Homework Tips

Each written assignment must include the three following 1/4 to 1/2 page summaries:

- Pathophysiology of main problem(s)
- Developmental assessment, at minimum describing:
  - Erickson's
  - Age-related changes
  - Advance Directives
  - Financial concerns
  - See Rubric in syllabus for grading guidelines
- Health Deviation assessment, including **ALL** health problems (not just the admitting diagnosis) **and** the patient's ability to meet healthcare needs after discharge (or if resources/placement are needed)

Each assignment must include:

- Completed medication template, including ALL meds the patient is prescribed, not just the ones you actually administer, and should include ongoing assessments as needed
- Completed lab template, including interpretation of pertinent labs for YOUR patient, implementation, and should include pertinent trends.

Copy only ONE H & P from the binder (hard chart). *Do not copy a procedure report*. If you cannot find an H & P on the chart, let instructor know and she will print it from the computer for you. Do not copy more than one document from that chart. CUT out all confidential information and MD names! *Have your resource person check your printout before you leave your unit*. A PI will be given if you are found to have copied more than one document from the chart, or if all confidential information and/or MD names are not deleted.

CTW

All sections are to be completed as applicable to your ***specific*** patient. Each section will have at minimum a #1, 3, & 5. Include a #2 & 4 **if** it applies to your patient (it often will!). Remember to include age-related changes as they apply. **Also remember to include diabetes in water/food, urine and kidney function in elimination, skin in hazards, Erickson's in developmental** (these are commonly omitted by students).

List all data that is PERTINENT to *your particular patient*, basic and comprehensive. Must be individualized to the patient you are writing about.

#2 Comprehensive should include history, meds (in hospital AND at home), other disciplines/departments, lab work, diagnostic test results, etc.

#3 Rationales: **<u>This is application</u>!** Must express **<u>WHY</u>** you think the assessment applies to THIS PARTICULAR patient – do not tell me what the assessment itself will provide. Think, "I did _____ <u>because</u> _____ ."
(this assessment) (how it applies to my patient)
Also think how a health deviation might influence your decision to assess something.
<u>You need to show links between theory and application here!</u>

#4 NANDA's should be written only if applicable. <u>Evidence must be listed in assessment sections #1 or #2 in that category</u>. If you write more than one NANDA in a section, list in order of priority.

#5 Should include at minimum:

- At least one predicted patient outcome, i.e., "No further incidences of chest pain" or "Verbalizes less pain," or "Lungs remain clear," or "No falls during stay," etc.
- Patient outcomes must be written in <u>patient</u> terms (not nursing goals), be realistic for your specific patient, and be measurable.
- Ongoing assessments or interventions, <u>with specific time frames</u>, i.e., "Offer pain med every 4 hrs" or "CDB every 2 hours" or "Auscultate heart sounds every shift," etc.
- Collaboration with other disciplines/referrals as pertinent for your patient

<u>NN's:</u>

<u>Date</u> each page and sign each entry!
Leave no empty lines between entries.
These are to be *narrative* notes – NOT focused notes, or "charting by exception"
OK to document in blocks of time

- Must have a start AND end time, i.e., 0800-1100
- Sentinel events must be documented at the specific time of occurrence, i.e., don't chart a fall, rapid response, code or patient incident in the middle of a block.

If you chart that you notify someone of something, you must also document their <u>name</u> and specifically what you reported. If it is an MD, you must also document the MD's response.

Tip: Develop a "system" for charting, i.e., organize by systems and/or chart the same way every time (this way you don't inadvertently skip something), etc.

If you have an abnormal assessment finding:

- your intervention should immediately follow the documentation of the assessment
- you should assess it again in the 2nd half of the shift. This evaluates your interventions and guides future interventions.