nursing undergraduate student handbook).
Final evaluation process:

1. **Complete and turn in self-evaluation by last day of classes in semester.**
   - **Final journal entry, including:**
     1) evidence of accomplishment of personal objectives
     2) evidence of accomplishment of course objectives
     3) listing of 3-5 changes in your perceptions of nursing and health related to this experience
     4) statement of your current definition of community health nursing.
   - Complete End of Semester Competencies Evaluation (in syllabus)
   - Complete Summary Final Clinical Evaluation Form (attached)

2. **Schedule/ complete final evaluation conference with clinical faculty.**

Note: All clinical documentation must be submitted by last clinical day in semester.
- All documentation in family and population folders, including summary reports.
- Final reports to referring agency: MSU Nursing Center, School Nurse

<table>
<thead>
<tr>
<th>Evaluation category</th>
<th>Possible points</th>
<th># Points requested</th>
<th>Evaluation evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family-focused care</td>
<td>35-50</td>
<td></td>
<td>Family-focused care activities/ conference sharing/ reports Documentation Joint visit observation CHN Final evaluation form</td>
</tr>
</tbody>
</table>
| Community-focused health planning:      | 0-5             |                    | Journal entry per guidelines
   - Description of group and meeting focus
   - Description of focal population and approaches used
   - Evaluation of what learned from experience |
| Professionalism                         | 30              |                    | End of semester competency evaluation
   - Attendance / hours clinical completed
   - Weekly folders: including critical reflection journals and clinical calendars
   - Participation in clinical group conferences/ seminars, activities
   - Theory application papers 2 Research application/ annotation done |
| Total Points                            | 100             |                    |                                                                                     |
Summary Final Clinical Evaluation Form

Population-focused care project: Focus___________________________
1. Project completed ____yes ____no
2. Documentation complete ____yes ____no
3. Report completed per guidelines ____yes ____no

Family-focused care
1. Total number of family clients followed: ____ in home ____ in school ____ other
2. Total number of family visits made: ____ home visits ____ phone visits ____
   school visits ____ other
3. Documentation complete for all clients ____ yes ____ no
4. Referral feedback report submitted to faculty ____ yes ____ no
5. Total number of family home visits conducted: ________

Community-focused health planning/ Other activities: Name, date, date of journal entry for report

Requested points for each clinical focus area:

<table>
<thead>
<tr>
<th>Focus</th>
<th>%Points Requested</th>
<th>% Points Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-focused care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate-focused care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individually-focused student health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family-focused care to home-based clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-focused health planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionalism</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

Summary Self-evaluation: After reviewing all completed self-evaluation documentation, circle the score that you believe best reflects your clinical performance this semester:

1.0      1.5      2.0      2.5      3.0      3.5      4.0

Course grade achieved: ____________%

Comments:

_________________________________________                       ________________
Signature, student                     date

_________________________________________                       ________________
Signature, faculty                      date
These forms will be given to you by your clinical faculty during September.
SEMINAR TOPICS

Each student will prepare a clinical seminar from the following topics. Not all topics can be covered during the term, so choices will have to be made based on priorities, interest, and the nature of the clinical experience.

1. Priority setting in community health.
2. School nursing.
3. Occupational health nursing.
5. Presentation of client situation.
6. The role of the nurse in communicable disease (CD) and sexually transmitted diseases (STD).
7. Adult and child immunizations
8. The role of the nurse with the homeless population.
9. The role of the nurse in rural America.
10. Transcultural Nursing.
11. Women’s health
12. Environmental health (specific issue to be identified)
13. An identified population-at-risk
14. Quality management / improvement in CHN
15. Other area of interest as arranged with clinical faculty
Directions: Submit each core assignment to your 410 clinical faculty when possible within two weeks of covering the associated theory material in 409. Insert the date next to the assignment when returned. (A copy of these theory assignment pages is to be kept in your folder to track completion of assignments.)

CORE ASSIGNMENTS:

1) Based upon the six public health nursing competencies identified by Zerwekh in a qualitative study, select two competencies which you believe you possess at this time. Also select two competencies which you believe require further development; substantiate your selections.

2) Conduct a windshield survey of your community health clinical site including the surrounding one mile radius. Describe this area based upon the components of a windshield survey discussed at orientation.

3) Review the sections about the following diseases, i.e., salmonella, chlamydia and pediculosis, identified in the Handbook of Communicable Disease in Man available at each clinical site. Compare & contrast them according to the following epidemiological parameters:
   a) the population at risk
   b) the agent-host-environment interaction
   c) the natural history of disease
   d) the primary approach to control the disease

4) Given an individual or family diagnosis identified for a client in your mini caseload, state an example of an intervention strategy for each of the three levels of prevention, i.e., primary, secondary, & tertiary.

5) Given the community in which your clinical site is located, describe an environmental issue you have identified. It can be related to a client, neighborhood, or broader community. Substantiate your selection. State a primary, secondary, and tertiary intervention which could be taken to alter this issue.

6) Select a health risk appraisal; ask one of your clients to complete it. Review the results with your client; ask your client to tell you what the results might suggest and what actions s/he believes could be taken (Document this activity in the client record.) Based upon your conversation with the client, describe your view of the value of using this assessment tool, the client’s response to the process & appraisal, and insights you had regarding the relationship between ‘knowing risks’ & ‘taking action’.
NUR 409/410 THEORY APPLICATION ASSIGNMENTS (PAGE 2)

OPTIONAL ASSIGNMENTS: TWO TO BE SELECTED (DISCUSS WITH FACULTY)

1) Select and contact a community agency (source may be from a client record); secure the following information: source(s) of funding, mission, philosophy, target clientele, services provided, costs to clients. State type of agency, e.g., public or private, and give two characteristics of the agency which support your conclusion.

2) Reflect upon the orientation you had at the Ingham County Health Department. Briefly describe ONE example of a population, aggregate, and aggregate at risk (vulnerable). Give rationale for the selection of each example.

3) Given a client in your mini caseload, analyze the referral information received using the criteria essential to an effective referral. Describe the criteria (met and not met) and provide rationale supporting your conclusions.

3) Based upon your discussion with a client, prepare a family genogram which reflects the following items; insert the genogram in the client’s family record.

   a) the names, birthdates, and relationships of the immediate family as well as two additional generations
   b) the perception of the current health status of each living person (e.g., poor, fair, good, excellent)
   c) the psycho social and physical health problems/conditions of persons living and deceased
   d) the year of death of deceased persons
   e) a talent, skill, or strength of each person

Based upon your analysis of the genogram, identify two themes that are present; describe their significance to you as a community health nurse working with the client.

Date completed
POPULATION-FOCUSED CARE REPORT GUIDELINES

(Note: These guidelines are to serve as a template for population-focused reports. The exact nature of the final report will vary depending on the specific project and should be determined in discussion with clinical faculty. Sections of the report will be due at staggered times throughout the project)

<table>
<thead>
<tr>
<th>Descriptive information:</th>
<th>Maximum points</th>
<th>Expectation for report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/aggregate _________________</td>
<td></td>
<td>Information presented in table/outline form</td>
</tr>
<tr>
<td>Focal area __________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dates of project: from _______ to _______</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Names of members of project team</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aggregate Assessment:</th>
<th>30%</th>
<th>The assessment process is clearly presented. (Data only becomes alive and usable when analyzed and interpreted.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present relevant data from multiple sources</td>
<td></td>
<td>Report format:</td>
</tr>
<tr>
<td>➢ Data from existing sources including relevant county/state/national comparative data</td>
<td></td>
<td>1. data presented in reader-friendly manner using narrative and tables</td>
</tr>
<tr>
<td>➢ Key informant interview data</td>
<td></td>
<td>2. data interpretation</td>
</tr>
<tr>
<td>➢ Direct observation data</td>
<td></td>
<td>3. delineation of strengths and health concerns/problems</td>
</tr>
<tr>
<td>Synthesize/Analyze and Interpret data, ie. state what data means</td>
<td></td>
<td>Note: The inclusion of research application in the assessment report will take the place of the one annotated article assigned.</td>
</tr>
<tr>
<td>Identify strengths and health concerns/problems of aggregate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apply literature-based information/research to interpretation of data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aggregate Diagnoses:</th>
<th>10%</th>
<th>4. Aggregate nursing diagnoses written per recommended format, flows from step 3 above</th>
</tr>
</thead>
<tbody>
<tr>
<td>diagnoses relevant to aggregate</td>
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<td></td>
</tr>
<tr>
<td>format (per NUR 409 content):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- description of strength/problem</td>
<td></td>
<td></td>
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<tr>
<td>- etiologically-related factors</td>
<td></td>
<td></td>
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<tr>
<td>- characteristic signs and symptoms</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aggregate Intervention</th>
<th>40%</th>
<th>5. Intervention flows from assessment and diagnoses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention process/planning,expected outcomes</td>
<td></td>
<td>6. All materials used in/created for intervention included.</td>
</tr>
<tr>
<td>Intervention objectives,methods and content.</td>
<td></td>
<td>7. Evaluation plan relevant and reasonable.</td>
</tr>
<tr>
<td>Evaluation plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation of Care Delivered</th>
<th>10%</th>
<th>8. Evaluation of project approaches and methods.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome evaluation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal evaluation of the project components</th>
<th>10%</th>
<th>10. Each person does own personal evaluation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>degree of learning achieved</td>
<td></td>
<td>Per criteria in left column</td>
</tr>
<tr>
<td>level of self/peer participation</td>
<td></td>
<td>Identified by project and name</td>
</tr>
<tr>
<td>faculty direction and support</td>
<td></td>
<td>Freely removable from report or put in folder.</td>
</tr>
<tr>
<td>setting factors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Per criteria in left column                  |    |                                                                                     |
| identified by project and name              |    |                                                                                     |
| freely removable from report or put in folder |    |                                                                                     |
ORIENTATION TO THE HOME VISIT

Content outline:
2. Screening Process To Secure Caseload
3. Feelings about your First Home Visit
4. Student-Peer home visiting
5. Guidelines for termination of family contacts.
6. Family Strengths

1. Guidelines For Safety

Nursing is a profession in which practitioners are exposed to many different kinds of risks. Personal safety is one risk that is of concern for all practicing nurses, faculty and nursing students, regardless of clinical practice setting. In community health nursing, nurses and nursing students serve a heterogeneous population in many different kinds of communities in both rural and urban settings. The following guidelines serve to reinforce general principles of safety and minimize risks during the community health nursing clinical experience. These are discussed with students during their orientation period.

A. Attire*

A professional image is one of the best insurances for one's safety in the community. Since dress is regarded as an important aspect of one's presentation as a professional, appropriate dress should include:

1. Comfortable but tailored clothing. Jeans, sweats, cutoffs and mini skirts are unacceptable.
2. Limited jewelry. Watches, wedding and engagements rings (unless unusually large) and button type earrings are acceptable.
3. Tailored shoes must be worn with stockings. Clogs, sneakers and sandals are unprofessional and unacceptable. Shoes or slippers should be carried into client homes during boot weather.
4. Purses, if used, should contain only essentials; purses may be locked in the trunk of the car.
5. Name pin for clear identification must be worn during clinical hours.

B. Demeanor

A caring yet confident attitude characterizes a professional image. The student nurse should:

1. Acknowledge neighborhood residents that she/he may encounter in a relaxed, yet well-modulated tone of voice and with eye contact.
2. Walk at a steady pace with head up to destination like you belong where you are.

* Students not adhering to dress code will not be allowed to participate in clinical until appearing professionally and appropriately dressed.
C. Nursing bag
The nursing bag generally symbolizes a helping person. It should be carried on all nursing visits. The student nurse should:
1. Let it be known that the nursing bag contains no drugs or needles. (The word gets around.)
2. Avoid leaving the nursing bag in the car. To do so invites temptation.
3. At the end of the day, take the nursing bag into your home or leave in the clinical office. If left in the trunk of a car, the heat/cold tends to destroy thermometers.

D. Preparation for home visits.
1. The faculty will discuss with students direct and purposeful routes to client homes and encourage the use of maps.
2. Home visits are to be made during daylight hours.
3. Home telephone numbers are not to be given to clients.
4. Clients are not to be transported by students in personal cars.
5. Home visits should not be made on non-clinical days without prior knowledge and approval of the clinical instructors.
6. Students should sign in and out of the clinical agency, note destinations and expected time of return. If destinations are altered or expected return times changes, students are to notify clinical instructor.
7. Faculty are on site in the clinical agencies and are available for telephone consultation and joint home visits during students' clinical experience. This practice assures an ongoing evaluation of potential risks.
8. Joint student-faculty home visits are made with each student on at least one occasion during the clinical experience. This may be at the request of the student or the faculty.
9. Faculty will provide emergency numbers appropriate to clinical site.
   a. agency
   b. police
   c. rescue squad

E. Strategies for assessing the level of safety in the home environment. Students are not to make a home visit:
1. When the client/care giver is not present.
2. If domestic disputes are in progress.
3. If the student fears for his/her safety.

F. Strategies for assessing the level of safety in the neighborhood. Students should:
1. Drive around the neighborhood to become familiar with the surroundings, taking note of places of social gathering, stores, gas stations, location of public telephones, public buildings and social agencies, vacant buildings and park areas.
2. Note vehicles and persons in the vicinity of your destination.
3. Park as close as possible to the client's residence.
4. Lock the car doors when driving around and as you leave your car.
G. Required materials
   1. Name pin
   2. Stethoscope
   3. Nursing bag (provided by College of Nursing)
   4. City and County maps (provided by student)

2. Screening Process To Secure Caseload
   In order to promote a positive and safe learning environment for students, the faculty utilize those institutionalized processes already in place which assure continuity of services to clients in need. While these processes may differ in certain particulars from agency to agency, each provide for a systematic accumulation of client data at several levels. This is pertinent to informed decision making and thereby serves as a safeguard for clients, staff and students.

Clients utilized for student experiences have first been screened by personnel in referring agency (hospitals, clinics, physician's office, etc.). Pertinent information as to reason for referral and client needs is then forwarded to the local community agency (VNS, local health departments, etc.). Staff nurses and agency supervisors screen all new referrals and currently active clients and select those deemed suitable for student learning according to the attached Criteria for Selection of Caseload.

Instructors review all records and referrals and discuss with staff and/or supervisor before making final assignments. Assignments by faculty are made in consideration of the following:
1. Caseload is representational of the broad range of services provided by the agency.
2. Known complexity. Students are not assigned to clients requiring the skills of experienced practitioners.

Criteria For Selections Of Caseload
1. Family situation which enables the student to provide intensive nursing service. (Visit once or twice per week.)
2. Family situations which provide the student an opportunity to observe, define and actively participate in the promotion of continuity of care; specifically those families who are recipients of services from varied health and allied disciplines.
3. Family situations which are newly referred to the agency; those which may enable the student to make initial assessment and plan for nursing action.
4. Family situations in which progress might be noted during the student's tenure. These might include: (a) families experiencing adjustment problems relative to diagnosis and care, (b) newly diagnosed patients requiring instruction of the patient and family relative to self care, (c) families needing rehabilitation services.
5. Family situations which will exemplify for the student that patients with complex nursing care requirements can be cared for in the home.
6. Family situations which afford the student the opportunity to work with wellness. Families for which the major thrust of visits would be on health maintenance.
7. Family situations where the emphasis needs to be on health matters (mental or physical); situations in which related social problems are present but not the major point of concern.
3. **Feelings about Your First Home Visit**

    Complete the following sentences with your *initial responses*.

1. As I prepare for this visit, I feel
2. My preparation for this visit is
3. When I knock on the door
4. The **best** thing that might happen during this visit is
5. The **worst** thing that might happen is
6. During the visit, I will feel
7. After the visit, I will feel
8. My strength(s) for this visit will be
9. My limitation(s) will be
10. The family I visit will feel
4. **Student-Peer Home Visiting**

Introduction: The student-peer home visit accomplishes the goals of allowing someone to observe the student practitioner in the home situation and from that firsthand knowledge offer suggestions, resource information, supervision and evaluation of effectiveness of the nursing process. It allows for immediate feedback, lets the students contribute to their own learning and provides an opportunity to participate in some of the roles expected of the students when they graduate.

**Guidelines For Student-Peer Visiting:**

**Practitioner role:** Choose a family from your current caseload for your combined home visit. Be sure to notify the family either by phone or on the previous visit that you will be bringing another student with you who will be observing you during the visit. The Practitioner will:

1. Share pertinent background information about family with the observer.
2. Identify: Nursing diagnoses, Mutual goals, Nursing approaches.
3. Give to the observer in writing before visit:
   - Nursing behavioral objectives for this visit.
   - Specific approaches for meeting objectives.
4. Makes a home visit with observer.
5. Meets with observer and instructor after the visit for evaluation.
6. Evaluates effectiveness of visit in relation to established criteria (own nursing objectives per per strengths, weaknesses and progress.)

**Observer Role:** Your responsibility is to be prepared with information about the patient, his nursing diagnoses, mutual and/or self-goals, behavioral outcomes and past nursing interventions in order to evaluate the practitioner. You will observe during the home visit to evaluate strengths and weaknesses of the practitioner. Do not participate in the conversation or nursing care. The observer will:

1. Meet with practitioner before visit to discuss the family and review necessary background information.
2. Make home visit with the practitioner.
3. Meet with practitioner and instructor after the visit for evaluation.
   - Identify two communication patterns between student and client.
   - Identify at least two strengths of the visit.
   - Evaluate nursing techniques (applicable).
   - Discuss objectives for the visit that were met and those that were not meet.
   - Gives one alternative practice intervention.
   - Shares ideas for future nursing care.
5. Guidelines For Termination Of Client Contacts

Student Responsibilities:

1. Discuss with instructor prior to termination visit re:
   • Appropriateness of termination.
   • If further public health nursing intervention is needed. Indicate whether student nurse or staff nurse is appropriate.
   • If referral to another agency is indicated.

2. Discussion with client about termination:
   • Review the progress made with client over contact period.
   • Discuss feeling about termination.
   • Discuss referral or continued intervention by student or agency, if appropriate, and client's preference.
   • Provide contact information for additional assistance

3. Continuity with referring agency: Prepare final typed summary using the feedback report format. Reports should be ~ ½ page and submitted one report per page to clinical faculty who will send them on to the agency.

Referral Feed Back Report

To: ____________________ (agency contact person)   Dates of follow-up ____to ____
From:__________________   # visits made_______
Re: ____________________: (name of client with ID #)   # phone contacts_______

Summary Assessment:

Focal Nursing Diagnosis:

Nursing InterventionA/ Activities:

Outcome/Evaluation:

Recommendations for future follow-up (agency/ future nursing student):

5. Completion of client record:

A. If closing record:
   1. SOAP off all problems.
   2. Reflect discussion of termination.
   3. Indicate that contact phone number to referring agency was given.
   4. Indicate reason for termination.

B. If referring clients:
   1. Indicate referral action taken and discussion with client.
   2. Put copy of referral in client record
6. **FAMILY STRENGTHS:** Dr. Herbert Otto, National Center for Exploration of Health Potential, LaJolla, CA

1. Having enough time together
2. Freedom to be alone
3. Common interests
4. A liking/loving/caring for each other
5. Mutual commitment
6. Shared faith
7. Sharing of feelings
8. Lots of mutual support
9. Common goals, values
10. Agreement on handling family finances
11. Willingness to forgive
12. Fostering spiritual growth in each other
13. A good circle of friends
14. Having a lot of fun together
15. Having a sense of mission
16. Good communication
17. Freedom of expression
18. Good sense of humor
19. Respect
20. Admiration
21. Shared dreams
22. Sharing the work
23. Self-awareness
24. Good food
25. Encouragement of talents
26. Developing responsibility
27. Capacity to reach out of the family
28. Family traditions, celebrations
29. Willingness to accept other lifestyles
30. Freedom to grow as persons
31. Sensitivity to each other's needs
32. Fostering creativity in each other
33. Self-worth and self reliance building
34. Structure for problem solving/decision making
35. Interest in the world community
36. Concern for others
DOCUMENTATION OF NURSING INTERACTIONS WITH CLIENTS

Documentation of care should reflect the recording of the nursing process that was systematically applied during an encounter with a client.

INITIAL HOME VISIT
On progress notes, record in following sequence:

- Source of referral, date of referral, and reason for referral.
- Brief statement of client home environment, i.e., physical surroundings, adequacy for family size and health status, safety features.
- Narrative of first home visit highlighting assessments of family situation, identification of client needs and concluding with an initial list of potential and/or existing nursing diagnosis (there may be one or more at this point in time) along with a beginning plan of care for each nursing diagnosis -- in other words -- what are you planning for the next home visit.
- Your signature (Nancy Nurse, SPHN).

USE OF SOAIEP FORMAT IN SUBSEQUENT CLIENT ENCOUNTERS
Each nursing diagnosis that is discussed during a client encounter must be recorded using the above format. The date of each encounter must be recorded.

S = Subjective data. Should support the nursing diagnosis, use direct quotes when possible.

O = Objective data. Observations of the situation that supports the nursing diagnosis. May include observations related to the client and the environment, lab values, assessment findings.

A = Analysis of S + O cues. The statement must reflect the degree to which the goals for each nursing diagnosis are being met, i.e., progress and change or lack of.

I = Interventions. Nursing interventions that were implemented during the visit.

E = Evaluation. Should include a statement of the client's response to the interventions implemented during the visit.

P = Plan of care. Should be recorded on Care Plan forms. Should include Goal(s) statement, nursing actions (NA) and client actions (CA) that assist in accomplishing goals. NAs and CAs should be dated, and measurable with anticipated times when they are to be accomplished. NAs and CAs are dynamic and should be consistent with changing client situation. They should be sufficiently specific to provide direction for subsequent client encounters. (You may validate their clarity with a peer or instructor -- in other words, if a peer or instructor were to make the next visit to your client, would the plan of care provide the necessary direction?)

The title of the nursing diagnosis should precede each SOAIEP.

Telephone calls, efforts to coordinate care with other resources should be recorded chronologically along with the outcomes of these contacts. (Some contacts may alter the plan of care.)
Order of client folders: All material in client folders should be in the appropriate order at all times. Each of the following sections should be present in this order (chronologically as indicated).

1. Client/family information sheet and database
2. Nursing diagnosis sheet
3. Progress recording sheets (chronologically with most recent information at end).
4. Reports of referrals, tests, communications (most recent on top).
5. Final summary reports (most recent on top)
6. Referral sheets (most recent on top)

All forms for client folders will be available at the clinical site from your clinical faculty.