OPEN UNIVERSITY MALAYSIA

FACULTY OF NURSING AND ALLIED HEALTH SCIENCES

NBNC 1307
CLINICAL PRACTICE 11
(TRAUMA & EMERGENCY NURSING)

CLINICAL PRACTICE COURSE KIT

SEPTEMBER SEMESTER 2015

INTRODUCTION

NBNC1307 Clinical Practice 11 on **Trauma & Emergency Nursing** course will focus on application of theory from the theoretical course subject **NBNS1504 Trauma & Emergency Nursing** into practicum. Hence, you are encouraged to read **NBNS1504 Trauma & Emergency Nursing** for theoretical input for your practicum in addition to this module.

Health assessment is an integral part of nursing. You may find it beneficial to revisit and review the module **NBHS1103 Advanced Nursing Assessment** to guide you in conducting assessments on clients at the Emergency Department and planning their nursing care by appropriately utilizing nursing process.

Additionally, you are also encouraged to apply all the knowledge and skills gained from your previous learning, especially relating to nursing management and professionalism.

In order to achieve **7 credit hours**, you would have to undertake BOTH the General Practicum and Specific Practicum as stipulated in the table below:

CLINICAL PLACEMENT	PRACTICUM HOURS / DURATION
1. General Practicum: • Practicum takes place in your respective area of practice. Your official working hours are considered as the practicum hour. • You do not need a preceptor for general practicum. • You are self-directed in implementing your learning activities. You are expected to apply or practice skills that you have learned from the specific practicum whenever possible.	**324 hours** Recommended practicum hours: • 41 days per semester. • At least 8 hours per day for 5 days per week.
2. Specific Practicum: • Placement will be in an Accident and Emergency setting. • You must set aside the practicum hours separately from your official working hours. • A Clinical Preceptor will be assigned for you / your group.	**96 hours** Recommended practicum hours: • 8 hours per week x 12 weeks (on weekends only) **OR** • 8 hours per week x 6 weeks (on weekends) + 8 hours per day x 6 days consecutively (including week days) **OR** • 8 hours per day x 12 days consecutively
TOTAL : 7 credits =	**14 weeks / 420 hours**

COURSE OBJECTIVES

At the end of the **General Practicum**, you should be able to:-

1. perform skills learned from the specific practicum where applicable.
2. deliver nursing care to the clients by using nursing process.
3. communicate with clients as well as their families and relatives with caring and empathy.

At the end of the Specific Practicum, you should be able to:-

1. utilise the nursing process approach in caring for trauma clients and their families; and managing emergency situations.

2. perform health assessment as part of the nursing process.

3. perform triaging and primary survey appropriately.

4. perform various methods of splinting or immobilization :-
   a. Performing modified jaw thrust.
   b. Assisting in and / or performing application of cervical collar.
   c. Spinal Logrolling.
   d. Splinting of the limb extremity.

5. perform non invasive hemodynamic monitoring:
   a. Monitor oxygen saturation via pulse oximetry.
   b. Monitor (and interpret) cardiac rhythm.
   c. Monitor blood pressure.
   d. Obtain recording of a 12 leaded ECG.

6. perform and assist in providing cardiac life support :-
   a. Insert an oropharyngeal airway.
   b. Deliver cardiopulmonary resuscitation. **(Please refer to Appendix 1 for the latest BLS for Healthcare Providers)**
   c. Deliver ventilation using the bag-mask-valve devices.
   d. Assist in endotracheal intubation.
   e. Assist in defibrillation.
   f. Manage foreign-body airway obstruction (choking).

7. administer initial oxygen therapy.

8. assist in performing of the following procedures:
   a. Venipuncture.
   b. Toilet and suturing of wound / Incision and drainage of abcess.

SUMMARY OF CLINICAL PRACTICE HOURS (GENERAL PRACTICUM)

Please record the summary of your Clinical Practice Hours in the table below. Make sure that you have a minimum of **324 hours of General Practicum.** This is **MANDATORY.**

Date	Time	Total Hours	Superior's Signature (e.g. Matron/Sister/Director)
TOTAL HOURS			

- Attach with additional paper if necessary.
- Attach the photocopies of your Roster / Records of Working Time (e.g. Punch Card)

SUMMARY OF CLINICAL PRACTICE HOURS (SPECIFIC PRACTICUM)

Please record the summary of your Clinical Practice Hours in the table below. Make sure that you have a minimum of **96 hours of Specific Practicum.** This is **MANDATORY.**

Date	Time	Total Hours	Local Preceptor's / Coordinator's Signature
TOTAL HOURS			

ASSESSMENT METHODS

You will be evaluated for the course **NBNC 1307 Clinical Practice 11** as follows:

SN	GRADED ASSESSMENT	ALLOCATION OF MARKS		REMARKS
1	Case Study	40%		Deadline for submission – **30 November 2015**
2	Clinical Practice Records: • General Practice Hours - achieved minimum of **324 hours** • Specialized Practice Hours - achieved minimum of **96 hours** • Bedside Teaching – attended **ALL** Bedside Teaching sessions (4 topics)	2% 4% 4%	10%	Attached with verified roster / record of working hours
3	Nursing Procedures: • Major Procedures (10) • Minor Procedures (10)	20% 10%	30%	Performed under the supervision of the LP and verified
4	Oral Presentation of the Case Study	20%		20-minutes presentation
	TOTAL	**100%**		

SN	NON-GRADED ASSESSMENT
1	Clinical Performance Evaluation (by Clinical Preceptor): • You will receive a non-graded feedback or evaluation from your Clinical Preceptor for your clinical performance.
2	Student's Evaluation of Clinical Practicum: • You are required to provide feedback by evaluating your clinical experience.
3	Student's Evaluation of Clinical Preceptor: • You are required to provide an evaluation of your Clinical Preceptor.

REMINDER TO CLINICAL PRECEPTORS

This Course Kit must go hand-in-hand with the module **NBNC 1307 Clinical Practice 11.** You **MUST HAVE BOTH COPIES** for your reference in planning and implementing your teaching and learning activities with the students

TOPICS FOR BEDSIDE TEACHING – TRAUMA & EMERGENCY NURSING

No.	Topic	Date	Preceptor's Signature	Student's Signature
1	Overview of trauma and emergency care nursing - Providing physical & psychological care and communicating with client and family			
2	Nursing role in triaging			
3	Nursing role in resuscitation			
4	Documentation and handling of medico legal case			
Total Number of Session Attended				
Total Marks				

PLEASE NOTE:

An attended Bedside Teaching session is entitled for a full mark of **1**
Total Marks for FULL attendance of **4** Bedside Teaching sessions is **4**

NURSING PROCEDURES ON TRAUMA & EMERGENCY NURSING

A. MAJOR PROCEDURES – 20%

NO.	PROCEDURES	DATE	STUDENT'S PERFORMANCE		PRECEPTOR'S SIGNATURE
			Good (2%)	Poor (1%)	
1.	Performing & assisting in providing cardiac life support:-				
	1.1 Inserting an oropharyngeal airway				
	1.2 *Delivering CPR- adult				
	1.3 *Delivering CPR - peadiatric				
	1.4 Managing choking- adults				
	1.5 Managing choking - pediatric				
	1.6 Delivering ventilation via bag-mask-valve devices				
	1.7 Assisting in endotracheal intubation.				
	1.8 Assisting in defibrillation.				
2.	Assist in performing of the following procedures:				
	2.1 Venipuncture				
	2.2 Toilet and suturing of wound				
TOTAL MARK ACHIEVED					

PLEASE NOTE:

A correctly (GOOD) performed Major Nursing Procedure is entitled for a full mark of **2%**
Total Marks for 10 correctly (GOOD) performed Major Nursing Procedure is **20%**

***(Please refer to Appendix 1 for the latest BLS for Healthcare Providers)**

B. MINOR PROCEDURES – 10%

NO.	PROCEDURES	DATE	STUDENT'S PERFORMANCE		PRECEPTOR'S SIGNATURE
			Good (1%)	Poor (0.5%)	
1.	Performing primary survey.				
2.	Perform methods splinting or immobilization:				
	2.1 Splinting of the limb extremity				
	2.2 Performing modified jaw thrust				
	2.3 Applying cervical collar				
	2.4 Spinal Logrolling				
3.	Performing non invasive monitoring & investigation:-				
	3.1 Setting up ECG, SpO2 and BP monitoring				
	3.2 Interpreting cardiac rhythm				
	3.3 Recording a 12 leaded ECG.				
4.	Administering initial oxygen therapy.				
5.	Monitoring neurological status (Glasgow Coma Scale or its equivalent)				
TOTAL MARK ACHIEVED					

PLEASE NOTE:

A correctly (GOOD) performed Minor Nursing Procedure is entitled for a full mark of **1%**
Total Marks for 10 correctly (GOOD) performed Minor Nursing Procedure is **10%**

Student's Signature: **Date:**

Local Preceptor's Signature: **Date:**

WRITTEN ASSIGNMENT – A CASE STUDY

- You are required to write a **Case Study of a Client in Trauma / Emergency condition** whom you have nursed during your Clinical Practice.

- The Title of the Case Study should be written as **"The Nursing Care and Management of a Client with ……"**

- The recommended framework / headings are:
  i. Section 1: Introduction
  ii. Section 2: Presentation of the case:
    - Demographic data
    - General health history
    - Assessment findings
    - Management and Nursing Care of the client – in chronological manner and by utilizing nursing process
  iii. Section 3: Conclusion / summary
  iv. Section 4: References
  v. Section 5: Appendixes

- Your work will be assessed based on the Rubrics provided (Appendix 2)

- **Format of the Case Study:**
  i. Words: 5,000 - 10,000 words
  ii. Font: Arial, Size 12
  iii. Spacing: 1.5
  iv. Binding: combed

- You are required to perform a 20-minute Oral Presentation on this Case Study to your Tutor at the Learning Centre after the completion of Clinical Practice. Please discuss with your Tutor to identify the date for Oral Presentation

- The deadline for submission your Case Study is on **30 November 2015**

ORAL PRESENTATION OF THE CASE STUDY

- Mode – Power Point Presentation
- Allocated Time – 20 minutes:
  Presentation - 15 minutes
  Question & Answer – 5 minutes
- Prior to Presentation – submit the printed PP Slides to the Tutor (2 PP Slides per page)
- Evaluation of Presentation – using the Rubrics as provided (Appendix 3)

<u>Instruction</u>

- Submit your Case Study directly to your Tutor after the Oral Presentation.
- Keep the copy of "Assignment Acceptance Verification Slip" as an evidence of submission.
- You are encouraged to keep a copy of your Case Study for future reference.

CLINICAL PERFORMANCE EVALUATION

Instructions to Local Preceptor:-

- This is a non-graded evaluation on student's performance. Tick (√) the level of performance for each criteria based on the scale. You may include additional points on the comments provided.
- Please complete the form at the end of the clinical placement.
- Please inform the student regarding the evaluation of his/her performance to enable them to improve. Have the student to acknowledge his/her performance.
- This form is part of the Clinical Practice Record and should be given to the student for compilation.
- Your evaluation is highly appreciated as an important feedback to students as well as to the Faculty.

Name: **Matrix No:**

Year: **Semester:**

Area of Specialized Practicum: **Course Code:**

Name of Local Preceptor:

Preceptor's Designation:

Scale: **1= poor** **2= average** **3= good** **4= excellent**

No	Performance Criteria	1	2	3	4
1.	**Appearance and Discipline:-**				
	1.1. Maintain cleanliness and neatness				
	1.2 Follow dress code of the organization				
	1.3 Punctual				
	1.4 Manage time effectively				
2.	**Communication Skills:-**				
	2.1 Communicate in a clear ,concise and fluent manner				
	2.2 Able to express sound opinion				
	2.3 Project appropriate non verbal communication				
3.	**Attitude : Responsibilities**				
	3.1 Adheres to protocol, policies and procedures of the organization				
	3.2 Follow standard practice and code of conduct				
	3.3 Understand the importance of preserving client's privacy and confidentiality				
4.	**Attitude: Assertiveness**				
	4.1 Demonstrate leadership skills				
	4.2 A team player / team participation				
	4.3 Accept constructive comments / criticism				
	4.4 Responsiveness to supervision				

5.	**Attitude: Establishing Relationship**				
	5.1 Able to function with other health care professional.				
	5.2 Good rapport with staff, clients and family.				
	5.3 Understanding multicultural issues/ individual differences.				
6.	**Attitude: Initiatives**				
	6.1 Able to search for learning activities.				
	6.2 Search further information when needed.				
	6.3 Seek supervision / consultation when needed.				
7.	**Knowledge and Skill:-**				
	7.1 Apply theory to practice appropriately				
	7.2 Identify client's needs or problems.				
	7.3 Demonstrate ability to solve problems.				
	7.4 Plan, implement and evaluate care.				
8.	**Documentation:**				
	8.1 Accurate documentation				
	8.2 Assess and report abnormal data				

Comments:

Student's Signature:

……..

Date:

Local Preceptor's Signature:

……

Date:

CLINICAL EXPERIENCE EVALUATION
Clinical Practice 11
Specialization – Trauma & Emergency Nursing

Instructions to Student:

- You need to evaluate your learning experience in the **SPECIALIZED PRACTICUM**. Tick (√) your level of agreement for each statements based on the scale. You may express your opinion or suggestions in the comments.
- Please complete the form at the end of the clinical placement.
- This form must be collated from the whole group of students and hand-in to the **Preceptor Coordinator**, whom should return back to the Faculty.
- Your evaluation is highly appreciated. It is crucial for continuous improvement of our program and to enable us to provide the best for you.

Name: **Matrix No:**

Year: **Semester:**

Area of Specialized Practicum:

Scale: 1=strongly disagree 2= disagree 3= indifferent 4= agree 5= strongly agree

No	Statement	1	2	3	4	5
1.	I have adequate opportunities to enhance my clinical skills and knowledge.					
2.	I have adequate opportunities to strengthen my communication skills.					
3.	I have adequate opportunities to achieve my learning outcomes.					
4.	The length of clinical placement was adequate.					
5.	The staff members were supportive of my learning needs.					
6.	The School was able to address my concerns / problems / questions.					

Comments:

EVALUATION OF LOCAL PRECEPTOR
Clinical Practice 11
Specialization – Trauma & Emergency Nursing

Instructions to Student:

- Tick (√) your level of agreement for each statements based on the scale. You may express your opinion or suggestions in the comments.
- Please complete the form at the end of the clinical placement.
- This form must be collated from the whole group of students and hand-in to the **Preceptor Coordinator**, whom should return back to the Faculty.
- Your evaluation is highly appreciated. It is crucial for continuous improvement of our program and to enable us to provide the best for you

Name: **Matrix No:**

Year: **Semester:**

Area of Specialized Practicum:

Name of Local Preceptor:

NO	CRITERIA	YES	NO	COMMENTS
1	Impart knowledge to students effectively.			
2	Motivated to conduct bedside teaching.			
3	Have good clinical skills.			
4	Establish good rapport with ward/hospital staff and client.			
5	Speak and give clear instructions.			
6	Responsible.			
7	Give regular and prompt feedback constructively.			
8	Sensitive and responsive to student's needs.			
9	Give supervision when needed.			
10	Demonstrate procedure as necessary.			
11	Check student's records & attendance regularly.			
12	Supportive, approachable and available.			
13	Helpful in guiding student to achieve learning outcomes.			
14	Appear pleasant and presentable.			
15	Give fair and objective evaluation.			
16	Always punctual			

Student's Signature:

Date:

IMPORTANT INSTRUCTION TO STUDENTS

Compile the following documents for submission:-

1. Clinical Practice Records:
   - Record of General Practice Hours
   - Record of Specialized Practice Hours
   - Record of Bedside Teaching sessions attended

2. Nursing Procedures:
   - List of Major Procedures performed
   - List of Minor Procedures performed

3. Clinical Performance Evaluation Form - by the Clinical Preceptor

4. Use the Format for Front Page as provided in Appendix 4

You must submit the compilation of your work on NBNC1307 Clinical Practice 11 to your course Tutor immediately after the Oral Presentation of your Case Study.

Appendix 1

BLS for Healthcare Providers Student Manual
Comparison Sheet
Based on *2010 AHA Guidelines for CPR and ECC*

BLS Changes			
	New	**Old**	**Rationale**
CPR	Chest compressions, Airway, Breathing (C-A-B) New science indicates the following order: 1. Check the patient for responsiveness and no breathing. 2. Call for help and get the AED 3. Check the pulse. 4. Give 30 compressions. 5. Open the airway and give 2 breaths. 6. Resume compressions.	Airway, Breathing, Chest compressions (A-B-C) Previously, after responsiveness was assessed, a call for help was made, the airway was opened, the patient was checked for breathing, and 2 breaths were given, followed by a pulse check and compressions.	Although ventilations are an important part of resuscitation, evidence shows that compressions are the critical element in adult resuscitation. In the A-B-C sequence, compressions are often delayed By changing the sequence to C-A-B, rescuers can start chest compressions sooner..
	Compressions should be initiated within 10 seconds of recognition of the arrest.	Compressions were to be given after airway and breathing were assessed, ventilations were given, and pulses were checked.	Although ventilations are an important part of resuscitation, evidence shows that compressions are the critical element in adult resuscitation. Compressions are often delayed while providers open the airway and deliver breaths.
	Compressions should be given at a rate of at least 100/min. Each set of 30 compressions should take approximately 18 seconds or less.	Compressions were to be given at a rate of about 100/min. Each cycle of 30 compressions was to be completed in 23 seconds or less.	Faster compressions are required to generate the pressures necessary to perfuse the coronary and cerebral arteries.
	Compression depths are as follows: x Adults: **at least** 2 inches (5 cm) x Children: **at least** one third the depth of the chest, approximately 2 inches (5 cm) x Infants: **at least** one third the depth of the chest, approximately 1½ inches (4 cm)	Compression depths were as follows: x Adults: 1½ to 2 inches x Children: one third to one half the diameter of the chest x Infants: one third to one half the diameter of the chest	Deeper compressions are required to generate the pressures necessary to perfuse the coronary and cerebral arteries.

Adapted from American Heart Association

Airway and Breathing	Cricoid pressure is no longer routinely recommended for use with ventilations.	If an adequate number of rescuers was available, one could apply cricoid pressure.	Randomized studies have demonstrated that cricoid pressure still allows for aspiration. It is also difficult to properly train providers to perform the maneuver correctly.
	"Look, listen, and feel for breathing" has been removed from the sequence for assessment of breathing after opening the airway. Healthcare providers briefly check for breathing when checking responsiveness to detect signs of cardiac arrest. After delivery of 30 compressions, lone rescuers open the victim's airway and deliver 2 breaths.	"Look, listen, and feel for breathing" was used to assess breathing after the airway was opened.	With the new chest compression–first sequence, CPR is performed if the adult victim is unresponsive and not breathing or not breathing normally (i.e. not breathing or only gasping) and begins with compressions (C-A-B sequence). Therefore, breathing is briefly checked as part of a check for cardiac arrest. After the first set of chest compressions, the airway is opened and the rescuer delivers 2 breaths.
AED Use	For children from 1 to 8 years of age, an AED with a pediatric dose-attenuator system should be used if available. If an AED with a dose attenuator is not available, a standard AED may be used. For infants (<1 year of age), a manual defibrillator is preferred. If a manual defibrillator is not available, an AED with a pediatric dose attenuator is desirable. If neither is available, an AED without a dose attenuator may be used.	This does not represent a change for children. In 2005 there was not sufficient evidence to recommend for or against the use of an AED in infants.	The lowest energy dose for effective defibrillation in infants and children is not known. The upper limit for safe defibrillation is also not known, but doses >4 J/kg (as high as 9 J/kg) have provided effective defibrillation in children and animal models of pediatric arrest, with no significant adverse effects. AEDs with relatively high energy doses have been used successfully in infants in cardiac arrest, with no clear adverse effects.

Adapted from American Heart Association

Appendix 2

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RUBRICS FOR CLINICAL WRITE-UP (CASE STUDY)

COURSE CODE : NBNC 1307

Criteria	Weight-age	(0)	Low (1)	Fair (2)	Above Average (3)	Excellent (4)	Score
1. Introduction	0.5	No introduction	The introduction is poor. The intent of the work is very vaguely explained and disorganized	The introduction is fair. The intent of the work is vaguely explained and disorganized	The introduction is good. The intent of the work is clearly explained and organized but the information is inadequate	The introduction is excellent, very clear and well organized. The intent of the work is explicitly and implicitly explained	**2**
2. Organization of Write-up	0.5	Information and organization of work presentation is disorganized	Information and organization of work presentation is occasionally organized	Information and organization of work presentation is partially organized	Information and presentation of work is generally organized in logical sequence; follows acceptable format	All information and presentation of work is excellently and creatively organized in logical sequence; follows acceptable format	**2**
3. Information on Patient's Demographic Data and General Health History	1	There is no information on patient's demographic data and general health history	Documents minimal information on patient's demographic data and general health history; critical information is missing	Fails to document most pertinent information on patient's demographic data and general health history; lacks of some critical information or rambling in history	Documents most pertinent information on patient's demographic data and general health history; includes critical information	Thoroughly documents all pertinent information on patient's demographic data and general health history; includes critical as well as supportive information	**4**

4. Documentation on Assessment Findings	1	Physical examination / assessment finding is not documented	Physical examination / assessment findings are superficial; misses several pertinent components	Documents some pertinent examination / assessment findings	Documents most pertinent examination / assessment findings	Thoroughly documents all pertinent examination / assessment findings; includes analytical information of the components	**4**
5. Discussion on Medical / Surgical Management of the Patient	3	Does not address on the management of the patient	Demonstrates insignificant management of the patient; management fails to address most issues raised by the diagnosis	Demonstrates reasonable management of the patient; management addresses only parts of the issues raised by the diagnosis; and does not present in chronological manner	Demonstrates considerable management of the patient; management addresses most issues raised by the diagnosis and presents in chronological manner	Demonstrates excellent management of the patient; management addresses all issues raised by the diagnosis; excellent insight into patient's needs and presents in chronological manner	**12**
6. Identification of Nursing Diagnoses and Interventions for the Patient	**3**	Does not identify any nursing diagnosis and interventions for the patient	Demonstrates insignificant identification of nursing diagnoses and interventions for the patient	Demonstrates reasonable identification of nursing diagnoses and interventions for the patient; indicates only 2 or less nursing diagnoses	Demonstrates reasonable identification of nursing diagnoses and interventions for the patient; indicates only 3 or 4 nursing diagnoses	Demonstrates considerable identification of nursing diagnoses with thorough and insightful discussion on nursing interventions for the patient; indicates 5 or more nursing diagnoses	**12**

7. Conclusion	**0.5**	No conclusion	A poor conclusion which does not indicate an attempt to synthesize the case study	A fair conclusion which indicates reasonable analysis and synthesis of ideas relating to the case study	A good conclusion which indicates considerable analysis and synthesis of ideas relating to the case study	An excellent conclusion which is concisely and precisely written. It provides concluding remarks that shows an analysis and synthesis of ideas relating to the case study	**2**
8. References and Citations	**0.5**	There is no reference or citation; or references are outdated / wrong format	Citations for statements included in the discussion are not present, or references which are included are not found in the text	Some citations for statements included in the discussion or references which are included are not found in the text	Most citations are included in the discussion and most references match with the citations according to the APA format	All citations are included in the discussion and references match the citations according to the APA format	**2**
TOTAL SCORE							**40**

Comments: _____

_____

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_____

Student's Name: _____ Matrix No: _____

Assessor's Signature: _____ Date: _____
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Appendix 3

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RUBRICS FOR ORAL PRESENTATION OF CASE STUDY

COURSE CODE : NBNC 1307

Criteria	Weight-age	(0)	Low (1)	Fair (2)	Above Average (3)	Excellent (4)	Score
CONTENT:							
1. Subject Knowledge	2	Student does not have grasp of information; cannot answer questions about the subject	Student demonstrates superficial knowledge; cannot answer questions about the subject	Student demonstrates reasonable knowledge; able to answer only rudimentary questions	Student demonstrates considerable knowledge; able to answer to all questions but without elaboration	Student demonstrates excellent knowledge by answering all questions with explanations and elaboration	**8**
2. Organization	1	Absolutely shows disorganized presentation	Student does not present information in logical sequence; jumps around; audience has difficulty following the presentation	Shows inconsistent presentation; at times ideas are cluttered audience has difficulty following the presentation	Student presents information in logical sequence which audience can follow	Student presents information in logical, interesting and creative sequence which audience can follow easily	**4**
VERBAL SKILLS:							
1. Enthusiasm	0.5	Shows absolutely no interest in the topic presented	Seldom shows interest in the topic presented	Occasionally shows some interest in the topic presented	Frequently shows interest with positive feeling about the topic	Demonstrate a very strong interest with positive feeling about the topic during entire presentation	**2**
2. Elocution	0.5	Student mumbles, incorrectly pronounces terms, and speaks too quietly for a majority of audience to	Student's voice is low. Student incorrectly pronounces terms. Audience members have difficulty	Intermittently student's voice is clear and soft. Occasionally pronounces words incorrectly. Only some	Student's voice is clear; pronounces most words correctly. Most audience members can hear the presentation	Student uses a clear voice and correct, precise pronunciation of terms so that all audience members can hear the presentation	**2**

		hear	hearing the presentation	audience members can hear the presentation			
NONVERBAL SKILLS:							
1. Eye Contact	0.5	No eye contact with audience, as entire report is read from the notes	Displayed minimal eye contact with audience, while reading mostly from the notes	Consistent use of direct eye contact with audience, but still returns to notes	Consistently hold attention of entire audience with the use of eye contact, seldom looking at notes	Totally hold attention of entire audience with the use of eye contact, without looking at notes	**2**
2. Body Language	0.5	No movement or descriptive gestures	Very little movement or descriptive gestures	Occasionally made proper movements or gestures	Made proper movements or gestures during the entire presentation that enhances articulation	Made proper movements or gestures during the entire presentation that seem excellently flowing and help the audience visualize	**2**
	TOTAL SCORE						**20**

Comments: _____

_____

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_____

Student's Name: _____ Matrix No: _____

Assessor: _____ Date: _____
( )

Appendix 4

CLINICAL PRACTICE RECORD
NBNC1307 Clinical Practice 11
(TRAUMA & EMERGENCY NURSING)

STUDENT'S PARTICULARS:-

Name:

Matrix No:

Semester & Year:

Ward / Area of Practice:-

i. **General Practicum:**

ii. **Specific Practicum:**

PRECEPTOR COORDINATOR:

Name:

Corresponding e-mail / Tel:

LOCAL PRECEPTOR:

Name:

Designation:

Corresponding e-mail / Tel:

COURSE TUTOR:

Name: