MICHIGAN STATE UNIVERSITY
COLLEGE OF NURSING

NURSING 410
Practicum in Community Health Nursing

COURSE SYLLABUS
Summer, 2002

Course Chairperson:
Jacqueline Wright,
Associate Professor
Course Number: NUR 410  
Course Title: PRACTICUM IN COMMUNITY HEALTH NURSING  
Course Placement: Level III  
Credit Hours: 3 (0-9)

Course Description:  
Clinical experience in community health nursing focusing on the application of public health and nursing principles in the care of individuals/families and populations in a variety of community-based settings.

Course Objectives:  
1. Apply strategies for assessment, planning, intervention and evaluation that are appropriate to individual/family and population clients in community settings.  
2. Provide comprehensive assessment data to support community health nursing diagnoses, including epidemiological, family, and community data.  
3. Apply established research findings as a basis for making judgments in community health nursing practice.  
4. Describe major legal, social, cultural, political and economic issues relevant to the delivery of community-based nursing care.  
5. Coordinate appropriate community resources in the care of the individual/family or population client.  
6. Accept individual responsibility and accountability in community health nursing practice.  
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.

Supplementary resources:  
A listing of web-based resources will be sent to all students during the first week of classes.

Course Chairperson:  
Jacqueline Wright  
Office: A 122 Life Science Bldg.
Phone: 353-8677 or 355-2337  
Email: jackiew@msu.edu  
Office hours: By appointment

Course Faculty:
All course faculty have mailboxes in the second floor mailroom in the College of Nursing. In order for you to place something in the mailbox, you must first sign the item in and leave it in the tray on the counter in room A230 Life Sciences Building. Individual faculty will provide students with information about telephone numbers during the first week of the semester. Faculty by clinical site are:

- Elaine McParlane,  
  Ingham County Health Department, Lansing  
- Jacqueline Wright,  
  Walnut Street School and 20th Precinct Community Center, Lansing  
- Pam Groner,  
  Calhoun County Health Department, Battle Creek  
- Jane Clark,  
  Barry-Eaton County Health Dept., Charlotte

Instructional Model:
Nine (9) hours per week will be spent in guided community-based nursing practice. Students will participate in community health nursing clinical experiences and conferences/seminars each week. Faculty will provide students with information about specific learning opportunities and expectations during the first week of clinical. All students are expected to meet course and College of Nursing clinical expectations outlined below and in the CON Undergraduate Student Handbook.

NUR 410 Basic Clinical Expectations:
1. Clinical preparation and professional behavior. Students are expected to be active and assertive learners throughout the semester. Using the clinical faculty as a resource person, students are to:

   a. Develop personal learning objectives based on course objectives/requirements, clinical learning opportunities and personal interests. Objectives must be active and measurable.
   b. Seek out, structure and direct own learning activities in collaboration with faculty to facilitate maximal attainment of personal and course objectives.
   c. Evaluate learning activities and progress in meeting objectives through weekly critical reflections and midterm / endterm evaluations.
   d. Approach faculty and appropriate others for consultation when indicated.
   e. Provide written plans of care based on theoretically sound rationale prior to each client encounter and document promptly following each client-related encounter.
   f. Apply promptly all feedback (verbal and written) from faculty to future performance.

Demonstrate the following qualities as ‘initiate and carryout’ each clinical day:
1) assertive and appropriate in expressing own thoughts, feelings, needs and concerns.
2) prepared to function independently in clinical role, seeking assistance appropriately.
3) active participant in group clinical activities.
4) efficient management and use of clinical time, including priority setting and planned back-up activities for the inevitable day when anticipated plans collapse.
5) demonstrate expected professional behavior, including timeliness, appropriate community health nursing attire* & MSU name tag.
6) provide own vehicle.
*Note: Appropriate community health nursing attire includes 1) non-white ‘business casual’ slacks/skirt, and 2) non-white leather shoes. Additionally, a suitable ‘business casual’ shirt may replace the uniform CON polo shirt. See ‘Guidelines for Client Encounters’ for further elaboration.

2. Clinical Conferences/Seminars. Conferences will occur each clinical day for the purpose of enhancing student learning and integrating theoretical concepts with community health practice. 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. Additionally, each student will facilitate one brief content-specific seminar to his or her clinical group.

3. Patient confidentiality, documentation and correspondence. Nursing 410 patient confidentiality guidelines will be described during orientation and must be followed at all times. Each student must sign the NUR 410 confidentiality agreement prior to initiating clinical activities.
   Students must document all community health nursing practice activities in family and population documentation folders each clinical week. Additionally, students are to provide midterm and end term reports to referring agencies for all family and population clients followed. All correspondence with agencies, other health professionals, clients, etc. 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 activities are designed to link 409 theory systematically to community health practice. Students are required to submit 5 theory application assignments to their clinical faculty within two weeks of the time the theory is covered in NUR 409.

5. Nursing research article annotations. To facilitate application of research to community health nursing practice, each student is required to prepare 2 brief annotations of research articles relevant to their community health nursing practice during the first half of the semester. The articles chosen for annotation must relate to issues encountered during clinical experience, be published in peer-reviewed research journals within the last 5 years and reflect a nursing research concern. A copy of the article is to be submitted attached to each annotation. The annotations should:

   a) Reference the article and source using APA format
   b) Describe the community health issue addressed
   c) Critique the research question and findings
   d) Discuss specific relevance of the research to situation/s encountered during clinical.
6. **Folders.** Students are to submit personal folders each week to clinical faculty that include:
   a) **Objectives sheet:** List of course and personal objectives for the semester.
   b) **Clinical calendar:** Ongoing calendar for a record of planned and actual weekly activities.
   c) **Critical reflections journal:** Weekly reflections on experiences that address the following questions:
      1) *What did I learn* this week in relation to course and personal objectives?
      2) *What theory* from NUR 409 and *research* did I apply this week?
      3) *What learning questions* were raised by this week’s experiences; where will I get the information to answer the learning questions?
      4) *What thoughts and feelings* do I have about this week’s experiences?
   d) **Assignments:** Theory application assignments and nursing research article annotations.
   e) **All other material** requested by your clinical faculty, including midterm and end term evaluations.

   *All submitted materials are to be typed. The date/time and method of submission of weekly folders will be arranged with faculty.*

7. **Nursing care delivery.** Throughout the semester, each student is to provide community health nursing services to both individual/family and population clients. Additionally, students are expected to participate in a minimum of one system-focused or public health observational experience.

**Levels of nursing care delivery in 410:**

1. **Population-focused care: Improving the health status of identified populations.** Students work together in groups or individually to assess, diagnose, plan and implement specific population-focused health projects that meet identified needs of a defined community group. Documentation of all population-focused activities must be maintained in an appropriately labeled folder. A population-focused report is to be submitted which summarizes the processes and outcomes of care following a community nursing process format (Population-focused care report guidelines).

   This experience is designed to provide an opportunity to develop personal knowledge and skill in working with populations to improve their health. All population-focused care must address a health need identified by the community and use a collaborative approach to the provision of care. Students are expected to partner with community members and empower them to meet their identified health needs. Examples include: nutrition education with parents, adolescents and/or school aged children; health teaching to senior citizens; being part of a community group planning a health fair or other community event; participating in a health promotion project such as passage of a clean air referendum, mental health parity legislation or development of a neighborhood exercise program in a school.

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 community-based clients. Care delivered to individuals is provided within the context of their family, and families are considered within the context of their community. Students are expected to partner with families and empower them with the knowledge and skills necessary to meet their identified health needs. Continuity across the continuum of care is emphasized. Caseloads are obtained from community-based primary care...
providers and from school nurses. Care is usually delivered in home and/or school settings.

4. System-focused care: Students may chose to be involved in health/ political system activities that impact public health. Activities may range from a health or political system ‘population project’ to attending/observing community health planning meetings. The clinical faculty / course chair will assist in identification of appropriate activities. Observational experiences must be reported in a separate entry in the weekly folder that includes:

   f) description of the community health group/activity and focus
   g) description of the focal population served & approaches used to address identified needs.
   h) evaluation of what was learned from this experience.

4. Public health observational experiences can be arranged according to gain a broader exposure to community/public health. These include but are not limited to observational experiences in occupational health, school health, correctional health, public health nursing, maternal child health and environmental health. These experiences must be reported in a separate entry in the weekly folder as noted for system-focused experiences (#3 above).

Attendance Policies:
Attendance at all clinical experiences (each clinical day) is required. A student who cannot attend a clinical experience must notify their clinical instructor prior to the start of the clinical day using the defined call-in protocol. 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 on the first clinical day regarding how to notify them of an anticipated absence from a clinical experience (call-in protocol). A student who misses a clinical experience may be required to 1) provide appropriate a written excuse from a health care provider for incidents of illness/injury, and 2) make-up the clinical time. Students with unexcused absences or excessive absences from clinical that are in jeopardy of failing to meet course objectives may be asked to withdraw or receive a ‘0’ in the course.

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.

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 unsafe or dishonest behavior, unexcused absences and failure to meet minimal course expectations.

NUR410 syllabus, page 6
The following scale will be used for grade determination:

<table>
<thead>
<tr>
<th>Percent</th>
<th>Grade Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 - 92</td>
<td>4.0</td>
</tr>
<tr>
<td>91 - 86</td>
<td>3.5</td>
</tr>
<tr>
<td>85 - 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>
<tr>
<td>&lt;60</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Each student will have a formal mid and end semester conference with their clinical faculty. Each student will be expected to submit a completed self-evaluation prior to the mid and end semester conferences. Progress toward goals will be discussed at mid-semester, identifying strengths and weaknesses in performance and an action plan formulated. The final clinical grade will reflect progress over the semester in achieving course objectives.

Student Progress:
All students are expected to critically reflect on their learning progress each week and to apply promptly all faculty feedback (verbal and written) to future performance. Students who believe they may be experiencing academic difficulties are urged to promptly obtain faculty guidance in proposed remedial activities.

Course concerns:
A student who has a concern related to the course is expected to approach their faculty to discuss the situation. Resolution of a concern on an informal basis between the student and faculty is encouraged. If the concern is not resolved at this level, the student is advised to set up an appointment with the Nursing 410 course chairperson to present the problem and discuss a proposed solution. Alternatively, student representatives may request a meeting with the course chair to present student concerns. 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. A joint meeting between the student, clinical faculty, the Nursing 410 course chairperson, and a Student Affairs representative may be required.
MSUCON 410 Evaluation Guidelines

Midterm evaluation process instructions

1. *Complete and turn in midterm self-evaluation* (due the Friday before midterm).
   
a. NUR 410 Community Health Nursing Competency Evaluation Form: Midterm self-ratings with rationale.
   
b. Midterm journal entry (1 page) that includes:
      (1) Evaluation of progress meeting personal objectives.
      (2) Evaluation of overall performance at mid-semester (strengths and areas to strengthen).
      (3) Listing of 2-3 ways in which your clinical faculty can facilitate your learning.
   
c. Evidence that theory application assignments are up to date and that research annotations are completed and turned in.

2. *Schedule and participate in midterm evaluation conference with faculty.*

Final evaluation process instructions

1. *Complete and turn in final self-evaluation* (due 2 days after the final clinical day).
   
a. NUR 410 Community Health Nursing Competencies Evaluation Form: Completed per instructions on form.
   
b. Final journal entry (≤ 2 pages) that presents:
      (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/public health nursing.
   
c. Final Clinical Evaluation Form: Complete.

2. *Schedule/complete final evaluation conference with clinical faculty,*
   
a. Participate in conference
   
b. Sign completed Final Clinical Evaluation Form during conference.

*Note:* All clinical documentation must be submitted by the final clinical day.
- All documentation organized in family folders.
- All documentation organized in population folders.
- Final reports to referring agency.
# MSUCON NUR410 Clinical Evaluation Form

<table>
<thead>
<tr>
<th>Course Expectations</th>
<th>Possible points</th>
<th>Points achieved</th>
<th>Evaluation evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Health Nursing Competencies</strong></td>
<td>80</td>
<td></td>
<td>Completed Competency</td>
</tr>
<tr>
<td>- Population-focused care</td>
<td></td>
<td></td>
<td>Evaluation Form</td>
</tr>
<tr>
<td>- Project title/s:</td>
<td></td>
<td></td>
<td>- Project activities</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td>- Project report/s</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td>- Documentation</td>
</tr>
<tr>
<td>Group report/s complete? yes___ no___</td>
<td></td>
<td></td>
<td>- Conference sharing</td>
</tr>
<tr>
<td>- Family-focused care</td>
<td></td>
<td></td>
<td>- Caregiving activities</td>
</tr>
<tr>
<td>No. clients followed _____</td>
<td></td>
<td></td>
<td>- Documentation</td>
</tr>
<tr>
<td>No. visits: home___ phone___ school___ other___</td>
<td></td>
<td></td>
<td>- Conference sharing</td>
</tr>
<tr>
<td>Documentation complete? yes___ no___</td>
<td></td>
<td></td>
<td>- Joint visits</td>
</tr>
<tr>
<td>- System-focused care &amp;/or observational experiences List:</td>
<td></td>
<td></td>
<td>- Journal entry</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Conference sharing</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>20</td>
<td></td>
<td>- Competency Evaluation</td>
</tr>
<tr>
<td>- Professionalism</td>
<td></td>
<td></td>
<td>Form Section D</td>
</tr>
<tr>
<td>- Participation in clinical group seminars</td>
<td></td>
<td></td>
<td>- Quality and effort in</td>
</tr>
<tr>
<td>- Weekly folders</td>
<td></td>
<td></td>
<td>meeting course requirements</td>
</tr>
<tr>
<td>- Theory application assignments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nursing research annotations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Points</strong></td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Summary Student Self-evaluation:** Circle the score that you believe best reflects the degree to which you have met course objectives: 1.0 1.5 2.0 2.5 3.0 3.5 4.0

**Course grade achieved:**

**Comments:**

---

Signature, student

Signature, faculty
MSUCON NUR410
Community Health Nursing Competency Evaluation Form

Directions: On the following list of community health competencies, circle your level of performance for each competency using the following rating scale. Whenever a 4 or 3 is selected, please give a specific example of performance evidence in the space provided.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 = Outstanding</td>
<td>Demonstrates consistent exceptional performance, goes beyond expected course requirements, consults with appropriate others when need arises, demonstrates self-direction, role model for others.</td>
</tr>
<tr>
<td>3.5 = Above Average</td>
<td>Demonstrates very good, appropriate performance, seeks appropriate guidance and incorporates suggestions into practice.</td>
</tr>
<tr>
<td>3.0 = Competent</td>
<td>Demonstrates good, appropriate performance with faculty oversight.</td>
</tr>
<tr>
<td>2.0 = Adequate</td>
<td>Carries out expected behavior safely with continuous directives from faculty.</td>
</tr>
<tr>
<td>1.0 = Unacceptable</td>
<td>Unable to meet the minimal level of performance with guidance.</td>
</tr>
<tr>
<td>NA = Non-applicable</td>
<td>Experiences not conducive to facilitating/demonstrating the competency.</td>
</tr>
</tbody>
</table>

Note: Client refers to family and population-focused 'group' clients.

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>Evaluation Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment, Analysis and Diagnosis</td>
<td></td>
</tr>
<tr>
<td>1. Systematically collects comprehensive data in partnership with the client.</td>
<td>na 1 2 3 3.5 4</td>
</tr>
<tr>
<td>2. Identifies clients at risk for health problems considering the determinants of health (behavior, biology, physical/social environments, access to quality health care, and political/economic factors).</td>
<td>na 1 2 3 3.5 4</td>
</tr>
<tr>
<td>3. Applies epidemiological principles and scientific knowledge to decision processes.</td>
<td>na 1 2 3 3.5 4</td>
</tr>
<tr>
<td>4. Analyzes client data in view of the nature of the problem in populations.</td>
<td>na 1 2 3 3.5 4</td>
</tr>
<tr>
<td>5. Formulates and prioritizes relevant data-based nursing diagnoses that are client-validated.</td>
<td>na 1 2 3 3.5 4</td>
</tr>
</tbody>
</table>
Planning and Implementation

6. Incorporates nursing research findings, health promotion/disease prevention guidelines, and scientific knowledge in care planning.  na 1 2 3 3.5 4

7. Identifies attainable expected outcomes relevant to the diagnoses.  na 1 2 3 3.5 4

8. Promotes client independence, control and decision-making abilities in implementing interventions to achieve identified outcomes.  na 1 2 3 3.5 4

9. Uses effective communication skills.  na 1 2 3 3.5 4

10. Collaborates with other health/social service professionals and community representatives to improve the health status of clients.  na 1 2 3 3.5 4

Evaluation

11. Evaluates interventions to determine client progress toward outcomes and to improve care processes.  na 1 2 3 3.5 4

Professional Development

12. Adheres to professional ethics and standards of practice, including protecting client privacy and maintaining personal and client safety.  na 1 2 3 3.5 4

13. Documents care accurately, appropriately and in a timely manner.  na 1 2 3 3.5 4

14. Demonstrates critical thinking and independent judgment in clinical decision making.  na 1 2 3 3.5 4
## Population-Focused Care Report Guidelines

<table>
<thead>
<tr>
<th>Descriptive information</th>
<th>points</th>
<th>Expectation for report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Project title and dates</td>
<td></td>
<td></td>
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<tr>
<td>• Project team members</td>
<td></td>
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<tr>
<td>• Project abstract (brief summary)</td>
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</tbody>
</table>

### Population Assessment:
- Synthesize relevant data from multiple sources
  - Data from existing sources including comparative county/state/national data
  - Key informant interview data
  - Direct observation & survey data
  - Scientific knowledge re. focal area
- Analyze and interpret data, apply literature-based information/research to interpretation of data
- Identify population assets and health concerns

The assessment process is clearly presented.

1) Data presented using narrative and tables
2) Data interpretation applies scientific knowledge and clearly tells what data means in relation to the focal population
3) Population assets and health concerns listed

### Population Diagnoses:
- Diagnoses flow from assessment data and are relevant to community health nursing

5) Diagnosis stated per NUR 409 content
   - Description of strength/problem
   - Etiologically-related factors
   - Characteristic signs and symptoms

### Population Intervention:
- Intervention plan (objectives, methods and content) and expected outcomes
- Evaluation plan

The intervention and evaluation are completely presented.

6) Intervention flows from assessment/diagnoses and considers desired outcomes
7) All materials used in/created for intervention included in report
8) Evaluation plan is attainable and relevant

### Evaluation of Care Delivered:
- Outcome evaluation
- Process evaluation of approaches/methods

Evaluation data and narrative presented

### Reference list

All data sources and references presented in APA format

### Personal evaluation of the project
- Degree of learning achieved
- Level of self/peer participation
- Faculty direction and support
- Environmental/setting factors

Each member does personal evaluation per criteria listed that is placed loose at end of report or included in personal folder identified by project/name

(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 may be due at staggered times throughout the project.)
NUR 409/410 THEORY APPLICATION ASSIGNMENTS
Submit each core assignment to your 410 clinical faculty within two weeks of covering the associated theory material in 409, insert the date submitted on the list below.

**CORE Assignments:**

1. Based upon the six public health nursing competencies identified by Zerwekh, a qualitative study discussed in NUR 409, select two competencies which you believe you possess at this time. Also select two competencies that you believe require further development; substantiate your selections (week 1).

2. Review the sections about salmonella, chlamydia and pediculosis in the *Communicable Disease Manual* (available at each clinical site and in MSU Library). Compare and contrast the diseases according to the following epidemiological parameters: population at risk, agent-host-environment interaction, natural history of the disease, and primary approach to control the disease (week 2).

3. Select a health risk appraisal and ask one of your clients to complete it. Review the results with the client. Ask the 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. In your write-up 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’ (week 3).

4. Select and visit a community agency relevant to your family or population-focused clients. Secure the following information about the agency: source(s) of funding, mission and philosophy, target clientele, services provided, costs to clients. State type of agency, e.g., public, private or mixed; give two characteristics of the agency that support your conclusion (week 4).

5. Describe an environmental issue you have identified related to a client, neighborhood or the broader community. Give rationale to support your selection as an environmental issue. State a primary, secondary, and tertiary intervention which could be taken to address this issue; substantiate your choice of each level of intervention. (week 5).

**Seminar Topics**
Each student will prepare and facilitate a clinical seminar from the following topics. The following are suggested topics.

1. Priority setting in community health.
2. School nursing.
3. Occupational health nursing.
5. Adult and child immunizations
6. Transcultural Nursing.
7. Women’s health
8. Environmental health (specific issue to be identified)
9. An identified population-at-risk
10. Quality management / improvement in CHN
Michigan State University College of Nursing  Name__________________________ Page # ___
NURS 410 Clinical Calendar
(The calendar provides a mechanism to plan and document your clinical activities each day. Please list the specific time, location and nature of all planned activities. Indicate phone number for all planned visits to homes/ agencies.)

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Activities Scheduled/Planned (complete prior to clinical day)</th>
<th>Activities Conducted (complete during/after clinical day)</th>
<th>Hrs. for Week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

NUR410 syllabus, page 14
Guidelines For Client Encounters

Content outline:
1. Safety.
2. Selection of Family Client Caseloads
3. Student-Peer home visiting
4. Documentation
5. Termination of family contacts.

1. Guidelines For Safety: Nursing is a profession in which practitioners are exposed to many different kinds of risks. 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.

A. Attire. A professional image is one of the best insurance 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 professional clothing. Jeans, visible midriff and thighs are unacceptable.
   2. Limited jewelry. Watches, wedding and small engagements rings and costume earrings are acceptable.
   3. Tailored shoes must be worn with stockings. Clogs and sandals are unacceptable. Shoes or slippers should be carried into client homes during boot weather.
   4. Purses, if used, should contain only essentials and must be locked in car trunk.
   5. Name pin for clear identification must be worn during clinical hours.

Students not adhering to dress code will not be allowed to participate in clinical until appearing professionally and appropriately dressed.

B. Demeanor. A caring yet confident attitude characterizes a professional image. The student nurse should:
   1. Know how to get to location prior to leaving.
   2. Acknowledge neighborhood residents/ individuals that she/he may encounter in a relaxed tone of voice and with eye contact.
   3. Walk at a steady pace with head up to destination, like you belong where you are.

C. Nursing bag. The nursing bag generally symbolizes a helping person. It should be carried on the initial client visit and be assessable w/in the car on subsequent visits. The student nurse should:
   1. Let it be known that the nursing bag contains no drugs or needles.
   2. Keep in trunk or covered in the care
   3. At the end of the day, take the nursing bag into your home or leave in the clinical office.

D. Home visit preparation and guidelines
   1. Identify the most direct and purposeful routes to client homes on a map as plan visit.
   2. Home visits are to be made during daylight hours.
   3. Home telephone numbers are not to be given to clients.
   4. Client records are not to be taken on home visits but are to remain at the clinical site. Do not remove for any reason.
   5. Clients are not to be transported by students in personal cars.
   6. Home visits should not be made on non-clinical days without prior knowledge and approval of the clinical instructors.
   7. 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.
8. Students must notify faculty when finish their clinical day in manner arranged.
9. Faculty are on site in the clinical agencies and are available for telephone consultation and joint home visits during students' clinical experience.
10. Joint student-faculty home visits are made with each student at least once during the clinical experience. This may be at the request of the student or the faculty.
11. In an emergency, dial 911 first and then contact faculty.

E. Strategies for assessing the level of safety in the home environment.
   Students are not to make a home visit when the client/care giver is not present, if domestic disputes are in progress, and if the student fears for his/her safety. Students should have a clear exit route available at all times.

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: Name pin, stethoscope, nursing bag, city/county maps, visit plans.

**Selection of Family Client Caseloads:** Personnel in referring agency have first screened family clients utilized for student experiences. Pertinent information as to reason for referral and client needs is then forwarded to 410 faculty. Faculty review all referrals and discuss with agency before making final assignments.

**Criteria For Selections Of Caseload:** Family situations that:
- enable the student to provide intensive nursing service with the primary emphasis on mental and/or physical health
- 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 social disciplines.
- allow the student to make an initial assessment and plan for nursing action.
- progress can be expected during the semester--these might include families experiencing developmental adjustments, newly diagnosed patients requiring self-management instruction for the patient and family, families needing rehabilitation services.
- afford the student the opportunity to work with wellness and health promotion.

**3. 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 (per own nursing objectives—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.
   - 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.

4. **Documentation Of Nursing Care:** Documentation of care should reflect the recording of the nursing process that was systematically applied during an encounter with a client. All home, population, phone visit attempts and encounters with other agencies on behalf of a client must be recorded. The precise format for documentation may vary depending on the unit of service, referral source and clinical site requirements.

   **First Family Client Encounter:** During the first encounter with family clients, complete / update the family information sheet in the chart.

   On progress notes, record in following sequence:

   - Date and type of visit made, if accompanied-by whom.
   - 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 (Kris Jones, MSU Nursing Student).

**Subsequent Family Client Encounters:** A nursing diagnosis must be written on the diagnosis sheet for each identified client concern that is addressed. Each nursing diagnosis discussed during a client encounter must be documented in a SOAIEP narrative note using the following format:
Name or reference number of the nursing diagnosis.

S = Subjective data. Data from client that support the nursing diagnosis, including direct quotes.

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

A = Analysis of S + O cues.

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 with expected outcomes, nursing actions (NA) and client actions (CA) that assist in accomplishing goals. They should be sufficiently specific to provide direction for future client encounters.

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).

i) Client/family information sheet and database
j) Nursing diagnosis sheet
k) Medication sheet
l) Progress recording sheets (chronologically with most recent information at end).
m) Reports of referrals, tests, communications (most recent on top).
n) Final summary reports (most recent on top)
o) Referral sheets (most recent on top).

5. Guidelines For Termination Of Client Contacts

Student Responsibilities:
1. Discuss with instructor prior to termination visit re:
   a. Appropriateness of termination.
   b. If further public health nursing intervention is needed.
   c. If referral to another agency is indicated.

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

3. Continuity with referring agency: Prepare final typed summary using the feedback report format. Reports should be ~ ½-1 page, single spaced, and submitted, one report per page, to clinical faculty who will send them on to the agency.

4. Completion of client record:
   a. If closing record:
      (1) SOAIEP 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
MSUCON Community Health Nursing Referral Feedback Report

To: __________________________ (agency contact person)  Dates of follow-up __/__ to __/__/__

From: _________________________, MSU Nursing Student  # direct visits made____

Re: ___________________________ (client identifier)  # phone visits____

Reason for referral:

Focal Nursing Diagnosis and summary of assessment:

Nursing interventions/activities:

Outcomes evaluation:

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

Signature

______________________________
Michigan State University College of Nursing
Nursing 410 Practicum in Community Health Nursing
Confidentiality Policy and Agreement

Policy Statement
The MSU College of Nursing 410 Practicum in Community Health Nursing is committed to protection of patient confidentiality in providing health care to clients and communities. All information about clients, whether from verbal, written, and/or electronic sources, will be held in the strictest of confidence. This includes but is not limited to reports, records, and data pertaining to testing, care treatment and reporting. Any information pertaining to the treatment, general health or whereabouts of a client will not be released without the written permission of the client. ‘NUR 410 Procedures To Maintain Patient Confidentiality’ will be followed at all times as outlined to assure patient privacy.

Confidentiality Agreement

1. I accept responsibility for maintaining confidentiality of all personal information entrusted to me.

2. I understand that personal information may not be released to anyone without the written consent or authorization of the individual, unless allowed by law.

3. I accept responsibility for the integrity and accuracy of all information I communicate in verbal, written, and/or electronic forms.

4. I understand that disposal of all personal health information shall be by shredding.

I have read the above statements and agree to adhere to and maintain confidentiality.