Health & Public Service

STUDENT CLINICAL MANUAL

Fall 2023

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Table of Contents

Article 1: Program Objectives 1

Section 1.01 Objectives 1

Section 1.02 Progression 2

Section 1.03 Duty to Report 3

Section 1.04 Professionalism 4

Section 1.05 Social Media 6

Section 1.06 White Paper: A Nurse's Guide to the Use of Social Media 7

Section 1.07 Criminal History 9

Article 2: General Clinical Agreements 10

Section 2.01 Student Agreement 10

Section 2.02 Clinical Information Acknowledgement 11

Section 2.03 Clinical Absence Rule 12

Section 2.04 Addendum to Clinical/Classroom Rules 14

Section 2.05 Unsafe Student Acknowledgement 16

Article 3: Required Clinical Paperwork 17

Section 3.01 Skills Allowed to Perform in Clinical Setting 18

Section 3.02 Grading Criteria 22

Section 3.03 23

Section 3.04 Pathophysiology 23

Section 3.06 Pediatric Assessment/Database 31

Section 3.07 Nursing Physical Assessment 32

Section 3.08 Weekly Skin Assessment 35

Section 3.09 Drug Card 36

Article 4: General Clinical Information 37

Section 4.01 Facility Directions/Addresses/Phone Numbers/Contacts 38

Cook Children clinics as assigned by the education department of Cook Childrens. 39

Section 4.02 Vocational Nursing Person Appearance 40

Section 4.02.01 The Nursing Department Look For Women 42

Section 4.02.02 The Nursing Department Look For Men 44

Section 4.03 Uniform Violation Rule Form 47

Section 4.04 Supervision of Medication Administration Rule IV Meds 48
Section 4.05 Procedure of Saline Lock Insertions and Medication Administration 49
Section 4.06 Potential or Actual Medication Error 51
Section 4.07 Clinical Probation 52
Section 4.08 Clinical Counseling Form 53
Section 4.09 Student Evaluation Form 54
Section 4.10 Clinical Facility Evaluation Form 55
Article 5 Clinical Documentation Tools 56
Section 5.01 Preparation for Clinical 56
Section 5.02 Clinical Reminders 57
Section 5.03 Chart Review 59
Section 5.04 Descriptive Terms 60
Section 5.05 Labs 65
Section 5.06 Communication Tools/Blocks 68
Section 5.07 Therapeutic Communication 73
Section 5.08 Clinical Conferences Outline 74
Section 5.09 Reporting 75
Section 5.10 SBAR Reporting 76
Section 5.11 Teaching Plan Process 77
Section 5.12 Goals 78
Section 5.13 Nursing Process Priorities 79
Section 5.14 Format for Nursing Process 80
Section 5.15 SimChart: Chart Notes for Clinicals 81
Name: Simchart & 5 Drug Cards VNSG1360 82
Description: Sim Chart Rubric/5 Drug Cards 82
Type: Used for Grading 82
‹ **2 of 3** › 82
Name:Simchart & 5 Drug Cards VNSG1360 86
Description:Sim Chart Rubric/5 Drug Cards 86
Type: Used for Grading 86
‹ **2 of 3** › 86

Section 5.16 NANDA International, Inc. 87
Article 6 Specialty/Ancillary Areas objectives/Forms (Level II & III Only) 88
Section 6.01 Autopsy 89
Section 6.02 Cardiac Cath Lab 90
Section 6.03 Daycare 91
Section 6.04 Dialysis 94
Section 6.05 Emergency Department 95
Section 6.06 Family Medicine/Physician Clinic 96
Section 6.07 Home Health/Hospice 97
Section 6.08 Infection Control 98
Section 6.09 Jail/Correctional Objectives 99
Section 6.10 Labor/Delivery/Postpartum/Nursery 100
Section 6.11 Laboratory 102
Section 6.12 Leadership 104
Section 6.13 NICU/ICU/CCU 105
Section 6.14 Nursery 106
Section 6.14.01 Newborn Assessment Database 107
Section 6.15 OB/GYN – Clinic 108
Section 6.16 Observation Unit 109
Section 6.17 Outpatient/Day surgery/Endoscopy 110
Section 6.18 Cook Children's or Pediatrician Office 111
Section 6.19 Physical Therapy/OT/ST 112
Section 6.20 Radiology 113
Section 6.21 Recovery Room 114
Section 6.22 Respiratory Therapy 115
Section 6.23 School Nurse 116
Section 6.24 Surgery 117
Section 6.25 WIC Women's, Infants, Children's Clinic 118
Section 6.26 Erickson's Psychosocial Stages of Development 119
Section 6.27 Team Leader 120
Section 6.28 Bioterrorism Objectives 122
Section 6.29 Process Reading 123

Article 7 Clinical Evaluations 125
Section 7.01 Clinical Evaluation Tool Level 1 125
Section 7.02 Clinical Evaluation Tool Level 2 127
Article 11 Differentiated Essential Competencies of Graduates of Texas Nursing Program 128
Section 11.01 Competency Statements for Vocational Nurse Graduates 128
Section 7.03 Exit Competencies 129
Section 7.04 Grading Rubric for Clinical Evaluation Tool (all Levels) 137
Article 13: Forms 139
Student Agreement 140
Clinical Information Acknowledgement 141
Addendum to Clinical/Classroom Rule 142
Unsafe Student Acknowledgement 143
SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING 144
Appearance Rule Acknowledgment 148
Uniform Rule Violations – Written Warning 149
Rules and Regulation Agreement 150
Infectious / Communicable Disease Exposure Rule 151
Texas Administrative Code (TAC) Acknowledgment 152
Texas Occupation Code (TOC) Acknowledgement 153
Potential or Actual Incident Report 154
Southern Association of Colleges Accreditation Statement 155

Article 1: Program Objectives

Section 1.01 Objectives

1. The curriculum will provide the student with the knowledge and skills needed to be safe and competent vocational nurses.

2. The curriculum will provide the student the opportunity to utilize critical thinking skills in identifying nursing/patient care goals based on individual needs and capabilities.

3. The curriculum will emphasize content relevant to health and nursing care of individuals and families. This collaborative process will be part of a larger community system and include other health care professionals.

Section 1.02 Progression

In order to continue in the Vocational Nursing Program, the student must pass **all** courses each semester with a grade of "C" or better before progressing to the next level.

NOTE: If a student fails one (1) nursing course and would like to retake the class the next time it is offered, the student needs to be aware that reentry will only be considered if there is an opening in the class, and the time frame for reentry falls within two (2) years, beginning at the initial date of withdrawal or failure. If the student has/will be out longer than one semester the student may be required to retake the appropriate clinical rotation and/or retake all skills tests (pass each with an 80% one attempt only) and the mathematical skills test (pass with an 90% one attempt only) after the program director has reviewed the students' clinical performance from previous semester(s) and conferred with the students' primary clinical instructor(s). The student will only be allowed to transfer twice and then if withdrawing or unsuccessful will need to apply to begin the program again. No limit on reentry when applying for beginning the program. If the student fails two courses the student must begin at entry level.

NOTE: If a student fails a nursing course and would like to retake the class the next time it is offered, the student needs to be aware that reentry will only be considered if there is an opening in the class, and the time frame for reentry falls within a two year period, beginning with the initial date of withdrawal or failure.

NOTE: After two years the student must begin at entry level and must follow entrance rules that are in place at the time of attempted reentry.

If a student is randomly tested for drugs and found positive for drugs, he/she will be required to have a second drug test done using the of hair follicle method, if available, within a 24-48 hour period. If the second drug test comes back positive for drugs, the student will be sent to the Director of Student Life for counseling. The student will not be allowed to participate in clinical or classroom settings as long as the drug screen is not clear.

Section 1.03 Duty to Report

Nursing Educational programs have the duty to report:

- Impairment or likely impairment of the students practice by chemical dependency.
- Impairment or likely impairment of the students practice by mental dependency.
- Information related to criminal convictions.

Section 1.04 Professionalism

Students are expected to conduct themselves in a professional manner while in the VN Program. This includes appropriate uniform, personal conduct, appropriate conflict resolution, and following rule and procedures outlined by Hill College, the VN Nursing Program, and any host facility. Compliance with rules and regulations of the Texas Board of Nursing and Standards of Nursing and the ANA Standards are also expected. Any inappropriate professional conduct will be grounds for discipline, and may include suspension or termination from the program.

Students are expected to maintain confidentiality at all times. Information regarding any student or client shall be repeated only in the classroom or a controlled clinical setting. Refer to the clients by initials rather than by names.

Due to the potential to discuss confidential care provided to clients, or sharing of personal student information, tape recording of any type is prohibited. Posting to any public media of any information obtained during any type Hill College activity is considered a breach of confidentiality and is strictly prohibited.

While all information contained in the above listed documents is important, the student must understand the following excerpts of the information can have an immediate impact the student's ability to progress through the program:

1. All written work must be submitted by college email using 12 font & New Times Roman or Arial type. Correct format includes APA format and doc or docx forms as provided.

2. All work must be submitted on time, with proper grammar, spelling and in properly typed format.

3. No Late work accepted.

4. Any breach of the Federal HIPAA Regulations will result in a grade of zero “0” for all work involved.

5. Any violation of HIPAA or confidentiality will be grounds for discipline, and may include suspension or termination from the course.

6. Due to the potential to discuss care provided clients, or sharing of personal student information, tape recording of any type is prohibited. This includes no phones in clinical settings or functioning phones during lecture/lab.

Posting to any public media of any information obtained during any type of Hill College activity is considered a breach of confidentiality and is strictly prohibited.

Section 1.05 Social Media

Hill College Vocational Nursing has a zero tolerance rule for social media violations. Any student found to have a violated the social media rule by the incident review committee will receive a failing grade in VNSG 1360, VNSG 1461, or VNSG 1462 and will not be allowed to progress in the program.

(Double Click on document to read)

Texas Board of Nursing
333 Guadalupe #3-460
Austin, Texas 78701

Position Statement
www.bon.texas.gov
(512) 305-6802
Page: 82

15.29 Use of Social Media by Nurses

With the rapidly growing use of social media sites and applications such as Facebook, Twitter, LinkedIn, YouTube, and blogs, professional obligations to patients, peers, and employers may be unclear. While the Board recognizes that the use of social media can be a valuable tool in healthcare, there are potential serious consequences if used inappropriately. Online postings may harm patients if protected health information is disclosed. These types of postings may reflect negatively on individual nurses, the nursing profession, the public's trust of our profession, as well as jeopardize careers.

Both the National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) endorse each other's guidelines and principles on the use of social media in order for it to be used appropriately and without harm to patients. The benefits of social media are many, and include:

- "Networking and nurturing relationships
- Exchange of knowledge and forum for collegial interchange
- Dissemination and discussion of nursing and health related education, research, best practices
- Educating the public on nursing and health related matters" (ANA, 2012, para. 4).

However, if used indiscriminately, the risks are great, and include:

- "Information taking on a life of its own where inaccuracies become fact
- Patient privacy being breached
- The public's trust of nurses being compromised
- Individual nursing careers being undermined" (ANA, 2012, para. 5).

In a recent survey by the NCSBN, many of the responding boards reported that they had received complaints about nurses inappropriately using social media sites. Nurses have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media (NCSBN, 2012).
To ensure the mission to protect and promote the welfare of the people of Texas, the Texas Board of Nursing supports both the guidelines and principles of social media use by the NCSBN and ANA. In keeping with the NCSBN guidelines, it is the Board's position that:

- *Nurses must recognize that they have an ethical & legal obligation to maintain patient privacy and confidentiality at all times.*
- *Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.*

Section 1.06 White Paper: A Nurse's Guide to the Use of Social Media

Double click on the document to read

Or use the following link: https://www.ncsbn.org/Social_Media.pdf

Pamphlet: https://www.ncsbn.org/Social_Media.pdf

Video: https://www.ncsbn.org/347.htm

NCSBN
Leading in Nursing Regulation

White Paper: A Nurse's Guide to the Use of Social Media

August 2011

Introduction

The use of social media and other electronic communication is increasing exponentially with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Nurses often use electronic media both personally and professionally. Instances of inappropriate use of electronic media by nurses have been reported to boards of nursing (BONs) and, in some cases, reported in nursing literature and the media. This document is intended to provide guidance to nurses using electronic media in a manner that maintains patient privacy and confidentiality.

Social media can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with patients and family members, and educating and informing consumers and health care professionals.

Nurses are increasingly using blogs, forums and social networking sites to share workplace experiences particularly events that have been challenging or emotionally charged. These outlets provide a venue for the nurse to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified as effective tools in nursing practice. The Internet provides an alternative media for nurses to engage in these helpful activities. Without a sense of caution, however, these understandable needs and potential benefits may result in the nurse disclosing too much information and violating patient privacy and confidentiality.

Health care organizations that utilize electronic and social media typically have policies governing employee use of such media in the workplace. Components of such policies often address personal use of employer computers and equipment, and personal computing during work hours. The policies may address types of websites that may or may not be accessed from employer computers. Health care organizations also maintain careful control of websites maintained by or associated with the organization, limiting what may be posted to the site and by whom.

The employer's policies, however, typically do not address the nurse's use of social media outside of the workplace. It is in this context that the nurse may face potentially serious consequences for inappropriate use of social media.

Confidentiality and Privacy

To understand the limits of appropriate use of social media, it is important to have an understanding of confidentiality and privacy in the health care context. Confidentiality and privacy are related, but distinct concepts. Any patient information learned by the nurse during the course of treatment must be safeguarded by that nurse. Such information may only be disclosed to other members of the health care team for health care purposes. Confidential information should be shared only with the patient's informed consent, when legally required or where failure to disclose the information could result in significant harm. Beyond these very limited exceptions the nurse's obligation to safeguard such confidential information is universal.

Privacy relates to the patient's expectation and right to be treated with dignity and respect. Effective nurse-patient relationships are built on trust. The patient needs to be confident that their most personal information and their basic dignity will be protected by the nurse. Patients will be hesitant to disclose personal information if they fear it will be disseminated beyond those who have a legitimate "need to know." Any breach of this trust, even inadvertent, damages the particular nurse-patient relationship and the general trustworthiness of the profession of nursing.

Federal law reinforces and further defines privacy through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulations are intended to protect patient privacy by defining individually identifiable information and establishing how this information may be used, by whom and under what circumstances. The definition of individually identifiable information includes any information that relates to the past, present or future physical or mental health of an individual, or provides enough information that leads someone to believe the information could be used to identify an individual.

Breaches of patient confidentiality or privacy can be intentional or inadvertent and can occur in a variety of ways. Nurses may breach confidentiality or privacy with information he or she posts via social media. Examples may include comments on social

Section 1.07 Criminal History

If a student has a criminal history and a facility's rule prohibits the student from attending clinical, the Hill College Vocational Nursing Program is not obligated to rearrange the clinical schedule to accommodate a single student. The student will receive a Zero (0) for each day missed.

Eligibility Issues Occurring while in Health Science

Any student in a Health Science program who is arrested and charged for criminal conduct other than minor traffic violations, or who is notified of an outstanding warrant for his or her arrest for a non-traffic violation, must report the issue within 72 hours or before next clinical assignment (whichever comes first) to the Program Director and submit paperwork reflecting the arrest and charges.

Any student with pending charges for criminal conduct other than a minor traffic violation will not be allowed to attend any clinical assignment until the student provides proof of charges being cleared or state agency approval (such as a Declaratory Order). Charges are considered "cleared" when documentation is received from a law enforcement agency or court of law indicating dismissal or acquittal of all charges. Any clinical days missed will result in absences and the program's absence rule will apply. No alternative clinical assignments will be made.

The student may withdraw and reapply for admission after charges are cleared or state agency approval is received. Readmission will be considered on an individual basis. Failure of the student to disclose eligibility issues at any time will result in dismissal from the health science program. Students must disclose eligibility issues and be cleared by the Texas Board of Nursing before entry into the program.

Article 2: General Clinical Agreements

Section 2.01 Student Agreement

To all Vocational Nursing students, this handbook is being provided to you for your clinical rotation. Enclosed you will find the objectives/evaluations you will be using during your Clinical I Practical Nurse, Clinical II Practical Nurse, and Clinical III Practical Nurse rotations.

You will find the following clinical paperwork enclosed in this book (you will need to make more than one copy as needed):

1. Format for Pathophysiology
2. Nursing process priorities
3. Care map
4. Drug Cards
5. Process for teaching plans
6. Nursing Assessment Clinical Data
7. Weekly Skin Assessment
8. Labor Assessment Data Base
9. Pediatric Assessment Data Base
10. Newborn Assessment Data Base
11. Postpartum Assessment Data Base

You will find the following objectives enclosed in this book:

1. Autopsy
2. Cardiac Cath Lab
3. Daycare
4. Dialysis
5. Emergency Department
6. Family Medicine/Physician clinic
7. Home Health/Hospice
8. Infection Control
9. Jail/Correctional Objectives
10. Labor/Delivery
11. Laboratory
12. Leadership
13. NICU/ICU/CCU
14. Nursery
15. OB/GYN – Clinic
16. Observation Unit
17. Outpatient/Day surgery /Endoscopy
18. Pediatrician Office
19. Physical Therapy/OT/ST
20. Radiology
21. Recovery Room
22. Respiratory Therapy
23. School Nurse
24. Surgery
25. WIC Women's, Infants, Children's Clinic

You will find the following general clinical information enclosed in this book:

1. Unsafe Students
2. Process reading
3. Communication Tools and Blocks
4. Therapeutic Communication
5. Supervision of Medication Administration/IV Medications
6. Procedure of Heparin lock insertion and Medication Administration
7. Potential of Actual Medication Error form
8. Descriptive terms commonly used in charting
9. Skills allowed to perform in clinical setting
10. Attendance Verification Sheet (copy and use for Specialty area rotations)
11. Semester I Exit Competencies
12. Semester II Exit Competencies
13. Semester III Exit Competencies

I have read the above and have received a copy of this student agreement. I acknowledge that it will be my responsibility to read and familiarize myself with this clinical handbook and bring it with me when I attend clinical as required. I acknowledge that I must complete the exit competencies for each semester before being allowed to progress to the next level. I further acknowledge that I must have copies of clinical paperwork as needed.

Section 2.02 Clinical Information Acknowledgement

1. All students will be scheduled for a clinical evaluation at the end of each semester. If the student is not present for his/her scheduled clinical evaluation or fails to sign the form he/she will be given an incomplete and will not be able to progress to the next level.

2. All students need to be aware it is part of their responsibility, as student vocational nurses, to seek out new learning potentials in the clinical areas. The student vocational nurse must recognize their own strengths and weaknesses to improve or enhance their potential to learn from the experiences at all clinical sites and all clinical instructors.

3. Clinical grading rule:

   90-100% - superior completion of clinical objectives
   80-89% - above average completion of clinical objectives
   75-79% - average completion of clinical objectives
   <75% - failure to meet minimal clinical requirements

4. The Hill College nursing department strives to maintain consistency in the material used so students learn all information needed to be competent student nurses', however; the student needs to be aware that not all instructors grade exactly the same. In the clinical setting there are different requirements for the various facilities i.e. Med/Surg related paperwork would not be exactly the same as OB or Pedi. Each facility will have different rules and regulations regarding what they require in the charts, it will enhance your learning experience to be exposed to the various ways of charting or the required paperwork assigned for that particular area.

5. If the student is going to be absent it is the students' responsibility to call in appropriately. The process for calling in appropriately is as follows:
   a. Call the program director before 6 AM (254) 205-1611.
   b. Call the Hill College Nursing Department 2546597920 before 6:00 am and leave a voice mail message

Section 2.03 Clinical Absence Rule

1. The student is allowed to miss up to 2 clinical days with 5 points off for each 8 hours missed in Semester I and up to 2 clinical days with 5 points off for each 12 hours missed in Semesters II and III. If the student misses more than 16 hours in Semester I or 24 hours in Semester II and III the student will need to go before an absence review committee (which will be made up of 1 faculty member from each VN program, EMS director, 1 academic faculty member, the VN program director, ADN coordinator, Criminal Justice Coordinator, Fire Science Coordinator, Echocardiology Coordinator, and the Director of Nursing). If the review committee excuses the absence, the student will be allowed to makeup the time. If the committee does not excuse the absence, the absence will result in another 10 points off of the clinical grade for each absence over the initial 16 hours in Semester I and 24 hours in Semesters II and III and could result in a failure in clinical. No student will be allowed to miss more than 32 hours in clinical for Semester I and 36 hours for Semesters II and III for any reason. If the student exceeds the allowable absence they will be referred to the absence review committee with recommendation of dismissal. The student may be allowed to complete discussion board assignment for post conference online on a day an absence occurs at the discretion of the director of the program. This will be determined on a case by case basis. A special assignment may be given as determined by the director with documentation of illness provided by the student from a qualified health care professional.

2. Clinical tardies: three (3) clinical tardies will constitute one absence. If the student is 5 minutes tardy to clinical, this will constitute one tardy. Correct time is based on the instructor's watch. If additional clinical tardies occur after the initial three tardies resulting in an 8 hour absence in Semester I and 12 hours absence in Semester II and III with 5 points off the overall clinical grade, the

student will be placed on clinical probation. Should the student continue to accrue tardies after being placed on clinical probation, tardies of three will result in additional absence of 8 hours in semester I and 12 hours in Semesters II and III with an additional 5 points off the overall clinical grade for a total of 10 points off the overall clinical grade. Referral will also be made to the Incident and Absence Review Committees.

3. If the student is greater than thirty minutes late for clinical, he/she will be given a “0” on all clinical objectives for that day (refer to the clinical objectives that corresponds to the clinical level you are currently attending) and will receive a “0” on all documentation for that day. Activity/assignment for the day will be at the instructor’s discretion.
4. If required clinical paperwork is not prepared and turned in to the instructor at as directed, the student will receive a grade of “0” for the day’s documentation and it will be addressed on the corresponding clinical objectives for that day.
5. If clinical work is not turned in as directed including CET (Clinical Evaluation Tool), Sim Chart, Objectives, Pathocare map, and any other written work a grade of zero will be given.
6. Covid 19 precautions will vary based on clinical facilities requirements. Student must follow clinical requirements of the facility or unexcused absence will result.

Definitions:

Late – 1 to 4 minutes later than assigned time of arrival.

Tardy – 5 to 30 minutes

Absence – any time greater than 30 minutes past assigned time of arrival.

Section 2.04 Addendum to Clinical/Classroom Rules

All incoming calls involving students will come through the nursing faculty and will be handled by them. Only emergency calls will be accepted.

The following are not be allowed within any clinical facility:

1. Cell phones
2. Incoming or outgoing personal phone calls unless emergency
3. Use of patients' telephone for personal use

Cell phones are only allowed in the nursing classroom at the instructor's direction.

Students may only use cell phones on class days on class breaks but must have the phone off in class unless being directed for use.

Emergency calls can be directed to the director of the program to allow quick notification to the student

Students who are going to be absent on clinical days *must* notify the director of the program 254-205-1611 and the nursing office 2546597920 by 6 AM of the assigned shift.

A minimum of three clinical evaluations will be completed by the Nursing Faculty
A minimum of three self-evaluations will be completed by the student.

The student must receive at least an average of 75% or higher for EACH clinical objective and overall grade of 75 to attain a passing clinical grade. The following criteria will be used to determine the course grade. This criterion is based on Differentiated Essential Competencies and clinical performance required for meeting clinical objectives.

Each of the clinical criteria will be evaluated utilizing percentage. Data provided by the student and observations of the instructor are used as a basis of assigning each rating. Each of the clinical criteria will be averaged at the end of the clinical rotation. These averages will be totaled and divided by the number of criteria to obtain a percent grade for each objective.

The average of the clinical objective grade will constitute 75% of the final course grade for VNSG 1360 and VNSG 1461 and 70% for VNSG 1462. Required written work will constitute the remaining 25% of the final course grade for VNSG 1360 and VNSG 1461 and 20% for VNSG 1462.

The Comprehensive PN Predictor first attempt will count as 10% of the final course grade for VNSG 1462.

Each clinical day of absence will result in a deduction from (refer to clinical attendance rule) 5% from the final course grade.

Grade Summary:
90-100% - superior completion of clinical objectives
80-89% - above average completion of clinical objectives
75-79% - average completion of clinical objectives
<75% - failure to meet minimal clinical requirements

Section 2.05 Unsafe Student Acknowledgement

Maintaining client safety is the overriding principle in clinical practice. Nursing faculty has the responsibility to ensure that students are providing safe care. Nursing students must function at the expected clinical level as stated in the course objectives and clinical evaluation forms. Unsafe behavior is the failure to perform in the manner that any prudent student nurse, at the same level of preparation, would perform in a particular clinical situation. Nursing faculty have the responsibility to identify student conduct and performance in the academic and/or clinical area that are unsafe, unethical, and/or unprofessional, take immediate corrective action, and provide remediation contracts, and remove from clinical setting if appropriate. Any faculty that perceives a student is unsafe will take immediate corrective action, document the incident fully, and refer the student to the program director and the Incident Review Committee (which will consist of: 1 faculty member from each VN program, EMS director, 1 academic faculty, the VN Coordinator, ADN Coordinator, Criminal Justice Coordinator, Fire Science Coordinator, Echocardiology Coordinator, and the Director of Nursing) for evaluation. The committee will then review all documentation, including student's comments, to make a determination on possible remediation contract or recommended for dismissal from the nursing program.

- Unsafe behavior includes, but is not limited to:
- Being under the influence of drugs or alcohol.
- Failure to use Standard precautions at all times.
- Failure to apply basic safety rules, such as leaving side rails down on beds and cribs.
- Failing to report an abnormal finding.
- Being unable to make sound judgments due to adversely affected thought processes and decision-making.
- Attending clinical with a possibly communicable infectious process.
- Failure to follow the five rights while administering medications.
- And any other action or failure to act that would jeopardize client safety.

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(See also Duty to Report)

Article 3: Required Clinical Paperwork

Required Weekly Clinical Work

Nursing notes written by hand (the physical assessment must be written) in the first semester. These also must be charted in Sim Chart.

Sim Charting (in second semester should begin have two patients) (Each student must care for at least two patients each day in the Semester III as census allows.

Five drug cards per week.

One pathocare map per week. A student should never repeat a diagnosis previously used. A new diagnosis for each patient. A list will be maintained by students. These will be tracked by faculty. If submitting previously submitted work this is considered to be plagiarism and will result in a zero for the pathocare map and being placed on clinical probation.

CET (clinical Evaluation Tool)

Any student that has a failing average in clinical or is failing clinical objectives will be placed on clinical probation until the deficiency can be corrected.

A student is not allowed to attend clinical if they do not have clear criminal history, immunizations are not current, or CPR is not up to date. A student should monitor their vaccines and CPR and be responsible to keep up to date.

Clinical Areas within the hospital or off site rotations will have objectives and/or quizzes that will need to be completed as well.

Section 3.01 Skills Allowed to Perform in Clinical Setting

Skills that may be performed by vocational nursing students in the clinical setting under the direct supervision of clinical instructor or preceptor:

Medication/IV Therapy:

1. Students must be supervised during the preparation, administration, and recording medications.
2. Students may administer percutaneous injections, oral, rectal, topical, and inhaled medications. Students must follow the six rights of medication administration, and check patient's ID band and allergies *every* time they administer meds or perform treatments.
3. Students may monitor selected intravenous infusions as determined by instructor / preceptor.
4. Students may add medications and hang intravenous infusions with supervision of instructor / preceptor. (IV piggyback infusions). Before the student prepares and administers these medications, the student and instructor must check the solution, orders, MAR and the medication.
5. Students may start IV's or saline locks under the direct supervision of the clinical instructor / preceptor according to hospital rule.
6. Students are **not** allowed to give IV push medications, including patient controlled analgesia pumps, with the exception of *saline* flush.
7. Students are **not** allowed to administer chemotherapy agents.
8. Students will **not** be responsible for titrating IV medications to regulate blood pressure or cardiac arrhythmias, or to administer IV drips used as sedation or as paralytic agents.
9. Students may **not** monitor/regulate Pitocin drips.
10. Students may only observe the checking and hanging of blood or blood products. They are **not** allowed to hang blood or blood products.
11. Students are **not** allowed to access or hang IVPB meds through central venous catheters, PICC lines, or arterial catheters, only peripheral intravenous lines under the previous guidelines.

Other Skills:

Students may (under direct supervision of preceptor):

1. Insert/irrigate urinary catheters and NG tubes
2. Provide wound care and dressing changes
3. Assist with CPR/code efforts
4. Document in the medical record with co-signature of preceptor
5. Perform oral, nasopharyngeal and trach suctioning
6. Perform drain care

Basically the vocational nursing students are able to perform skills as appropriate for new GVN's under the direct supervision of their preceptor. Please call the number provided for the nursing instructor if there are any questions. Thank you for your cooperation.

SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING

***Supervised by instructor each time ** At instructors discretion * Can perform independently

Skills	Write in the date and have clinical instructor initial. EX: 1-4 / KC											
1. NGT/Enteral Tube												
Feeding **												
Insertion ***												
2. Bedmaking *												
3. Handwashing *												
4. Gowning/Gloving ***												
5. ROM *												
6. Restraints **												
7. Bath/Personal Care *												
8. Pt. Positioning/Transfer *												
9. CPR *												
10. VS/Neuro Signs *												
11. Documentation ***												
12. I & O *												
13. Urinary Cath Insertion ***												
14. Urinary Collection												
DC Foley**												
Clean Catch*												
Catheter**												
I & O*												
15. Bowel Elim.												
Fecal Impaction**												
Enemas**												
Occult Blood Test*												
Ostomy												
Bag Changes**												
Emptying**												
16. Pt. Physical Assessment*												
FSBS **												

SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING

***Supervised by instructor each time ** At instructors discretion * Can perform independently

17. Wound Care												
Dressing Changes **												
18. Nasopharynix Suction **												
19. Trach												
Care **												
Suctioning **												
20. Drains												
Emptying & Removal **												
Hemovac												
J-P												
21. Chest Tubes												
Monitoring **												
22. Sutures												
Monitoring/Removal **												
Staples												
23. Packing												
Monitoring/Removal **												
Wound												
Vaginal												
Rectal												
24. SCD / AV Boots												
25. Medication Admin.												
Oral **												
Rectal												
SL												
Vaginal												
Inhalers												
Nasal												

SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING

***Supervised by instructor each time ** At instructors discretion * Can perform independently

Eye												
Ear												
Patches												
NGT												
Parenteral												
ID												
SQ												
IM												
IV/PIGs												
Insertion ***												
Changing Bags **												
Changing Tubing **												
Pump/Monitor **												
IV to SL **												
Removing IV												
Inhalation Therapy **												
Perform Leopold Maneuver**												
Assess FHT **												
Surgery observed												
NB Assessment **												
NB Care												
Cord**												
Circumcision **												
Vitamin K ***												
Eye Care **												
Measure/Weigh**												
Bath**												
Bulb-Syringe Suction**												
26. Observed												
Vag delivery												
C-sect delivery												

Section 3.02 Grading Criteria

(Reminder; all levels)

Clinical Levels I and II

1. The student must receive an average of 75% or higher on each of the clinical objectives and overall grade average of 75% to pass clinical. The average of these will count as 75% of your final clinical grade.

2. The student must complete all written clinical assignments. This will count as 25% of your final clinical grade.

3. The student is allowed to miss up to 2 clinical days with 5 points off for each 8 hours missed. If the student misses more than 16 hours the student will need to go before an absence review committee (which will be made up of 2 VN instructors, EMS director, 1 academic faculty member and the VN program director, ADN coordinator, Director of Nursing).

Clinical Levels III

1. The student must receive an average of 75% or higher on each of the clinical objectives and an overall average of 75% in course. The average of these will count as 70% of your final clinical grade.

2. The student must complete all written clinical assignments. This will count as 20% of your final clinical grade.

3. The ATI Comprehensive PN Predictor first attempt will count as 10% of the clinical grade.

4. Students will be required to pass the PN Predictor exam with a score of 70 or above to complete the class and/or program.

   If student does not pass the PN Predictor test:
   a. Student will be counseled on unacceptable scores and requirements needed to complete the class/program.
   b. Student will be required to do remediation as outlined in the matrix.
   c. Student will then retake PN Predictor test. The cost of the second exit exam will be the student's responsibility.
   d. If the student fails the second Comprehensive PN Predictor with a score of less than 70, he/she will be required to complete 2000 NCLEX questions.
   e. The student will be given an incomplete grade until requirements met.

Section 3.04 Pathophysiology

(All levels)

Pathophysiology

Student Name		Clinical Date	
Fill in the information in the white areas of the form			
Medical/Surgical Diagnosis (Primary/Pertinent):			
Pathophysiology (description or definition of medical/surgical diagnosis):			
Textbook Etiology			
Patient Etiology			
Textbook Clinical Manifestations (include how ADL's are affected)			
Patient Clinical Manifestations (include how ADL's are affected)			
Textbook Laboratory Diagnostic Tests			
Patient Laboratory Diagnostic Tests			

Type of Order	Textbook Picture	Patient Receiving
Diet		
Vital Signs		
Oxygenation		
Activity Level		
Treatment / Procedures		

Note: If you need to add a line if you hover over the left edge, the add line button will appear, click on it to add a line.

Concept Map

Student Name		Clinical Date	

Fill in the information in the white areas of the form

Medical/Surgical Diagnosis (from pathophysiology page)			
2 collaborative problems:			
1.		2.	
Highest Priority Problem			
Supportive data for this problem (your subjective/objective assessment data) (Minimum of 4)			

Nursing Interventions with textbook rationales (minimum of 4)	
Intervention	**Rational**

Textbook references for interventions/rationales:			
Book	**Author**	**Page#**	**Year**

Note: If you need to add a line if you hover over the left edge, the add line button will appear, click on it to add a line.

Pathophysiology Example

Student Name		Clinical Date	

Fill in the information in the white areas of the form

Medical/Surgical Diagnosis (Primary/Pertinent):
Pneumonia
Pathophysiology (description or definition of medical/surgical diagnosis):
Inflammatory process affecting the bronchioles and alveoli
Textbook Etiology
Noninfectious agents: aspiration of food, inhalation toxic gases/ infectious agents: bacteria, funji, viruses
Patient Etiology
Bacteria
Textbook Clinical Manifestations (include how ADL's are affected)
Fever, chills, abdominal pain, cough, SOB, sweats, dizziness, rust color sputum, breathing causes pain, weakness
Patient Clinical Manifestations (include how ADL's are affected)
Cough, sweats, SOB, unable to get around without feeling weak, interruption of usual sleep pattern
Textbook Laboratory Diagnostic Tests
Chest xray, sputum culture, cbc
Patient Laboratory Diagnostic Tests
Chest xray, CBC, BUN, ABG's

Type of Order	Textbook Picture	Patient Receiving
Diet	Regular diet/increase fluid uptake	Diabetic diet
Vital Signs	B/P 110/70-138/80, HR 60-100, Temp 98.6 Resp 12-20	88/66, 140 HR
Oxygenation	95-100 pulse oximeter	90
Activity Level	Regular activity ambulatory without assistance	Weak
Treatment / Procedures	Antibiotics, nebulizer, deep breathing, productive cough,	Erythromycin, nebulizer

Note: If you need to add a line if you hover over the left edge, the add line button will appear, click on it to add a line.

Concept Map Example

Student Name		Clinical Date	

Fill in the information in the white areas of the form

Medical/Surgical Diagnosis (from pathophysiology page)			
Pneumonia			
2 collaborative problems:			
1.	Coughing unable to clear airway	2.	Weakness
Highest Priority Problem			
Coughing unable to clear airway			
Supportive data for this problem (your subjective/objective assessment data) (Minimum of 4)			
Changes in rate/depth of respirations			
Abnormal breath sounds			
Dyspnea			
Ineffective cough			

Nursing Interventions with textbook rationales (minimum of 4)	
Intervention	**Rational**
Elevate head of bed	Lowers diaphragm and promotes chest expansion
Force fluids at least 3000 mL/day	Aid in mobilization and expectoration of secretions
Monitor x-ray/ pulse ox/ABG's	Follow progress and effects of therapeutic regimen
Access the rate/depth of respirations and chest movement	Tachypnea, asymmetric chest movement are frequently present because of discomfort of moving chest

Textbook references for interventions/rationales:			
Book	**Author**	**Page#**	**Year**
Medical-surgical nursing	deWit	701	2017

Note: If you need to add a line if you hover over the left edge, the add line button will appear, click on it to add a line.

Pathocare Map Grading Rubric

	Expert	Proficient	Competent	Needs Improvement	Unacceptable
Diagnosis (Primary)	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Patho	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Etiology	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Manifestations	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Diagnostic Tests	Select this level of achievement Points: 9 (9%)	Select this level of achievement Points: 8.1 (8.1%)	Select this level of achievement Points: 6.75 (6.75%)	Select this level of achievement Points: 4.5 (4.5%)	Select this level of achievement Points: 0 (0%)
Orders	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Collaborative Problems	Select this level of achievement Points: 9 (9%)	Select this level of achievement Points: 8.1 (8.1%)	Select this level of achievement Points: 6.75 (6.75%)	Select this level of achievement Points: 4.5 (4.5%)	Select this level of achievement Points: 0 (0%)

	Expert	Proficient	Competent	Needs Improvement	Unacceptable
Priority Problem	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Supportive Data	Select this level of achievement Points: 9 (9%)	Select this level of achievement Points: 8.1 (8.1%)	Select this level of achievement Points: 6.75 (6.75%)	Select this level of achievement Points: 4.5 (4.5%)	Select this level of achievement Points: 0 (0%)
Interventions	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)
Rationales	Select this level of achievement Points: 9 (9%)	Select this level of achievement Points: 8.1 (8.1%)	Select this level of achievement Points: 6.75 (6.75%)	Select this level of achievement Points: 4.5 (4.5%)	Select this level of achievement Points: 0 (0%)
References	Select this level of achievement Points: 8 (8%)	Select this level of achievement Points: 7.2 (7.2%)	Select this level of achievement Points: 6 (6%)	Select this level of achievement Points: 4 (4%)	Select this level of achievement Points: 0 (0%)

Raw Total: 0.00 (of 100.0)

Change the number of points out of 100.0 to:

Feedback to Learner

NURSES NOTES		
Date	Time	

Section 3.06 Pediatric Assessment/Database

System Descriptors	System Descriptors	System Descriptors	System Descriptors
Neurological	**Throat/Mouth:**	**Cough (continued)**	**Cyanosis (Continued)**
LOC:	drooling	croupy	(jaundiced)
alert	abn. suck/swallow	productive	petechiae
oriented by age	**Nose:**	**Retractions:**	diaper rash
coordination movements	normal	suprasternal	**Cyanosis**
normal motor strength	(congested)	intercostal	rash
responds to commands	drainage	substernal	lesions
responds to pain only	(epistaxis)	(grunting)	pruritus
listless	**CARDIOVASCULAR**	(nasal flaring)	other
lethargic	Heart Rate:	**GASTROINTESTINAL**	**Texture/Temp:**
irritable	regular	**Abdomen:**	soft
comatose	irregular	soft	dry
uncoordinated movements	bradycardia	flat	warm hot flushed
decreased motor strength	tachycardia	full	parchment-like
Fontanels: FOC	**Pulse: Apical/Peripheral**	distended	moist
flat/normotensive	full	firm	diaphoretic
bulging	equal	rigid	clammy
depressed	unequal	pain	cool
pulsating	strong	pain (site)	turgor
Pupils	weak	**Bowel sounds**	**Umbilicus:**
equal	thready	present: WNL	dry
reactive	**Heat Sounds:**	hyperactive	moist
unequal	normal	hypoactive	drainage
fixed	faint	absent	foul odor
dilated	bounding	nausea vomiting	hernia
pin point	murmur	anorexia	(reddened)
EENT	**PULMONARY**	flatulent	cord intact
Eyes:	**Breath sounds:**	incontinent	MUSCULOSKELETAL
symmetry asym./sym	clear	other	**ROM:**
tearing	equal	GENITOURINARY	normal
starry	diminished R L	**Urinary:**	limited
(sunken)	stridor	color conc. mucus	Joint Pain
(edematous)	wheezing	clarity	**Muscle Tone:**
redness	coarse	odor	isotonic
Mucous Membranes:	other	frequency	hypertonic
moist pink	**Respirations:**	urgency	hypotonic
dry	eupnea	dysuria	flaccid
reddened	tachypnea	incontinent	nuchal rigidity
discharge	bradypnea	distention	opisthotonic
Ears:	periodic	**INTEGUMENTARY**	Pain
normal	apnea	**Color:**	Key: = present RL = circle right or left ( ) = indicate severity 1 = mild 2 = moderate 3 = severe CDI = Clean, dry & intact
pulling/pain R L	dyspnea	pink nailbeds	
drainage R L	Cough:	pale	
Throat/Mouth:	absent	mottled	
moist, pink	dry	flushed	
dry	absent	**Cyanosis:**	
plaque	moist	generalized	
bleeding	frequent	circumoral	
other	congested	acrocyanosis	
Notes:			List and describe Ostomies, Tubes, Drains, and Dressings below in notes.

Section 3.07 Nursing Physical Assessment

NURSING NOTES CHECKLIST

Received report from N. Nurse LVN. Assumed Care.

HEAD TO TOE This is most of what you will need to document in your chart

NEURO
Mental status - alert/drowsy/lethargic/does not respond
Orientation – orient to person/place/time – oriented to person only – disoriented – unable to determine orientation
Pupil response – PERRLA/sluggish/right pupil larger than left in MM if abnormal/3mm/4mm
Verbal response – unable to speak- speech clear/slurred speech
Pain – level – location/quality - denies pain or discomfort – moaning – moving in bed
Neurochecks completed as ordered see neuro flow sheet (all head injuries/CVA/TIA must have this form)
Denies dizziness/numbness

Pulmonary
Lung sounds – clear to auscultation
Respiration regular/irregular
Resp Labored/Unlabored
Cough present/absent / productive/ nonproductive – if productive thick green/yellow/white sputum
O2 Saturation if below 95 report (have deep breath and see if it will come up)

Cardiovascular
Peripheral pulses present
Capillary refill
Heart sounds present
Heart rhythm regular/irregular
Telemetry
Edema – no peripheral edema – pitting 1+/2+/3+/4+ dependent

GI/GU
Bowels sounds present in all quadrants/hypoactive/hyperactive/absent
Colostomy/ileostomy/ urostomy/ stoma moist pink with appliance in place
Abdomen soft/firm/hard/tender
Feeding self/fed
Amount eaten
Stool description and last stool
Urine description/foley catheter
Incontinent of bowel and bladder
Wears a brief
Voids per urinal or BSC
Foley catheter patent draining clear yellow urine to bedside drainage
Gastrostomy/PEG tube in place – no drainage from site

Musculoskeletal
Bilateral grips and leg strength equal
Moves all extremities
Contractures
Limited movement - traction in place what kind
Restraints – see restraint flow sheet – where are the restraints
Paralysis
Repositioned
Unable to ambulate
Requires assistance to transfer with 2 staff/lift
Up to wheelchair/gerichair with assist
Ambulatory with walker/standby assist/cane/crutches
Requires total assist to reposition/ repositioned to right/left/supine/heel pads in place

Integumentary
Skin warm pink dry
No skin breakdown seen
Skin cool/moist/dusky/cyanotic
Skin turgor no tenting or tenting appropriate for age

Mucous membranes moist
Nail beds pink/dusky/cyanotic/
Lesions what area/bruises/skin tears/steristrips/staples/sutures/tegaderm
IV R/L infusing per pump 100 mL/hr – no redness or edema at site
Central line to left chest proximal and medial ports clamped/distal port has IV TPN infusion 60 ml/hr/dressing intact

Miscellaneous
Dressing clean dry intact to area/Serous sanguinous drainage noted 3 cm area on dressing
Jackson Pratt drain/Davol drain/penrose drain/ hemovac in place. Drainage serous sanguinous
PRN/One time medications (If drainage what color)
Accuchecks recorded on diabetic flow sheet
Reported problems to N. Nurse RN
Reports received from N. Nurse LVN and reported off to N. Nurse LVN
Oral care/catheter care/PEG tube site care given
Assessment unchanged

Safety
Side rails up X2/4
Call light in reach
Bed low
HOB 30 degrees

Always sign your name Nurse Nancy SVN (Student Vocational Nurse). If writing out a note draw a line and put name at the end of the line. Leave no blank spaces.

General Survey:

Initials, DOB, Gender
Allergies
Meds (List with dosage i.e. 20 mg daily)
Surgeries (with year)
Chronic Illness (i.e. HTN, DM, Asthma)
Denies fever, chills, or recent illness
Denies unexplained weight gain or loss
Alcohol, tobacco, drugs (list, type, amount, frequency)
VS
Pain (use PQRST)
Physical Assessment (narrative)

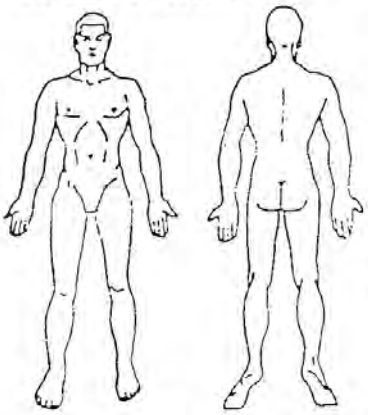
March 9, 2017 8:00 AM Observed in bed, alert, oriented x3. Pleasant, cooperative, responds appropriately to commands. Speech clear. Head round non-tender, free of lumps, lesions. Hair evenly distributed , thick, brown. Face symmetrical . PERRL 3 mm reactive. Sclera white, conjunctivae clear, no drainage noted. Denies vision problems or use of corrective lenses. Denies pain or tenderness to external ear. Slight cerumen visible with no drainage noted. Denies problems with hearing or use of hearing aids. Denies tenderness to nose and sinuses. Nares patent. No drainage noted. Lips, gums, tongue, and oral mucosa moist, pink, intact with no lesions noted. All teeth present and intact. Respirations even, unlabored. Breath sounds clear anteriorly and posteriorly bilaterally x 5 lobes. Denies SOB and cough. S1, S2 presnt. No extra heart sounds heard. Apical pulse regular. Carotid, radial, pedal pulses 2+ bilaterally. Capillary refill less than 3 seconds. No edema or JVD noted. Abdomen round, soft, non-tender. No masses noted. Active bowel sounds present in all quadrants. Posture erect, gait steady. No abnormal curvature of spine noted. Neck, spine, and all extremities have full active ROM. Hand grips and pedal pushes strong and equal. Denies weakness, numbness or assistive devices. Skin warm, pink, dry, intact. Turgor elastic over clavicle. Relates continence of bowel and bladder. LBM (date) formed, soft, brown. Denies pain while defecating. Denies blood in stool. Last void clear, yellow. Denies frequency of urination, pain, discharge, odor, or hematuria. LMP (date) or denies any prostate problems.

_____ Nancy Nurse SVN

Section 3.08 Weekly Skin Assessment

SITE OF SKIN PROBLEM: _____

INDICATE ON DIAGRAM



WEEKLY SKIN ASSESSMENT

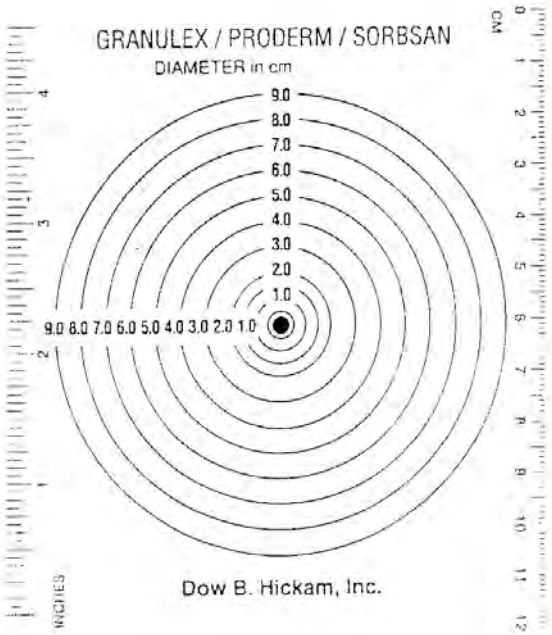
DATE:	NURSE:
Stage Decubitl Only	
Condition of Surrounding Tissue:	
Size in Centimeters:	
Appearance:	
Drainage: No____ Yes____ If Yes, Describe:	
Odor: No____ Yes____ If Yes, Describe:	
Inflamation: Undermining or Tunneling:	
Color:	
Treatment:	
Responding:	

Stage I Reddened area that does not disappear in 60 min. after pressure is removed.

Stage II Destruction of cells - blister, heat, superficial skin break, extra coloration, swelling and firmness.

Stage III Deeper subcaneous, full skin thickness destroyed with exposed open hole in the skin.

Stage IV Muscle & bone are exposed and involved in the destruction process.



Drug Cards

Student Name		Clinical Date	
Fill in the information in the white areas of the form			
Trade Name		Generic Name	
Therapeutic Classification		Pharmacologic Classification	
Route		Dosage	
Frequency		Safe Dose Range	

Indications: (Include reason why patient taking med)
Therapeutic Effects:
Actions:
Side Effects or Adverse Reactions:
Life Threatening Considerations
Nursing Considerations:
Laboratory Considerations:
Comments and Additional Medication Information:
References:

Book	Author	Page#	Year

Note: If you need to add a line if you hover over the left edge, the add line button will appear, click on it to add a line.

Important – Please read

All Students must contact their scheduled Ancillary rotation site ***the day before*** their scheduled rotation to verify the time of rotation and location of the facility.

If you must miss your scheduled clinical rotation ***you must*** notify your clinical instructor ***AND*** the facility you are scheduled to attend.

Every attempt has been made to ensure that all facility information is correct; the student needs to be aware that changes will occur at the above facilities without the nursing department's knowledge. At the time of publication all contact names and phone numbers are correct. If you have difficulty reaching the contact named above or the phone number has changed; please notify the director of the nursing program. Remember if you are scheduled to attend one of the above facilities.

Note: Specialty areas have specific times of attendance. No student will be allowed to ask for a change in the designated hours of a clinical rotation. If a student has concerns about the clinical hours the director of the nursing program should be contacted.

At no time should a student ask to leave a clinical facility early unless due to a family emergency or illness. Regularly scheduled activities are not an excused reason to leave clinical early.

Goodall-Witcher Hospital
101 Posey Avenue
Clifton, Texas 76634
254-675-8322
Contact: CNO

Hill Regional Hospital
101 Circle Drive, Hillsboro TX 76645
254-580-8500
CNO:Michelle Valero, RN CNO

Hillsboro ISD
121 E. Elm St, Hillsboro, TX 76645
HES (Hillsboro Elementary School): Kate Versluis- 254-582-4140
HIS (Hillsboro Intermediate School): Meredith Peterson 254-582-4170

Town Hall Estates (Keene Texas)
P.O. Box 588, Keene TX 76059
Phone: 817 641-9843,
Directions from Cleburne: Take 67 east to FM 2280 turn left (Grundy's service station) Stay on this road, Town Hall estates is on the right side, there will be a sign that says Town Hall Estates.

Directions from I-35: Take 67 west to FM 2280 turn right (Grundy's service station) Stay on this road Town Hall Estates is on the right side there will be a sign that says Town Hall Estates.

Grandview Nursing Home
301 W. Criner St., Grandview TX 76050
Phone#: 817-866-3367

Johnson County Jail
1800 Ridgemar, Cleburne TX 76031
Phone: 817 556-6010, Contact: Ashley Lawrence
Directions: From the nursing building, take Hwy from the nursing building take Hwy 67 East – to Hwy 174 North turn right at the Dairy Queen. Go about 4-5 blocks and off to your left you can see the facility. Turn left and go thru the gates. This will put you in the parking lot. Go to the main entrance and state who you are and whom you need to see.

Vitas - Inpatient Unit (3rd Floor)
Baylor All Saints Hospital
1701 W. Rosedale St., Fort Worth TX 76104
Phone #: 817-922-4570,
Hours: 7:00 am – 3:00 pm (observation only, you may assist with non-invasive procedures).
Directions: From Cleburne Take I-35 (north) to Fort Worth take the Rosedale Exit, turn west on Rosedale. At the light at 8th street, turn left (south). At the light on Magnolia, turn Right (west). All Saints Hospital parking lot. Go in the Southeast entrance (facing Magnolia St.). Once in the building, go left to the elevators go to the right to the inpatient hospice unit.

FMC – Hillsboro Kidney Center
1507 Hillview Dr., Hillsboro TX 76645
254-582-5577

Contact:

Cook Children clinics as assigned by the education department of Cook Childrens.

Section 4.02 Vocational Nursing Person Appearance

Standards for Personal Appearance
Your Clinical Working Day

Our patients expect the best. Students have a responsibility to all of the patients to provide the best in health care services. To do this, here are some of your responsibilities during working day:

THE AVERAGE DAY PERSONAL APPEARANCE

Dress, grooming, and personal cleanliness standards contribute to the morale of all students and affect the professional image we present to patients, visitors, and the community. All female students are normally expected to wear hose if wearing a dress uniform. All students are expected to have their hair properly groomed and contained. Male students should be clean-shaven, or should keep their beards neatly trimmed. Clean hands and fingernails are a must. Students who work with patients should not use perfume or cologne. All students shall wear shoes with quiet heels and soles at all times. Students are not to wear pins, patches, or other items unless authorized to do so under Hill College Nursing departmental rules and procedures. ***Students who appear for clinical inappropriately dressed, or without a name badge, will be sent home and receive an absence.*** In the event the student continues to report to clinical inappropriately dressed, the student will be subject to further corrective action, probation and/or could include dismissal from the program if the practice continues. Violations of the uniform dress code will be addressed on IC and ID of the clinical evaluation tool and repeated violations may result in clinical probation.

Consult your clinical instructor if you have questions as to what constitutes appropriate attire.

ATTENDANCE AND PUNCTUALITY

To maintain a productive clinical experience the Nursing Department expects students to be reliable and to be punctual in reporting for scheduled clinical assignment. Absenteeism and tardiness place a burden on everyone.

ALL NURSING STUDENTS ARE EXPECTED TO COMPLY WITH THE FOLLOWING STANDARDS FOR PROFESSIONAL APPEARANCE THIS INCLUDES CLASSROOM, CLINICAL LAB, AND THE CLINICAL SETTINGS.

Please note the following information for purposes of this dress code.

All CLINICAL STUDENTS are UNIFORMED.

Departmental, unit, or clinic guidelines may have additional requirements, but may not waive any of the following guidelines set forth in these rules. The only appropriate approved jacket is a white lab coat with Hill College Vocational Nursing patch or emblem on left upper arm one inch below the shoulder seam. (No jackets, hoodies, or coats are to be worn during clinical lab or in the clinical

setting.) (Students are allowed to wear hair in a ponytail in the classroom and may wear a jacket but no hood is allowed). If the student has to go to the lab or clinical setting they must abide by clinical dress rules including having the hair in a tight bun with no hair hanging free. Students may not enter the clinical lab or clinical site without a name badge. No blankets or pillows will be allowed in the classroom. Students may wear a headband or clips the color of the hair to restrain hair. Banana clips are not permitted.

REQUIREMENTS FOR ALL NURSING STUDENTS

AFTERSHAVE/PERFUME:
Aftershave, cologne, perfume or scented lotion should not be worn in patient care areas. They may be worn in non-patient care areas provided the scent is light and used in moderation. **Heavy scents are prohibited**

BUTTON/PINS:
Wear only insignias that have been approved by the Nursing Department.

CLOTHING:
Clothing worn by nursing students should be neat, clean and in good repair.

DEODORANT:
Due to close contact with others, all students must wear deodorants or an antiperspirant.

GROOMING/HYGIENE:
Daily bathing is required by all students, and hair must be shampooed regularly to promote a neat and clean appearance. Daily oral hygiene is required.

GUM:
Chewing gum is not permitted. Breath mints or breath sprays are allowed.

NAME BADGES:
All students must wear an identification badge worn in the shoulder area in an upright, readable position with photo visible at all times this includes class or clinical lab.

BADGES MUST BE REMOVED WHEN AWAY FROM CLINICAL SITE. If the student is going to be in a healthcare facility following the clinical day they need change out of clinical attire.

SUNGLASSES:
Students do not wear sunglasses indoors.

TATTOOS:
Conspicuous tattoos are not considered to be in the best interest of the Nursing Department and are unacceptable. A tattoo can be considered conspicuous when it is visible. Methods to conceal tattoo, such as, but not limited to, makeup or bandages, **are not acceptable**. **THE ONLY ACCEPTABLE COVERING IS CLOTHING UNLESS**

APPROVED BY THE PROGRAM DIRECTOR. If a student has a tattoo on the neck, hands or ears concealing makeup will need to be used to cover the tattoo. Tattoos on the back of the neck need to be covered with a turtleneck or dickie so they will not be seen.

Student wears the uniform prescribed by the department. A white shirt that should not be dingy may be worn under the navy scrubs or white uniform top. No short sleeve t-shirts are allowed. Any white shirt under a uniform top should be tucked in and no skin or underclothing should be seen when bending over or when hands are raised.

(See form Appearance Rules Acknowledgment)

(See form Uniform Rules Violations – Written Warning

Section 4.02.01 The Nursing Department Look For Women

CLOTHING

Student wears the uniform prescribed by the department.

UNDERGARMENTS

Students are required to wear appropriate undergarments, such as underwear, slip, and a bra at all times. If a student has a tattoo on the back then a camisole or tshirt will need to be work that is white to cover when in the white uniform top.

It is unacceptable for the student to wear undergarments that are visible, or visible through the outer garments.

SHOES

Shoes are polished and kept in good repair. Shoelaces are of the same color as the shoes and are tied for safety.

ALL WHITE (excluding logo) leather, or simulated leather, athletic-type or nursing shoes must be worn, unless other specific footwear is required due to the nature of the job.

HOSIERY/SOCKS

Hosiery of white color is worn to coordinate with clothing. Tops of the hosiery should not be NON-UNIFORMED visible and should be **midcalf.** White socks or white compression stockings only are permissible with uniforms. **Hosiery or socks are required to be worn at all times. No peds or ankle socks are to be worn while in uniform.**

RINGS: Wear small ring or wedding band on ring finger limited to one ring.

WATCHES: Wear only one (1) plain watch with second hand. No smartwatches (i.e. Apple Watch).
No digital watches.

JEWELRY

Bracelets: No bracelets may be worn in clinical areas except for medical alert bracelets.

Necklaces: A single chain not exceeding 20 inches, including a small pendant not to exceed the size of a quarter, of gold or silver may be worn inside the neckline of the uniform.

Earrings: Select matched pair(s) of small stud in lower lobe only. Only one set may be worn.

Earrings, nose rings and other body piercing jewelry are not acceptable - this includes tongue, eyebrow.

HAIR

A neat, natural hairstyle is an essential part of a well-groomed appearance. Students must select styles that will not fall forward over the face while performing job duties. Teasing for body or shape is kept to a minimum. **Hair must be up off the shoulders (this means pulled up). No rabbit ears or braids that come forward. Hair must be worn where it falls down the back in a pony tail if in class or up in a smooth tight bun if in the clinical lab or on the clinical site. Hair must be pulled up in a bun in the clinical lab or in the clinical setting. Microorganisms are on hair. Hair must not fall forward in any way that hair could fall on the patient or patient's linen possibly causing infection.**

Facial hair must be neat and trimmed. The beard must be close cropped and trimmed and cannot extend below the chin.

NOT ACCEPTABLE

Extreme fashion statements such as shaving the head, radical haircuts or tinting hair in unnatural colors - blue, green, pink etc. Hair must be uniform natural colors. Not acceptable example: blonde with black underneath.

ALL STUDENTS

HAIR ACCESSORIES

Hair accessories may be worn for the purpose of preventing hair from falling forward on the face only. **Appropriate hair confinement is worn in areas required by law.**

Barrettes, combs and hair bands may be gold, silver or any color that coordinates with hair coloring.

MAKEUP

Foundation: If foundation bases are worn, students should select shades complementary to natural coloring. Application is light and well blended in order to avoid stains on clothing.

Blushers: Blushers may be used to enhance appearance, natural tones.

Eye Makeup: Eye makeup and mascara may be used to highlight the eyes in complimentary shades. **No artificial or weaved eyelashes are allowed. Only natural length and color.**

Lipstick: Lipstick may be applied in colors to enhance appearance, neutral tones.

FINGERNAILS

Fingernails are kept clean and well groomed and do not exceed one-eighth of an inch beyond the fingertip (this means when looking at the palm no fingernails should extend over the end of the finger). No fingernail polish of any color may be worn.

NOT ACCEPTABLE - Acrylic or Artificial nails may not be worn.

Section 4.02.02 The Nursing Department Look For Men

CLOTHING

Student wears the uniform prescribed by the department.

UNDERGARMENTS

Students are required to wear appropriate undergarments at all times. It is unacceptable for the student to wear undergarments that are visible, or visible through the outer garments.

SHOES

Shoes are polished and kept in good repair. Shoelaces are of the same color as the shoes and are tied for safety. Must be clean and neat!

ALL WHITE (excluding logo) leather, or simulated leather, athletic-type or nursing shoes must be worn, unless other specific footwear is required due to the nature of the job.

HOSIERY/SOCKS

Socks must be worn at all times and must coordinate with clothing. Tops of the socks should not be visible and should be **midcalf.** White athletic socks are permissible with uniforms.

RINGS

Wear a small ring or wedding band on the ring finger only limited to one ring.

WATCHES

Wear only one (1) plain watch with second hand. No smartwatches (i.e. Apple Watch). No digital watches.

JEWELRY

Bracelets: No bracelets may be worn in clinical areas.

Necklaces: A single chain not exceeding 20 inches, including a small pendant not to exceed the size of a quarter, of gold or silver may be worn inside the neckline of the uniform.

Earrings: Earrings, nose rings and other body piercing jewelry are not acceptable this includes tongue, eyebrow.

HAIR

A neat, natural hairstyle is an essential part of a well-groomed appearance. Students must select styles that will not fall forward over the face while performing job duties. Appropriate hair confinement is worn in areas required by law. **Hair must be up off the shoulders (this means pulled up). No rabbit ears or braids that come forward. Hair must be worn where it falls down the back in a pony tail in the classroom or up in a tight smooth bun in the clinical lab or at the clinical setting. Hair must be pulled up in a bun in the clinical lab or in the clinical setting. Microorganisms are on hair. Hair must not fall forward in any way that hair could fall on the patient or patient's linen possibly causing infection. A headband the same color as the hair may be used to contain loose hair.**

Facial hair must be neat and trimmed. The beard must be close cropped and trimmed and cannot extend below the chin.

NOT ACCEPTABLE

Extreme fashion statements such as shaving the head, radical haircuts or tinting hair in unnatural colors - blue, green, pink etc. Hair must be uniform natural colors. Not acceptable example: blonde with black underneath.

FINGERNAILS

Fingernails are kept clean and well groomed and do not exceed one-eighth of an inch beyond the fingertip.

SMOKING

The use and sale of all tobacco and/or e-cigarette products is prohibited inside all College District facilities. Students who are found with residue from, or items such as, but not limited to, cigarette butts, spittoons, tobacco juice, and tobacco waste in Hill College facilities are subject to disciplinary action. E-cigarette means an electronic cigarette or any other device that simulates smoking by using a mechanical heating element, battery, or electronic circuit to deliver nicotine or other substances to the individual inhaling from the device. Prior to clinical, during clinical time and while in uniform – this includes use of any tobacco products or E-cigarettes.

SMOKING IS NOT PERMITTED!

Written Warning

Student Name (printed) _____

You are hereby given a written warning for uniform rule violations for the following reason(s). Repeated violations of the uniform rule will result in probation.

Circle the number of all that apply:

1. **Hair down in face or inappropriate colors**
2. **Excessive makeup**
3. **Tattoos exposed**
4. **Excessive/inappropriate jewelry**
5. **Pant length (touching floor)**
6. **Inappropriate/visible or no undergarments**
7. **Uniforms dirty/wrinkled**
8. **Inappropriate/dirty shoes**
9. **School patch loosely secured**
10. **Inappropriate or missing watch**
11. **Missing ID badge**
12. **Excessive scents (perfume, lotions, colognes, body odors)**
13. **Sagging pants**
14. **Uniform too small**
15. **Inappropriate or no socks**
16. **Dangling Earrings/tongue rings/or other visible piercings**
17. **Acrylic nails or nail polish**

Student comments:

_____
_____
_____
_____

Instructor comments:

_____
_____
_____
_____

_____ _____
Student signature **Date**

_____ _____
Instructor signature **Date**

Section 4.04 Supervision of Medication Administration Rule IV Meds

The supervision of medication administration in the clinical area is under the direct supervision of the clinical instructor or staff RN. The goal is to insure the highest quality of patient care while providing maximum learning experience.

1. Students will be supervised during the preparation, administration, and recording of injectable medications.

2 Students may monitor selected intravenous infusions as determined by the instructor.

3. Students may monitor solutions administered by pump infusion devices as determined by the instructor.

4. Students may add medications and hand intravenous infusions with supervision of instructor.

5. Students may prepare I.V. piggyback infusions with direct supervision. Before the student prepares and administers these infusions, the instructor must check the solution, card, Kardex, and medication vial. I.V. admixture preparations will be checked prior to administration.

6. Students may "start" intravenous infusions under the direct supervision of the clinical instructor or staff RN in designated clinical facilities according to hospital rule.

7. Students are not allowed to mix or hang hyperalimentation solutions.

8. Students may administer I.V. piggyback medications through a saline lock with direct supervision according to hospital procedures.

9. No intravenous push medications including patient-controlled analgesic pumps may be given.

10. Students are not allowed to administer intravenous chemotherapy agents.

11. Students may only observe the checking and hanging of blood and blood components. Students are not allowed to hang blood and blood components.

12. In specialty areas (ICU, CCU) the student will not be responsible for titrating I.V. medications to regulate blood pressure or cardiac arrhythmias.

13. In maternity areas (L & D) student will not be responsible for monitoring Pitocin I.V. administration.

Section 4.05 Procedure of Saline Lock Insertions and Medication Administration

1. Wash hands.

2. Explain procedure to the patient.

3. Gather equipment.

4. Apply tourniquet; select vein (a vein in the lower forearm is ideal as it allows maximum mobility).

5. Remove the intermittent infusion set from the package, cleanse the latex diaphragm with an alcohol sponge and insert the needle of the syringe containing 2 cc of NaCL and clear the tubing of the infusion set with this solution.

6. Cleanse the insertion site on the patient according to hospital procedure, outward in a circular motion.

7. With the syringe still in place, perform venipuncture with the infusion set needle, with the syringe pull back on the plunger to confirm needle placement (blood flashback).

8. Release the tourniquet; tape the device securely in place. Slowly inject the remainder of the NaCL, observing for infiltration. If infiltration appears, remove present infusion set and perform venipuncture again with a new infusion set.

9. Remove syringe from diaphragm when venipuncture is successful.

10. Cover with a sterile 2x2 or Band-Aid. Coil the tubing on top of the cover dressing and tape in place, leaving the latex diaphragm exposed.

11. Label the I.V. site with date, time, size of infusion set used and your initials.

12. If first dose of medication is to be given:

HILL COLLEGE MEDICATION GUIDELINES DO NOT ALLOW STUDENTS TO PUSH MEDICATIONS, BUT THIS IS THE PROCEDURE FOR DOING SO.

a. I.V. Push Medication

1. Cleanse the latex diaphragm with an alcohol sponge.

2. Insert the medication syringe needle into the diaphragm, being careful not to puncture the tubing. Slowly inject the medication into the diaphragm, again observing for infiltration.

b. I.V. Drip Medication

1. Insert administration set or volutrol set into Medication bag or bottle as instructed in I.V.P.B. guidelines. Attach a 22 or 23 gauge needle to the administration set.

2. Cleanse the latex diaphragm with an alcohol sponge and insert the tubing needle into the diaphragm being careful not to puncture the tubing.

3. Open roll and regulate drip rate.

13. If no medication is to be given, flush with saline immediately and every eight hours.

14. Teach the patient regarding keeping the site dry, taking caution not to bump or lie on needle. Instruct patient to report any swelling or pain or bruising at site.

15. Check the integrity of the saline lock each time before giving medications.

16. IV site change frequencies vary with individual hospital policies. Most policies state that sites should be changed at least every 72 hours.

17. Charting information should include: insertion procedure size and type of needle, the site used, reactions of the patient, teaching done, condition of the site, care of the site daily.

NO VOCATIONAL NURSING STUDENT CAN ADMINISTER ANY MEDICATION THROUGH A PICC LINE OR CENTRAL CATHETER PER THE TEXAS BOARD OF NURSING

Section 4.06 Potential or Actual Medication Error

1. An institutional incident report should be made out when the student is injured while in the clinical area.

2. In the event of unusual occurrences involving a student, and/or patient, the following procedure should be followed:

    a. Notify the clinical instructor and the nurse in charge of the clinical area where the incident occurred.
    b. Complete incident report form with the assistance of the instructor.

3. An unusual occurrence may include such things as a medication error, patient injury witnessed by a student, and/or student injury.

(See form Potential or Actual Incident Report)

Section 4.07 Clinical Probation

Vocational Nursing students are involved in instruction, which may involve the comfort, health and well being of others. It is essential that all clinical instruction be carried out in accordance with accepted nursing standards. In the opinion of the clinical instructor, _____ and Coordinator/Director_____, the student _____, warranted clinical probation in accordance with the following rules:

1. The student will be warned verbally of the deficiency.

   Date of Warning: _____

2. The student will receive written notification of the cause and terms of probation.

   Cause: _____

   Terms: _____

3. The student will be counseled by the instructor in an attempt to improve performance to an acceptable level.

   Date of Counseling: _____

4. The probation period will be for a specified period of time.

   Probation period: _____

5. The student will be reevaluated at the end of the probation period.

   Reevaluation date(s): _____

If deficiency is corrected, the student will be allowed to finish the program. If the deficiency is not corrected or is violated, the student will be dismissed from the nursing program. If the student feels probationary placement is unwarranted, student may follow grievance procedure.

_____
_____

Vocational Nursing Student Date

_____

Coordinator/Director of Vocational Nursing Date

Section 4.08 Clinical Counseling Form

Counseling Form _____

Clinical Performance _____

Situation:_____

_____

_____

_____

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Instructor's Signature_____Date_____

Student's Comments: _____

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Student's Signature_____Date_____

Section 4.09 Student Evaluation Form

Student Name:_____Room #_____Date:_____

1. Patient care
   a. Care complete..... Yes_____No_____
   b. Care organized..... Yes_____No_____
   c. Communicates well with the nurse about care given ..... Yes_____No_____
   d. Patient room: Neat, safe ..... Yes_____No_____
2. Documentation
   a. Complete, concise, timely ..... Yes_____No_____
   b. Entry every two hours ..... Yes_____No_____
   c. Legible and signed..... Yes_____No_____
   d. Addressed any needed nursing diagnosis/problem..... Yes_____No_____
3. Assessment
   a. Complete, concise..... Yes_____No_____
   b. Problems documented professionally ..... Yes_____No_____
4. Medications
   a. Administered, timely and safely and documented..... Yes_____No_____
   b. IV monitored and documented ..... Yes_____No_____
5. Professionalism
   a. Appropriate attire..... Yes_____No_____
   b. Professional behavior..... Yes_____No_____
   c. Maintains sterile/clean techniques ..... Yes_____No_____

Comments: (please make a general statement)_____

_____ _____

Primary nurse signature Student nurse signature

Section 4.10 Clinical Facility Evaluation Form

Facility: _____ Course and #_____

Semester/Year: _____

In order to evaluate the effectiveness of the facilities used for the clinical component of your education, please take the time to give us your opinion as to the effectiveness of the facility in the following areas:

Circle the number that best represents your opinion.

	Agree				Disagree
1. Adequate parking facilities were available.	1	2	3	4	5
2. Adequate secured area to store purses, books, and coats was available.	1	2	3	4	5
3. Adequate area for pre/post conferences was provided.	1	2	3	4	5
4. Nursing staff was helpful in offering learning experiences.	1	2	3	4	5
5. Nursing staff served as professional role models.	1	2	3	4	5
6. Nursing staff encouraged communication and questions.	1	2	3	4	5
7. Nursing staff provided recognition and feedback to students.	1	2	3	4	5
8. Clinical use of nursing diagnosis/care planning was compatible with classroom instruction.	1	2	3	4	5
9. Adequate learning experiences were available to meet clinical course objectives.	1	2	3	4	5
10. Client care delivery system promoted organization of care.	1	2	3	4	5
11. Medication delivery system was conducive to student participation.	1	2	3	4	5
12. Overall, the facility offered adequate learning experiences.	1	2	3	4	5

Please place additional comments on back.

Article 5 Clinical Documentation Tools

Section 5.01 Preparation for Clinical

Consult procedure manual for any procedure you have not done in THIS hospital before, i.e. foley care, heparin flush, etc.

Research each patient's diagnosis (All), problems, tests, treatment, paraphernalia, traction, roto-rest bed, tube feeding, set-up, etc.). Use texts, hospital library, journal articles; lecture notes from throughout the curriculum and other references from the school library.

Cover all areas in making your preliminary care plan for each patient:

Meds	Diet/Tube Feeding/Hyperalimentation
Treatment	Tests
IV's	Equipment Care and Use
Communication	Growth and Development Aspects
Safety	Level of Activity
Rest	Tubes and Lines
Elimination	Assistance with ADL/Hygiene
Teaching	Psychosocial needs
	Consider areas of needed assessment

Have everything ready the night before (make lunch, get gas in car, kids' stuff ready, polish shoes, iron uniform, etc.). Leave whatever you need to take with you by the front door where you have to trip over it on your way out – then you cannot forget it.

GET A GOOD NIGHTS SLEEP

Remember to take your sense of humor with you!

Section 5.02 Clinical Reminders

1. Does following on unit:
   a. Introduce self to nurse in charge of patient or Head Nurse.
   b. Introduce self to patient with explanation of what he/she is to do at all times.
   c. Identify self, patient and room number when seeking help.

2. Organizes care daily.

3. Seeks out instructor when needed.

4. Looks for skill/check-off in all assigned areas.

5. Monitors safety of patients and self:
   a. Has the bed in a comfortable working level.
   b. Lowers bed level when patient care is complete.
   c. Puts the side rails down when giving patient care.
   d. Puts the side rail up when patient care is complete.
   e. Checks catheter tubing to be sure it is patent following regulations of side rail.
   f. Places signal or call bell within the patient's reach when care is complete.
   g. Leaves waste paper basket, water pitcher, and the bedside table with phone and/or personal articles within reach when care is completed.
   h. Offers oral hygiene prior to or after breakfast, combs the patient's hair.
   i. Checks IV tubing and/or catheter tubing when turning a patient to be sure it is patent.
   j. Asks patient, "Is there anything more I can do for you?" when care is completed.
   k. Reports immediately any abnormal assessments found during patient care or may need to ask for verification of finding at once.
   l. Washes hands after patient care. Uses gloves as instructed during patient care.

6. Does not spend time talking (socializing) with nursing personnel or other students in area.

7. Stays with the patient when the physician comes into the room.

8. Collects terminology each day of patient related tests, treatments, drugs, etc.

9. Checks patient's identification wrist band and identifies allergies before giving medications or performing a procedure.

10. "Does not talk too much"; instead of using communication as a mechanism of understanding the patient's verbal and nonverbal conversation.

11. Make certain the patient has plenty of water before giving a medication.

12. Calls for the instructor to come for a skills/check-off.
    a. Reviewed the procedure manual.
    b. Gathered all needed materials.
    c. Planned for patient privacy.
    d. Been aware of any breaks in technique.
    e. Planned on what assessment is needed for charting.

13. Keeps only appropriate equipment on bedside table, e.g.. no urinals.

14. Assists patients to eat.

15. Avoids saying to patients:
    a. “This is the first time I’ve done this.”
    b. “I’ve never seen an incision like this.”
    c. “It’s been a long time since I’ve done this.”
    d. “My goodness, what happened to you? I’ve never seen anything like this.”
    e. “Oh, my you must have something horribly wrong with you.”
    f. “I’ve never done this before.”
    g. “I really don’t think this will help you.”
    h. “I’m just a student, but I think I know how to do this.”

Section 5.03 Chart Review

The following guidelines should help you with preparing yourself for a clinical experience:

1. Your time is valuable and you should not be spending more than 10-15 minutes on each patient chart.

2. Begin with reviewing the doctor's orders; this provides you with a legal basis for delivering nursing care.

3. Always consult the admitting orders first, followed by the daily updates.

4. If your patient has surgery/delivery, remember that all preoperative orders were canceled.

5. Pay particular attention to medication orders and intravenous fluid orders.

6. Check the patient information sheet next for age, sex, religion, etc.

7. Quickly read over the doctor's history and physical if the chart has one. (In teaching hospitals, there may be several versions of the History and Physical – residents, medical students and interns. Choose the one that is the legible to read. They basically say the same thing. You do not need to read all of them.

8. Elicit from the History and Physical the chief complaint and the admitting diagnosis—not important. Focus on the system review from the system(s) that would be most affected by the chief complaint. For example, if the patient was admitted for shortness of breath, focus on the cardiac and respiratory systems. OB patients focus on Prenatal, Labor and Delivery, immediate postpartum recovery room, and postpartum. Note the status of the newborn.

9. Next read the doctor's progress notes from the past several days. If the patient had surgery, be sure to read the operative report in the progress notes.

10. After you have digested the information from the doctor's section, read the nursing history and assessment and the past twenty-four and forty-eight hours of nurse's notes.

11. If the patient is having laboratory tests done on a frequent basis to monitor disease progress such as protimes and CBC's, check the laboratory reports. Sometimes you will find this information incorporated in the progress notes. Medical students are supposed to put it there.

12. Finally, if the patient has had major diagnostic tests such as a CAT scan or a gall bladder series, read the results of the studies. Don't necessarily focus on understanding every word of the report, but do comprehend the findings.

13. If your hospital includes daily medication records in the chart, you will also need to review them at this time. Make sure that what is ordered in the doctor's orders is reflected in the medication records.

14. Last but not least, do not be hesitant to ask one of the staff nurses about your patient. He/She may confide in you that she hasn't read the chart other than the doctor's orders. However, he/she may have attended rounds with the physicians and will be able to give you insight from that aspect.

    - Don't forget to consult the nursing Kardex also for pertinent information regarding the car of your patient. But remember, for legal purposes, the information that is in the chart is what must guide your actions.
    - These fourteen suggestions are intended to help you with efficient use of your valuable time. There are times; for example, with patients that have been hospitalized for a long time or have very complicated problems that fifteen minutes will not be adequate. You will have to be the judge of that.

Section 5.04 Descriptive Terms

TABLE OF DESCRIPTIVE TERMS (NEVER USE TERM NORMAL)

CONCERNING	FACTOR TO BE CHARTED	SUGGESTED TERMINOLOGY
ABDOMEN	1. Large and extends outward 2. Black and blue marks present 3. Hard, boardlike 4. Soft, flabby, flat 5. Hurts when touched 6. Appears swollen, rounded 7. Presence of rash 8. Scars present	1. Enlarged-protruding 2. Ecchymosed 3. Hard, rigid 4. Relaxed, flaccid, flat 5. Sensitive to touch 6. Distended 7. Rash present (mild, severe) 8. scars present (describe length/location)
Amounts	1. Large amount 2. Moderate amount 3. Small amount	1. Profuse, copious, free, excessive measured amount 2. Moderate, usual, measured amount 3. Small amount, scanty, slight, measured amount
Appearance	1. Thin and undernourished and wasted 2. Fat, greatly overweight 3. Seems very sick 4. Not very sick	1. Emaciated, debilitated 2. Obese 3. Acutely ill 4. Not acutely ill
Appetite	1. Very fussy about food-refuses to eat many foods 2. Refuses to eat	1. Has very definite likes and dislikes concerning food 2. Refused food (state reason)
Arm	1. Shoulder to elbow 2. Elbow to wrist 3. Right arm artificial	1. Upper arm (right or left) 2. Lower arm, forearm 3. Right prosthesis
Attitude, Mental	1. Hard to please 2. Distrustful 3. Happy 4. Afraid 5. Sad 6. Loss of Memory 7. Has “don’t care” attitude	1. Irritable, fault-finding 2. Suspicious 3. Optimistic 4. Apprehensive, anxious 5. Depressed, moody 6. Amnesia 7. Apathetic
Back areas:	1. Upper back 2. Small of back 3. End of spine 4. Gluteal area 5. Hump back 6. Sway back 7. Lateral curvature	1. Interscapular region, shoulder area 2. Lumbar region 3. Sacral region 4. Buttocks 5. Kyphosis 6. Lordosis 7. Scoliosis
Belch	1. Belching	1. Eructation

Breathing	1. Act of breathing 2. Difficult breathing 3. Short period when breathing ceases 4. Inability to breathe lying down 5. Normal breathing 6. Rapid breathing 7. Increasing dyspnea with periods of apnea 8. Large volume of air inspired 9. Small volume of air inspired 10. Abnormal variations in rhythm 11. Noisy breathing 12. Other descriptive terms	1. Respiration 2. Dyspnea 3. Apnea 4. Orthopnea 5. Eupnea 6. Hyperpnea 7. Cheyne-stokes respirations 8. Deep breathing 9. Shallow breathing 10. Irregular respirations 11. Stertorous 12. Quite, sighing, gasping, rapid, shallow, costal, noisy, audible
Color	1. Colorless 2. Resembling clay 3. Looks same as tar 4. Tinged with blood	1. Clear 2. Clay colored 3. Tarry 4. Blood tinged
Consistency	1. Retains its shape 2. Watery 3. Thick, sticky or glue-like 4. Containing or resembling mucous	1. Formed 2. Liquid 3. Concentrated, tenacious, viscid 4. Mucoid
Cough	1. Coughs all the time 2. Coughing over long period of time 3. Coughs up material 4. Occurring in spasms 5. Coughs quire frequent 6. Coughs that does not produce material from lungs 7. Self-explanatory types of cough	1. Continuous cough 2. Persistent cough 3. Productive cough 4. Spasmodic cough 5. Frequent cough 6. Non-productive cough 7. Tight, loose, deep, dry, hacking, harsh, painful, rasping, explosive, shallow, exhaustive
Consciousness	1. Fully conscious, aware of surroundings 2. Only partly conscious 3. Unconscious, but can be aroused 4. Unconscious, cannot be aroused 5. Pretended unconsciousness	1. Alert and oriented 2. Semi-conscious 3. Stuporous 4. Comatose 5.Feigned unconsciousness
Convulsion	1. Continuous shaking 2. Shaking with intervals of rest 3. Began without warning 4. Of hearing 5. Of smell 6. Of taste 7. Of sight	1. Tonic tremor 2. Clonic tremor 3. Sudden onset 4. Auditory hallucination 5. Olfactory hallucination 6. Gustatory hallucination 7. Visual hallucination
Defecation	1. Bowel movement (material) 2. Bowel movement (act of)	1. Feces, stool 2. Defecation

Drainage	1. Watery, from nose 2. Containing pus 3. Bloody 4. Consists of feces 5. Of lymphatic fluid 6. Contains mucous and pus 7. Tough, sticky	1. Coryza 2. Purulent 3. Sanguineous 4. Fecal 5. Serous 6. Mucopurulent 7. Tenacious
Face	1. Without color 2. Pink 3. Broken out 4. Marked with pits and scabs 5. Characteristic expression worn 6. Appears swollen, rounded 7. Presence of rash 8. Scars present	1. Pale 2. Flushed 3. Presence of rash, acne 4. Pocked marked 5. Anxiety, defiance, anger, pain, boredom, fear, worry happiness, apathy, sorrow, dissatisfaction
Feet-applies to entire body	1. Reddened spots or areas caused by pressure or friction	1. Pressure areas present excessive, measured amount
Gas	1. Gas in digestive tract	1. Flatus
Hives	1. Hives 2. Itching	1. Urticaria 2. Pruritis
Nails	1. Blue in color	1. Cyanotic
Pain	1. Great pain 2. Little pain 3. Comes in seizures 4. Spreads to distant areas 5. Started all at once 6. Hurts all at once 7. Other descriptive terms	1. Severe 2. Slight 3. Paroxysmal, spasmodic 4. Radiating 5. Sudden onset 6. Increased by movement 7. Sharp, sudden, darting, cramping, shooting, burning, stabbing, persistent, transient, constant, shifting, localized, deep superficial
Paralysis	1. Of the muscles of the face 2. Of the legs 3. Of one side of the body 4. Of a single limb 5. Of all 4 limbs 6. Large amount 7. Small amount	1. Facial paralysis 2. Paraplegia 3. Hemiplegia 4. Monoplegia 5. Quadriplegia 6. Profuse, excessive, diaphoresis 7. Scanty
Perspiration	1. Presence of 2. Large amount 3. Small amount 4. Continued excessive amount	1. Diaphoresis 2. Profuse, excessive 3. Scanty 4. Diaphoretic
Positional	1. Flat on back, arms straight at side 2. On side, knees flexed 3. On left side, left arm behind back, left leg slightly flexed, right leg greatly flexed 4. Semierect, head up, knees flexed	1. Horizontal 2. Lateral 3. Sim=s 4. Fowler=s

Pulse	1. Beats missed at intervals 2. Very rapid, beats indistinct 3. One scarcely perceptible 4. Small, rapid and tense 5. Cannot be felt 6. With excessive recoil wave 7. Rapid, quite distant beats	1. Intermittent 2. Running 3. Thready 4. Wiry 5. Imperceptible 6. Dicrotic 7. Pounding, bounding
Respiration	1. Above 25 respirations/minute 2. Snoring 3. Other descriptive terms	1. Accelerated 2. Stertorous 3. Quiet, sighing, gasping, rapid, shallow, deep, costal, audible, noisy, abdominal
Scalp	1. Covered with dandruff 2. Covered with scales 3. Lice found 4. Baldness	1. Dandruff present 2. Scaly 3. Pedicule present 4. Alopecia
Sensation	1. Descriptive terms	1. Tingling, burning, stinging, prickling
Skin	1. Normal 2. Pink, Hot 3. Blue in color 4. Very white 5.Shines 6. Raw surface 7. Yellow in color 8. Torn 9. Cold and moist 10. Birthmarks 11. Wart 12. Boil 13. Other terms 14. Indicate presence of:	1. Healthy 2. Flushed 3. Cyanotic 4. Extreme pallor, pale 5. Glossy 6. Excoriation 7. Jaundiced 8. Lacerated 9. Clammy 10. Nevi 11. Verruca 12. Furuncle 13. Mottled, discolored, moist, dry, hot, cold, warm, oily, broken, calloused, wrinkled, tight, coarse, of fine texture, tanned 14. Rash, abrasion, laceration, eruption, acne, crusts, scars, ulcers, moles, fissures, insect bites
Specimens	Taken to laboratory	Specimen to _____, Lab or Specimen to_____, Dr. office
Speech	1. Speaks normal 2. Not understandable 3. Meaningless, wandering 4. Runs words together 5. Stammering, stuttering 6. Not heard distinctly 7. Speaks long and well 8. Difficulty 9. Unable to speak	1. Normal speech 2. Inarticulate 3. Rambling 4. Slurring 5. Stammering and/or stuttering 6. inarticulate 7. Fluent 8. Dysphasia 9. Aphasia
Symptoms	1. Observed only by patient 2. Observed by someone other than patient 3. A group of symptoms	1. Subjective 2. Objective 3. Syndrome

Teeth	1. False 2. Decay of 3. Collection of foul material 4. Other descriptive terms 5. Without teeth	1. Dentures 2. Dental caries 3. Sordes 4. Natural, notched, decayed, crooked, protruding, crowded, irregular, broken, loose, discolored 5. Edentulous
Throat	1. Difficulty in swallowing 2. Inability to swallow	1. Dysphagia 2. Aphagia
Tongue	Descriptive terms	Pink, moist, dry, cracked, coated, raw, swollen, inflamed, ulcerated, scarred, fissured
Treatment	1. Preventive 2. Offering temporary relief	1. Prophylactic 2. Palliative
Urination	1. To urinate 2. No control over urination 3. Large amount of urine voided 4. Increased amount voided 5. Painful urination 6. Scantiness of urine	1. Void, micturate 2. Involuntary, incontinent 3. Diuresis 4. Polyuria 5. Dysuria 6. Oliguria

LABS

Significance of Blood Analysis	
Calcium	Mineral in the blood required for bone formation.
Phosphorus	Mineral in the blood required for bone formation.
Glucose	Blood sugar, which is elevated in diabetes.
BUN	Substance which when elevated may indicate kidney disease.
Uric Acid	Acid, which is elevated in gout.
Cholesterol	Fatty substance in blood, which may contribute to the development of atherosclerosis.
HDL (High Density Lipoproteins)	Substance, which may play a role in the development of/or protection against heart disease.
Total Protein	Indication of nutritional status and liver function.
Albumin	Protein fraction, which is decreased in liver disease, kidney disease, and malnutrition.
Alkaline Phosphatase	Enzyme, which may be elevated in liver or bone disease.
Total Bilirubin	Red blood cell pigment metabolized by the liver which is increased in liver disorders and causes a yellow tint to the skin.
Globulin	Protein fraction elevated in liver disease or immune disorders.
A/G Ratio	Measurement of percentage of total protein as an albumin, useful in evaluating liver function.
LDH	Enzyme elevated in liver, lung, and cardiac disorders.
SGOT	Enzyme elevated in liver disease and heart disease.
SGPT	Enzyme elevated in liver disease.
Creatinine	Substance elevated in kidney disease.
Iron	Mineral necessary for red blood cell formation.
Triglyceride	Fatty substance in blood, which may contribute to the development of atherosclerosis.
Sodium, Potassium and Chloride	Basic minerals in blood, which reflect, body acidity or alkalinity and can be affected by nutritional imbalance or may reflect disorders of the kidneys or the endocrine glands.
CO_2	Carbon dioxide content of blood. Deviation from normal may reflect kidney or ling disorders.

LABS (continued)

Complete Blood Count	
White Blood Cells	Type of blood cell, which fights infection.
Red Blood Cells	Contains hemoglobin and iron. A low red blood cell count may indicate anemia.
Hemoglobin	Protein contained in red blood cell. A low level of hemoglobin may indicate anemia.
Hematocrit	Percentage of red blood cells by volume in whole blood.
M.C.V.	Mean Corpuscular Volume – the size of a red blood cell.
M.C.H.	Mean Corpuscular Hemoglobin – the amount of hemoglobin in a red blood cell.
M.C.H.C.	Mean Corpuscular Hemoglobin Concentration - % of hemoglobin in relation to size of a red blood cell.
	M.C.V., M.C.H., M.C.H.C. are helpful in classifying the type of anemia. Minor variations of M.C.V., M.C.H., M.C.H.C. are usually not significant unless anemia is present.

Routine Urinalysis	
Color	Yellow is normal
Appearance	Clear is normal
Specific Gravity	Measures the concentration of particles such as sediment and epithelial cells in the urine.
Amorphous Sediment	Normal constituent of urine.
Squamous Epithelial Cells Round Epithelial Cells	Normal constituent of urine.
Reaction pH	Measures the acidity of urine.
WBC/HPF	Amount of white blood cells visualized on microscopic examination of the urine.
RBC/HPF	Amount of red blood cells visualized on microscopic examination of the urine.
Acetone Qualitative	If positive, significant only in known diabetes. Minor variation in the above is usually not significant unless specifically noted in your report.
Glucose Qualitative	Sugar in urine – present in diabetes.
Protein Qualitative	If present, may signify kidney dysfunction.
Occult Blood	Signifies the presence of blood in the urine.
Bile Qualitative	Present only in liver disease.

Bacteria	May signify kidney or bladder infection; occasionally seen under normal circumstances in women.

LABS Continued

Appendix A: Explanation of Blood Analysis Report

On your SMAC blood analysis report, you have the results of your blood test. To the right of each test, there is numerical value signifying if the test component is within or outside of the normal range (for adults). If you are outside (high or low) of the normal range. CONSULT YOUR PHYSICIAN FOR FURTHER INFORMATION.

A brief explanation of each component of the test is provided:

SODIUM	This is an important (positively charged ion) found outside the cell which: 1. Controls the osmotic pressure of the extracellular fluid of the body, 2. Is involved in nerve impulse transmission, and 3. Is involved in muscle contraction. Normal values are 135 – 145 mEq/1. High level of sodium may cause high blood pressure.
POTASSIUM	It is a major cation found inside the cells. The normal adult values are form 3.5 – 5 mEq/1. High levels are seen in renal failure. Low levels cause changes or arrhythmias in the electrocardiogram.
GLUCOSE-SERUM	This is blood sugar. Normal levels for an adult 65-110 mg/dl. Significantly high levels may indicate a diabetic tendency or actual diabetes. It is not uncommon to have a mild elevation due to laboratory variation.
UREA NITROGEN BLOOD-BUN	Urea is the major end product of protein metabolism. Most urea is formed in the liver. It is then passed into the blood (referred to an BUN) and is excreted via the urine. Normal adult values range from 0-20 mg/dl. High elevations of the BUN may be found during dehydration, excessive protein breakdown, kidney disease, and blood in the GI tract. Low BUN does not appear to be clinically significant.
CREATININE	It is formed in the skeletal muscle and is part of the fastest method of providing immediate energy to muscles. Some creatinine travels into the blood stream and is excreted in the urine. High levels of creatinine are seen after heavy exercise, in kidney disease, and in muscle disease, example: muscular dystrophy. The normal values are .7-1.3 mg/dl.
URIC ACID	This is formed from the breakdown of proteins. The amount in the blood or urine is influenced by the dietary intake of protein rich foods (meats, legumes) as well as individual variations in protein breakdown. Normal values range from 2.2-8 mb/dl. High uric acid levels are found in kidney disease (nephritis), kidney stones, gout, and starvation. High values are also a secondary risk factor to coronary artery disease.
CALCIUM	Most calcium is found in bones and teeth. Calcium has a number of functions, such as: preserving the skeletal structure, helping to initiate the blood clotting process, transmitting nerve transmission, cause electrocardiogram disturbances, cause constipation, and a loss of appetite. Low serum values (hypocalcemia, less than 6 mg/dl.) Also affects the nervous system.
CHLORIDE	This is an anion (negatively charged ion) involved in regulating the acid-base balance of the blood. Normal adult levels range from 95-106 mEq/1. Chloride ions are also found outside and inside cells and play a passive role in nerve impulse transmission and muscle contraction.
PHOSPHORUS	This is an important constituent of nucleic acids, phospholipid, nucleotide, and bone. The adult range is from 2.5-4.5 mg/dl. Higher values (5-7 mg/dl) are seen in growing children. Levels are strongly dependent on the time of day the sample is drawn. Samples should be taken in the mourning in the fasting state. Most dietary phosphorus is excreted from the body.

Techniques of Therapeutic Communication

I Non-directive

A. Using Broad Opening Statements

The use of these allows the patient to set the direction of the conversation. "Is there something bothering you?" "Is there something you'd like to talk about?"

B. Using General Leads

During the conversation, using general leads such as "yes", "oh", or "uh-huh" will usually encourage the patient to continue. The nurse indicates she has understood what the patient has said, and that she wishes him to proceed.

C. Reflecting - Restating

In reflecting or restating, all or part of the patient's statement is slightly rephrased to encourage him to go on. In reflecting, the phrase may be repeated as the patient said the statement.

D. Sharing Observations

The nurse shares observations she makes about the patient's behavior. It may focus on either the patient's physical or apparent emotional state. It may convey to him/her concern and interest in further discussion. "You are trembling." "You seem upset."

E. Acknowledging the Patient's Feelings

The nurse helps the patient to know that his feelings are understood and accepted and encourages him to continue expressing them.

Patient: "I hate it here; I wish I could go home."

Nurse: "You feel it is very hard for you to be away from home?"

F. Selective Reflecting - Focusing

The nurse selects what she thinks to be the most important ideas contained in what the patient has said and directs it back to him.

Patient: "I feel so tired; I don't like it here."

Nurse: "You seem to feel being here and not liking it is making you tired?"

G. Using Silence

In certain circumstances, an accepting, attentive silence may be preferable to a verbal response. This allows the nurse to temporarily slow the pace of the conversation and gives the patient an opportunity to reflect upon and then speak about his feelings.

COMMUNICATION TOOLS AND BLOCKS

II. Explanatory Responses

A. Clarifying

If the nurse has not understood the meaning of what the patient has said, she clarifies immediately by further questioning the patient.

Nurse: "I'm not sure I follow."

Nurse: "Are you using this word to mean..."

B. Verbalizing Implied Thoughts and Feelings

The nurse voices what the patient seems to have fairly obviously implied, rather than what he has actually said.

Patient: “It’s a waste of time to do these exercises."

Nurse: "You feel they aren't benefitting you?"

Besides enabling her to verify her impressions, this technique may also help the patient become more fully aware of his feelings.

C. Validating

When the nurse feels that the patient's need has been met she should validate her impression with him. "Do you feel more relaxed?" "Are you feeling better now?" If his answers to these suggests his needs have not been met, the nurse should renew her efforts to assist him.

D. Placing in Time Sequence/Encouraging Comparisons

These two techniques allows the nurse to assist the patient to explore the situation more fully, while she remains non-judgmental.

III. Aids in Decision Making

A. Giving Information - Serving as a Resource

Frequently the nurse may be able to provide the patient with specific information which will answer questions or dispel misconceptions and help him better evaluate his situation. "Children under 14 can visit if special arrangements are made."

There are several ways to assist the person to establish goal and make decision for themselves. Such techniques may include:

1. Pointing out information: "Have you considered?"

2. Reviewing: "Now you said..."

3. Considering the consequences: "If you do...what might happen?"

4. Encouraging formulation of a plan: "What do you think you might do?"

Blocks to Communication

I. Using Reassuring Clichés

Reassuring clichés are often given automatically, or they may be used when a person has difficulty knowing what to say. The nurse uses them to reduce her own anxiety. "Everything will be all right." "You don't need to worry." "You're doing fine."

II. Giving Information

By telling the patient what he should do, the nurse imposes her own opinions and solutions on him, rather than helping him to explore his ideas so that he can arrive at his own conclusions. Even when a patient clearly asks for advice, the nurse should be cautious in giving it. "What you should do is..." "Why don't you...?"

III. Demanding/Requesting an Explanation

By requesting an explanation, the nurse asks the patient to immediately analyze and explain his feelings or actions. Questions which ask "why" are often intimidating. He may invent a reply. The patient may not be truthful and will tell you what he thinks you are expecting him to say. "Why are you upset?" "Why did you do that?"

IV. Agreeing/Disagreeing with the Patient -

Approving/Disapproving

When the nurse introduces her own opinions or values into the conversation it can prevent the patient from expressing himself freely. By approving of one emotion or feeling, you are indicating disapproval of the opposite emotion or feeling.

A. Agreeing: "I agree with you." "That's right."

B. Disagreeing: "You're wrong." "That's not true."

C. Approving: "I'm glad to see you cheerful today."

D. Disapproving: "Now don't be so glum."

V. Belittling the Patient

Although the nurse is trying to show that she understands, statements which equate patient's feelings with those felt by herself or others imply that his feelings are not unusual, thereby denying the importance they have for him. This suggests that he and his problems are no unique. "I know just how you feel." "Everyone gets depressed at times."

VI. Defending

When the nurse becomes defensive in responding to a patient's criticism, she in effect tells him that his negative comments are unfounded, and implies that he has no right to express such opinions or feelings. By responding defensively the nurse is likely to discourage the patient from continuing. "Your doctor is quite capable." "This hospital is well-equipped." "She's a very good nurse."

VII. Making Stereotyped Comments

By using social clichés or trite phrases, the nurse may lead the patient to reply in a like manner, thus keeping the conversation at a superficial level. "How are you feeling?" "Isn't it a beautiful day?"

VIII. Changing the Subject/Introducing an Unrelated Topic

When the nurse responds to a patient's statement by changing the subject, she directs the course of the conversation, rather than allowing the patient to discuss what he wishes. Having been blocked once, he may abandon further attempts to make his feelings known. "Oh, by the way..."

IX. Interpreting

By interpreting the statements for the patient the nurse "may put words into the patient's mouth." You are unconsciously placing your values and opinions on the patient. Let the patient decide what he/she means. "Underneath you really feel..."

Section 5.07 Therapeutic Communication

RESPONSE	EXAMPLE
Exploring	What seems to be the problem? Tell me more about...
Reflecting	I am really mad at my mother for grounding me. You sound angry.
Focusing	Give an example of what you mean. Let's look at this more closely.
Clarifying	I'm not sure that I understand what you're saying. Do you mean...?
Using general leads	Go on...? Talk more about...
Broad opening leads	Where would you like to begin? Talk more about...
Validating	Did I understand you to say
Informing	The time is... My name is...
Accepting	Yes Okay (nodding) Uh hmm.
Sharing observations	You appear anxious. I noticed that you haven't been coming to lunch with the group
Presenting reality	I do not hear a noise or see the lights blinking. I am not Cleopatra; I am your nurse.
Summarizing	During the past hour...
Using silence	Nurse remains silent
False reassurance	Don't worry, you will be better in a few weeks. Don't worry, I had an operation just like it; it was a snap.
Giving advice	What you should do is... If I were you, I would...
Rejecting	I don't like it when you... Please, don't ever talk about...
Belittling	Everybody feels that way. Why, you shouldn't feel that way.
Probing	Tell me more about you relationship with other men.
Overloading	Hi, I am JoAnn, your student nurse. How old are you? What brought you to the hospital? How many children do you have? Do you want to fill out you menu right now?
Underloading	Not giving clear enough information so that the meaning is clear; withholding information.
Clichés	Gee, the weather is beautiful outside.

Section 5.08 Clinical Conferences Outline

Pre-conference

1. Identify role as student and preparing for clinical experience.

2. Receiving and confirming assignments.

Post-conference

1. Presentation of patient.
   a) Diagnosis and definition
   b) Textbook signs and symptoms
   c) Nursing care and treatment
   d) Medications, if applicable

1. Nursing interventions

2. Experiences

3. In-services, if applicable

4. Films, if applicable

Section 5.09 Reporting

The purpose of giving a report is to impart information about the patient's existing condition. It should be complete, concise, and contain pertinent information about the events that occurred during the time you administered nursing care to the patient. The following are some guidelines for good patient condition reports:

1. First, state the patient's room number, name, diagnosis, and doctor's name.
2. Use the nursing care plan as a guide to giving your report.
3. Report information about what was done for the patient and how he responded, as well as what should be done and how to do it.
4. Call attention to pertinent changes in the patient's condition or behavior.
5. Report any deviation from the routine of carrying out the physician's orders.
6. Keep the report on a professional level.

   Example: Be concise and brief. Avoid gossiping or derogatory statements. Use medical terminology.

Section 5.10 SBAR Reporting

SBARCommTool_SHeisler.pdf

GenericReportToPhysician.pdf

Section 5.11 Teaching Plan Process

I. Assess patient for:

   a. What is the need for information or skill?

   b. Are they ready to learn? How do you know?

   c. What is their motivation to learn?

   d. Are there any cultural factors that affect learning? If yes, what are they?

   e. Is there any prior education or experience that will affect content to be taught? If yes, what is it?

   f. What is their level of anxiety or fatigue?

   g. Are there any socioeconomic factors that will affect the learning process? If yes, what are they?

   h. Patient's abilities and disabilities that will affect learning:

II. Write objectives for learning, covering goals for the teaching/learning process for this individual.

III. Outline content to be taught:

IV. Identify the method or strategies to be used for teaching various areas of content.

V. List supplies, equipment, audio or visual aids to be used for teaching, if appropriate.

VI. Evaluate the process:
   a. Write out how each objective was met or not met by the patient.

   b. Assess patient for further learning needs and list them.

   c. Who could you refer this patient to for follow-up?

   d. Write out a paragraph describing:
      i. Your areas of greatest effectiveness in teaching.

      ii. Areas of weakness or areas needing more planning or improvement on your part as a teacher.

Section 5.12 Goals

- Use this format when writing goals:

  The patient will (Pt. centered)

  Have a bowel movement (identifies measurable criteria that reflect the problem)

  In 2 days (identifies a target date for achievement, within a realistic time frame)

Other examples:

1. The patient will verbalize 2 ways to decrease discomfort by end of visit.
2. The patient will show no signs of respiratory distress *AEB* respirations within 12-20, regular and even respirations, within 1 hour of treatment.
3. The patient will verbalize a decrease in pain from a “7” to a “3” (on a pain scale from 1-10) within 30 minutes of med. Administration.
4. The patient will demonstrate the techniques of active ROM by end of shift.
5. The patient will have no signs of infection, *AEB* no increase in temperature above 100.4 during hospital stay.

- Make them short and sweet!
- Must be patient centered
- Measurable
- Realistic
- Have a target date/time for a goal to be met

Section 5.13 Nursing Process Priorities

When preparing to do your nursing process, the rationale is to use this method consistently. This will help you become systematic and comprehensive.

Priority #1: Problems interfering with physiological needs (e.g., respiration, circulation, nutrition, hydration, elimination, temperature regulation, and physical comfort)

Priority #2: Problems interfering with safety and security (e.g., environmental hazards, and fear.)

Priority #3: Problems interfering with love and belonging (e.g., isolation or loss of a love one.)

Priority #4: Problems interfering with self-esteem (e.g., Inability to wash hair, perform normal activities.)

Priority #5: Problems interfering with the ability to achieve personal goals.

Section 5.14 Format for Nursing Process

1. **Assessment**: Gather and examine data using database.

   a. Subjective Data: What the patient actually says.

   b. Objective Data: What you observe.

2. **Analysis**: Actual and/or potential problems. Analysis data collecting.

3. **Planning**: Set priorities and determine nursing interventions (see nursing process priorities).

   a. A "Goal" statement is a patient goal and must include a time factor.

   b. Listed interventions also include the "frequency".

4. **Implementation:** Putting the plan into action.

   a. Performing nursing interventions and activities.

   b. Recording (charting) and communicating your patient's status and response to nursing interventions.

5. **Evaluation**: Were the goals that were set during the planning phase achieved? This step includes revision/deletions of goals or plans. Record this on the Nursing Process Tool.

Section 5.15 SimChart: Chart Notes for Clinicals

Double click on the picture to open the document or

Use the link to open the document:
http://coursewareobjects.elsevier.com/objects/simchart/v1/content/student/Inst3.11_Chart%20Notes%20For%20Clinical.pdf

Name: Simchart & 5 Drug Cards VNSG1360

Description: Sim Chart Rubric/5 Drug Cards

Type: Used for Grading

2 of 3

- Grid View
- List View

	Novice	Competent	Proficient	New Column4	New Column5	New Column6	New Column7	New Column11	New Column12
Clinical set up details	Points: 1 (1%) Charted all of the following: 1. Provider Name (initials only) 2. Student Last name, 1st initial, SVN 3. Patient Initials 4. Gender/Age 5. Allergies/Code Status	Points: .8 (.8%) Four of the following: -Provider Name (initials only) - Student Last name, 1st initial, SVN - Patient Initials - Gender/Age - Allergies/ Code Status	Points: .6 (.6%) Three of the following: -Provider Name (initials only) - Student Last name, 1st initial, SVN - Patient Initials - Gender/Age - Allergies/Code Status	Points: .4 (.4%) Two of the following: -Provider Name (initials only) - Student Last name, 1st initial, SVN - Patient Initials - Gender/Age - Allergies/ Code Status	Points: .2 (.2%) One of the following: -Provider Name (initials only) - Student Last name, 1st initial, SVN - Patient Initials - Gender/Age - Allergies/ Code Status	Points: 0 (0%) None of the following charted:- Provider Name (initials only) - Student Last name, 1st initial, SVN - Patient Initials - Gender/Age - Allergies/ Code Status	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Pre-Clinical Manager Diagnosis	Points: 1 (1%) Diagnosis Documented	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Pre-Clinical Manager Medications	Points: 5 (5%) 5 Drug Cards Completed	Points: 4 (4%) 4 Drug Cards Completed	Points: 3 (3%) 3 Drug Cards Completed	Points: 2 (2%) 2 Drug Cards Completed	Points: 1 (1%) 1 Drug Card Completed	Points: 0 (0%) No Drug Cards Completed	Points: 0 (0%) N/A	Points: 0 (0%)	Points: 0 (0%)
Pre-Clinical Manager Laboratory Tests	Points: 1 (1%) Abnormal labs identified with Rational	Points: .5 (.5%) Abnormal labs identified with no rational	Points: 0 (0%) No labs Documented	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Admission History	Points: 1 (1%) Health History, Allergy Information	Points: .5 (.5%) 1 of 2	Points: 0 (0%) No docuementation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Integumentary Assessment	Points: 5 (5%) 1. Color 2. Appearance 3. Turgor 4. Temp 5. Integrity 6. Moisture 7.	Points: 4.38 (4.38%) 7 of 8	Points: 3.75 (3.75%) 6 of 8	Points: 3.13 (3.12%) 5 of 8	Points: 2.5 (2.5%) 4 of 8	Points: 1.88 (1.88%) 3 of 8	Points: 1.25 (1.25%) 2 of 8	Points: .63 (.62%) 1 of 8	Points: 0 (0%) No Documentation

	Novice	Competent	Proficient	New Column4	New Column5	New Column6	New Column7	New Column11	New Column12
	Intactness 8. Incisions, wounds, rashes								
Head/Neck	Points: 5 (5%) 1. Inspect/palpate scalp 2. hair consistency 3. Color 4. Distribution 5. Facial Symmetry	Points: 4 (4%) 4 of 5	Points: 3 (3%) 3 of 5	Points: 2 (2%) 2 of 5	Points: 1 (1%) 1 of 5	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Ears	Points: 2 (2%) 1. Hearing 2. Hearing aids 3. Palpate auricle 4. Palpate lobe 5. Palpate Tragus 6. Mastoid process 7. Inspect auditory canal	Points: 1.71 (1.71%) 6 of 7	Points: 1.43 (1.43%) 5 of 7	Points: 1.14 (1.14%) 4 of 7	Points: .86 (.86%) 3 of 7	Points: .57 (.57%) 2 of 7	Points: .29 (.29%) 1 of 7	Points: 0 (0%) No documentation	Points: 0 (0%)
Nose	Points: 2 (2%) 1. Inspect/palpate external nose 2. Check patency of nares, 3. Inspect internal nose 4. drainage 5. Palpate sinuses	Points: 1.6 (1.6%) 4 of 5	Points: 1.2 (1.2%) 3 of 5	Points: .8 (.8%) 2 of 5	Points: .4 (.4%) 1 of 5	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Throat	Points: 2 (2%) 1. Inspect Lips 2. teeth 3. gums 4. inspect buccal mucosa 5. palate 6. tongue 7. uvula 8. tonsils	Points: 1.63 (1.63%) 7 of 8	Points: 1.5 (1.5%) 6 of 8	Points: 1.25 (1.25%) 5 of 8	Points: 1 (1%) 4 of 8	Points: .75 (.75%) 3 of 8	Points: .5 (.5%) 2 of 8	Points: .25 (.25%) 1 of 8	Points: 0 (0%) No Documentation
Eyes/Vision	Points: 5 (5%) 1. Vision 2. Corrective lenses 3. inspect sclera 4. conjunctiva 5. drainage 6. pupillary response.	Points: 4.19 (4.19%) 5 of 6	Points: 3.33 (3.33%) 4 of 6	Points: 2.5 (2.5%) 3 of 6	Points: 1.67 (1.67%) 2 of 6	Points: .84 (.84%) 1 of 6	Points: 0 (0%) No Docuemntation	Points: 0 (0%)	Points: 0 (0%)
Respiratory Assessment	Points: 5 (5%) 1. Effort 2. Pattern 3. Rate 4. Auscultate Posterior Fields 5. Auscultate Anterior Fields 6. Cough 7. Shortness of Breath 8. Oxygen	Points: 4.38 (4.38%) 7 of 8	Points: 3.75 (3.75%) 6 of 8	Points: 3.13 (3.12%) 5 of 8	Points: 2.5 (2.5%) 4 of 8	Points: 1.88 (1.88%) 3 of 8	Points: 1.25 (1.25%) 2 of 8	Points: .63 (.62%) 1 of 8	Points: 0 (0%) No Documentation
Cardiovascular Assessment	Points: 2.5 (2.5%) 1. Auscultate Heart Sounds 2. Apical Pulse	Points: 1.25 (1.25%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Peripheral Vascular	Points: 2.5 (2.5%) 1. Palpate Carotid 2. Radial pulses 3. Pedal pulses 4. Capillary refill 5. JVD 6. Edema	Points: 2.09 (2.09%) 5 of 6	Points: 1.67 (1.67%) 4 of 6	Points: 1.25 (1.25%) 3 of 6	Points: .83 (.83%) 2 of 6	Points: .42 (.42%) 1 of 6	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)
Neurological Assessment	Points: 5 (5%) 1. LOC:Person,Place,Time	Points: 4 (4%) 4 of 5	Points: 3 (3%) 3 of 5	Points: 2 (2%) 2 of 5	Points: 1 (1%) 1 of 5	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)

	Novice	Competent	Proficient	New Column4	New Column5	New Column6	New Column7	New Column11	New Column12
	,Situation 2. Mood/Effect 3. Hand Grips 4. Foot Pumps 5. Weakness/numbness					No Documentation			
Musculoskeletal Assessment	Points: 5 (5%) 1. Inspect joints 2. Inspect spine 3. ROM 4. Posture 5. Gait 6. Assistive Devices	Points: 4.19 (4.19%) 5 of 6	Points: 3.33 (3.33%) 4 of 6	Points: 2.5 (2.5%) 3 of 6	Points: 1.67 (1.67%) 2 of 6	Points: .84 (.84%) 1 of 6	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)
Gastrointestinal Assessment	Points: 5 (5%) 1. Abdomen Contour 2. Palpate Abdomen 3. Bowel Sounds 4. Last BM 5. Continence 6. Characteristics 7. Blood	Points: 4.38 (4.38%) 7 of 8	Points: 3.75 (3.75%) 6 of 8	Points: 3.13 (3.12%) 5 of 8	Points: 2.5 (2.5%) 4 of 8	Points: 1.88 (1.88%) 3 of 8	Points: 1.25 (1.25%) 2 of 8	Points: .63 (.62%) 1 of 8	Points: 0 (0%) No Documentation
Genitourinary Assessment	Points: 5 (5%) 1. Last Void 2. Urine Color 3. Characteristics 4. Hematuria 5. LMP/Prostate/Flow	Points: 4 (4%) 4 of 5	Points: 3 (3%) 3 of 5	Points: 2 (2%) 2 of 5	Points: 1 (1%) 1 of 5	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Basic Nursing Care Safety Fall Precautions	Points: 5 (5%) 1. Side Rails 2. Bed Low Position 3. Bed wheels locked 4. Call light in reach 5. Bedside table in reach 6. Instruct call for assistance (If Applicable: Potential Harm to Self or Others)	Points: 4.17 (4.17%) 5 of 6	Points: 3.33 (3.33%) 4 of 6	Points: 2.5 (2.5%) 3 of 6	Points: 1.67 (1.67%) 2 of 6	Points: .84 (.84%) 1 of 6	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)
Activity	Points: 1 (1%) All Documented 1. Activity 2. Ambulation/Locomotion 3. Turning/Range of Motion	Points: .67 (.67%) 2 of 3	Points: .34 (.34%) 1 of 3	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Hygiene/Dressing/ Comfort	Points: 1 (1%) All Documented 1. Comfort 2. Bath/Shower 3. Mouth Care 4. Shave 5. Hair/Nails 6. Dressing 7. Linens/Housekeeping	Points: .86 (.86%) 6 of 7	Points: .71 (.71%) 5 of 7	Points: .57 (.57%) 4 of 7	Points: .43 (.43%) 3 of 7	Points: .29 (.29%) 2 of 7	Points: .14 (.14%) 1 of 7	Points: 0 (0%) No Documentation	Points: 0 (0%)
Nutrition/Hydration	Points: 1 (1%) 1. Nutrition 2. Hydration 3. Diabetic Care (credit given if not diabetic)	Points: .67 (.67%) 2 of 3	Points: .34 (.34%) 1 of 3	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Elimination	Points: 1 (1%) 1. Functional Ability 2. Elimination Nursing Actions	Points: .5 (.5%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Skin Care	Points: 1 (1%) 1. Skin Care 2. Pressure Ulcer Reduction	Points: .5 (.5%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)

	Novice	Competent	Proficient	New Column4	New Column5	New Column6	New Column7	New Column11	New Column12
Pain Assessment/FLACC Scale	Points: 2 (2%) Documented correct pain scale if non verbal FLACC Scale	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Psychosocial Assessment	Points: 4 (4%) All Documented	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Safety Assessment	Points: 4 (4%) 1. Orientation 2. Fall Risk complete Morse Fall Scale Fall precautions documented in Basic Nursing Care 3. Bracelet Check If applicable: Restraints with special Precautions documented	Points: 2.68 (2.68%) 2 of 3	Points: 1.32 (1.32%) 1 of 3	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Special Precautions/Isolation Assessment	Points: 2 (2%) Documented Standard or if applies Respiratory, Contact, Droplet	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Special Charts	Points: 2 (2%) 1. Braden Scale 2. Glasgow Coma Scale	Points: 1 (1%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Wounds/Drains/Tubes	Points: 2 (2%) Documented Wounds/Drains/Tubes, (credit if none)	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Vital Signs	Points: 2 (2%) Minimum of 2 separate entries of vital signs	Points: 1 (1%) 1 of 2 vitals documented	Points: 0 (0%) No Vital Signs Documented	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Intake/Output	Points: 2 (2%) Documented Intake and output	Points: 1 (1%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Height/Weight	Points: 1 (1%) Documented Height/Weight	Points: .5 (.5%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
General Orders/Nutrition	Points: 2 (2%) 1. General Orders Code Status 2. Nutrition Orders	Points: 1 (1%) 1 of 2	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)
Patient Teaching	Points: 2 (2%) At least 2 different patient teaching documented	Points: 1 (1%) 1 of 2 documented	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)

	Novice	Competent	Proficient	New Column4	New Column5	New Column6	New Column7	New Column11	New Column12
Two Hour Nurses Notes	Points: 5 (5%) 4 complete 2 hour nurses notes	Points: 3.75 (3.75%) 3 complete notes	Points: 2.5 (2.5%) 2 complete notes	Points: 1.25 (1.25%) 1 complete notes	Points: 0 (0%) No Documentation	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)	Points: 0 (0%)

Name:Simchart & 5 Drug Cards VNSG1360

Description:Sim Chart Rubric/5 Drug Cards

Type: Used for Grading

2 of 3

Section 5.16 NANDA International, Inc.

Double click on the picture to open the document or

Use the following link: http://fnm.tums.ac.ir/userfiles/education/en/pediatrics/Student/3.pdf

Nursing Diagnoses 2012 – 2014

Domain 1 – Health Promotion

Domain 2 – Nutrition

Domain 3 – Elimination and Exchange

Domain 4 – Activity/ Rest

Domain 5 – Perception/ Cognition

Domain 6 – Self-Perception

Domain 8 – Sexuality

Figure 1 2012-2014 Nursing Diagnosis List

NANDA NURSING DIAGNOSES

Figure 2 Older document includes good definitions of Nursing Diagnosis

Use the following link: http://fnm.tums.ac.ir/userfiles/education/en/pediatrics/Student/3.pdf

Article 6 Specialty/Ancillary Areas objectives/Forms (Level II & III Only)

Included in this section are the objectives to be completed in the specified department. Please be advised that your instructor has the option to make any changes necessary to meet his/her specific requirements.

The student must check with their assigned clinical instructor prior to their rotation in any of the following specialty/ancillary areas to find out the required paperwork the instructor will require for each facility you are scheduled.
The student must complete a pathophysiology and care map for each clinical day.

1. Student Evaluation/Attendance Verification
2. Specialty Areas/Ancillary Departments form
3. Autopsy
4. Cardiac Cath Lab
5. Daycare
6. Dialysis
7. Emergency Department
8. Family Medicine/Physician clinic
9. Home Health/Hospice
10. Infection Control
11. Jail/Correctional Objectives
12. Labor/Delivery
13. Laboratory
14. Leadership
15. NICU/ICU/CCU
16. Nursery
17. OB/GYN – Clinic
18. Observation Unit
19. Outpatient/Day surgery/Endoscopy
20. Pediatrician Office
21. Physical Therapy/OT/ST
22. Radiology
23. Recovery Room
24. Respiratory Therapy
25. School Nurse
26. Surgery
27. WIC Women's, Infants, Children's Clinic

Students must call the outside specialty/ancillary area the day before the scheduled rotation during business hours to confirm schedule.

Section 6.01 Autopsy

1. Describe the role of the medical examiner.

2. Describe the procedures and analysis performed on the organs that you observed in one of the cases this rotation.

3. Explain the cause of death for the individual.

4. What type of personal protective equipment is warranted when performing or observing an autopsy?

5. Describe your reaction to this rotation.

Dress:

You may wear your blue scrubs with your picture ID and name badge. You may also bring with you a face mask, goggles, from your protective kit, provided in your Vocational Nursing supply kit. You will need to arrive at the JPS parking lot by 07:45 am. We will meet there and your attendance will be recorded. We will then walk together to the ME office. If you have any questions or if you are unable to attend please contact clinical instructor.

Section 6.02 Cardiac Cath Lab

Cardiac Catheterization Lab

1. Describe the role of the nurse in the cardiac catheterization lab.

2. State the purpose of a cardiac catheterization.

3. List six (6) nursing care considerations that should be carried out **BEFORE** the procedure.

4. List seven (7) nursing care considerations that should be carried out **AFTER** the procedures.

5. Describe your reaction to this rotation. Would you make any recommendations or changes?

Use: Lippincott Manual of Nursing Practice to assist you in completing these objectives.

Section 6.03 Daycare

Day Care
Toddlers/Preschoolers
(Level II)

During the rotation in the day care center, the student will be observing toddlers and preschoolers based on the concept of normal growth and development. Upon completion of the day care rotation, the student should be able to complete the following objectives:

1. List the development patterns exhibited by the child you chose to observe.
    A. A Physical appearance
    B. Motor skills
    C. Psychosocial

2. Relate these observations to the normal according to Erickson's stages.

3. Observe the typical play in which this child was involved and compare with the normal pattern for his/her age.

4. Observe and record vocalization of this child such as vocabulary. Compare your observations with the normal as listed in your maternal child textbook.

5. Describe the activities that suggest creativity, leadership, and self-image in play.

6. Observe the child during nourishment time and lunch. Make a list of foods offered and eaten. Compare this with the proper nutrition for his age according to your maternal child textbook.

7. Describe the activities that suggest assumption of a sex role.

8. Describe the child's reaction to parental separation.

9. Describe, in a written narrative, your reaction to the day care observation.

10. Give/provide staffing requirements/guidelines for daycare.

11. Complete a care map and pathophysiology observed on one child in this rotation.

Toddler-Preschool
Daycare Objective.d

Day Care
Infants
(Level III)

During the rotation in the day care center, the student will be observing infants based on the concept of normal growth and development. Upon completion of the day care rotation, the student should be able to complete the following objectives:

1. List the development patterns exhibited by the child you chose to observe.
    D. Physical appearance
    E. Motor skills
    F. Psychosocial

2. Relate these observations to the normal according to Erickson's stages.

3. Observe the typical play in which this child was involved and compare with the normal pattern for his/her age.

4. Observe and record vocalization of this child such as vocabulary. Compare your observations with the normal as listed in your maternal child textbook.

5. Describe the activities that suggest creativity, leadership, and self-image in play.

6. Observe the child during nourishment time and lunch. Make a list of foods offered and eaten. Compare this with the proper nutrition for his age according to your maternal child textbook.

7. Describe the activities that suggest assumption of a sex role.

8. Describe the child's reaction to parental separation.

9. Describe, in a written narrative, your reaction to the day care observation.

10. Give/provide staffing requirements/guidelines for daycare.

Infant Daycare Objective.docx

Section 6.04 Dialysis

1. State the purpose of kidney dialysis.

2. Describe the standard (universal) precautions used by the staff, and state what they were doing when they practiced them.

3. Describe the renal transplant recipient selection criteria.

4. Describe some general rules that the patient will need to follow while they are on dialysis. a. Example: It is best not to eat while being dialyzed because of nausea and vomiting, thus aspiration.

5. What determines the length of dialysis / # of days dialyzed.

6. Describe the dietary regimen of a patient receiving dialysis.

7. Describe the possible complications of kidney dialysis.

8. Choose one patient and describe the following:
    a. Reason for dialysis
    b. Length of dialysis
    c. Nursing care provided
    d. Interview the patient and describe his/her reaction to dialysis

9. Are you interested in working with patients who are being dialyzed?

10. Describe your reaction to this rotation. Would you make and recommendations or changes.

Dialysis Objectives.docx

Section 6.05 Emergency Department

Emergency Department

1. Describe the role of the nurse in the emergency department.

2. Make a log of the patients you observed
    a. Medical diagnosis
    b. Treatment
    c. Medications given to each patient
    d. Teaching

3. Define Triage and explain how patients are processed in the ER using this system.

4. List and describe the types of rooms incorporated into the ER and the types of patients treated in these rooms.

5. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.06 Family Medicine/Physician Clinic

Family Medicine/Physician Clinic

1. Describe the role of the nurse in this area.

2. Make a log of up to 10 clients/patients seen and include:
    a. Patient complaint
    b. Medical diagnosis
    c. Treatment
    d. Medication given during visit with drug card
    e. Teaching to patient or family
    f. Lab or other diagnostic tests ordered or done during visit.

3. Describe your reaction to this rotation. Would you make any recommendations or changes?

OB/GYN Patients (If OB/GYN Patients seen)

1. Describe the role of the obstetrical nurse. What are his/her responsibilities?

2. Select two patients during this rotation, one OB and one GYN) and answer the following questions?
    a. Is patient pregnant or gynecological patient? If pregnant, how many weeks gestation? If gynecological, what is the reason for Doctor visit?
    b. Signs and Symptoms, if any, presented by patients.
    c. Nursing care given.
    d. Medical care given.
    e. Medications prescribed or already taking (attach drug cards)

Pediatric Patients (If Pediatric Patients seen)

1. Describe the role of the pediatric clinic nurse. What are his/her responsibilities?

2. Select one patient and answer the following questions.
    a. Diagnosis with textbook definition
    b. Signs and symptoms (both textbook and those presented by the patient)
    c. Nursing care (out-patient) (both textbook and what you observed)
    d. Medical care (out-patient) (both textbook and what you observed)
    e. Medications prescribed (attach drug cards)
    f. Has this patient had all required immunizations? (list with dates)

Section 6.07 Home Health/Hospice

Home Health/Hospice

1. Describe the role of the nurse in this area.

2. Describe one client-family teaching aspect during this rotation. Teaching needs to be specific.

3. Make a log of patient-client seen including:

   Age
   Diagnosis
   Medication list
   Treatment
   Teaching

4. Complete the quiz in the assignment folder for this rotation.

5. What was your opinion of this rotation? Would you recommend any changes?

Section 6.08 Infection Control

Infection Control

1. What is the role of the Infection Control Nurse?

2. Define the following:
    a. Medical Asepsis
    b. Surgical Asepsis

3. What is meant by Standard Precautions and what was it previously called?

4. What is the most basic and effective method of preventing cross-contamination?

5. What is meant by?
    a. Airborne Precautions
    b. Droplet Precautions
    c. Contact Precautions

6. What equipment/supplies would you need for?
    a. Airborne Precautions
    b. Droplet Precautions
    c. Contact Precautions

7. What is meant by reverse isolation?

8. Give 2 examples of illness for each of the following, when you would use: Airborne Precautions
    a. Droplet Precautions
    b. Contact Precautions

9. Who is responsible for infection control?

Section 6.09 Jail/Correctional Objectives

Jail/Correctional Objectives

1. Describe the role of the jail nurse.
2. What special training (if any) is the jail nurse required to have?
3. List three situations that may occur that are unique to the jail.
4. Describe in detail the nurses' responsibility regarding inmates' medications.
5. What is the nurses' responsibility when an inmate is injured while incarcerated? What steps and documentation must occur?
6. Describe your reaction to this rotation.

Section 6.10 Labor/Delivery/Postpartum/Nursery

Labor/Delivery/Postpartum/Nursery

1. Describe the role of the nurse in this area.
2. List and describe the stages of labor.
3. Describe 2 complications of delivery.
4. Complete the Labor and Delivery Database on one delivery you saw.
5. What comfort technique did you use or see used with this patient?
6. If delivery was C-Section, what was the reason?
7. If vaginal delivery, what was the presentation and was the vacuum or forceps utilized? If vacuum or forceps were utilized describe.
8. What was the QBL and EBL? Were the membranes ruptured and if so when and what color was the fluid?
9. Did the patient have tears or lacerations and if so describe?
10. Placenta was expelled in which way?
11. Complete database on patient(s) postpartum and nursery if patient is delivery. The labor portion will also need to be completed by reviewing the medical record.
12. Describe the pattern seen on the EFM (external fetal monitor). What was the fetal heart rate?
13. Describe the postpartum patient assessment and complications.
14. What medications was the labor and postpartum patient administered?
15. Complete drug cards on the above medications.
16. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.10.01 Postpartum Assessment/Data Base

Neuro	MS	
⎕ Alert and oriented	⎕ Moves all extremities	
⎕ Behavior appropriate	⎕ other	
⎕ other	⎕ other	
⎕ other	Wound	
Skin	⎕ Abdominal incision; dressing	
⎕ Color	⎕ Clean/Dry/intact	
⎕ Warm and Dry	⎕ Redness	
⎕ Cool	⎕ Staples/Sutures/Strips	
⎕ other	⎕ other	
Cardiac	Treatment	
⎕ AP regular	⎕ Breast pump	
⎕ Pedal Pulses	⎕ Breast binder	
⎕ Homan's sign +/-	⎕ Breast shield	
⎕ Edema	⎕ Cold pack (Breast/Perineal)	
⎕ other	⎕ K-pad ⎕ Peri Light/Sitz	
Resp.	Postpartum	
⎕ Clear breath sounds	Breast	⎕ Soft / Non tender
⎕ Even and unlabored		⎕ Filling / Tender
⎕ Cough		⎕ Engorged
⎕ other		⎕ Bra
Elimination	Nipples	⎕ Intact
⎕ Voiding (clear yellow)		⎕ Cracked
⎕ Bladder (palpable, nonpalpable)		⎕ Inverted
⎕ Foley cath.	Fundus	⎕ Placement
⎕ Stool		⎕ Firmness
⎕ EMESIS		⎕ Height
⎕ other	Perineum	⎕ Intact
Abdomen		⎕ Clean / Dry
⎕ Soft and nondistended		⎕ Edema
⎕ Active bowel sounds		⎕ Bruising
⎕ Distended		⎕ Other
⎕ Hypoactive bowels sounds	Hemorrhoids	⎕Visible
⎕ Flatus		⎕ Painful
		⎕ Other

Abbreviations

N/A = Non-Applicable
= Positive
= Normal

Uterus

Placement: ML = Midline; R = Right; L = Left

Firmness: F = Firm; B = Boggy; FM = Firm c massage

Height: U = Umbilicus; +a-u = Above or Below

Lochia

Color: R = Rubia; S = Serosa; A = Alba

Amount: A = Large; Md = Moderate; Sm = Small; Sc = Scant; C = Clots

Stool

S = Soft
H = Hard
D = Diarrhea
E = Enema
Sp = Suppository

Section 6.11 Laboratory

LABORATORY OBJECTIVES
Levels II and III

1. Name the functions of the laboratory and each section.
    a. Hematology - Coagulation
    b. Chemistry
    c. Urinalysis
    d. Serology
    e. Microbiology – Parasitology

2. Observe test being performed on blood samples. Describe the following (be prepared by looking up the definition of each test their procedure): Make lab cards on them to be turned in with this objective.
    a. Complete blood count
    b. Blood Chemistries: Glucose, BUN, Electrolytes, and Cardiac Enzymes
    c. Blood Cultures
    d. Arterial Blood Gases
    e. Coagulation (i.e. PT and PTT)

    The above are to include normal values and clinical significance.

3. Observe urinalysis being performed. Describe the following:
    a. Normal values
    b. State the reason urine should be fresh when sent to the lab and the importance of early morning collection.
    c. State the reason a "sterile" specimen of urine is needed for a culture and sensitivity and review collection procedure.
    d. State how soon results could be obtained from a culture and sensitivity of urine and others
    e. State the procedure used in collecting and storing a 12-hour and 24 hour urine test. What type tests are run on these specimens?

4. Describe the blood collecting procedures

5. Define different types of blood specimens and explain how each is obtained.
    a. whole blood
    b. plasma
    c. serum

6. Observe the typing and cross matching of blood. Describe all of the following on extra sheet of paper and turn in with other objectives.
    a. Procedure for typing and cross matching Antibodies testing
    b. Methods of storing blood and length of time it can be stored: criteria for donor collection

c. General policies and procedures for checking out blood from the Blood Bank and understand the absolute need for accuracy in each step.

7. Observe stool specimens being performed. Describe the following:
    a. Types of test performed stool specimens
    b. Procedure for these tests.

8. State how the laboratory handles tissue samples

9. State the nurse's role in assisting the laboratory dept.

Section 6.12 Leadership

Leadership Rotation

1. Describe the role of the charge nurse or ADON/DON.

2. From the handout on leadership, list the characteristics that you observed in your charge nurse or ADON, and describe the action he/she displayed.

3. What type of management system did the charge nurse of ADON display? (Use the handout)

4. List six concepts used in leadership and management. Which one did you observe in the charge nurse/ADON?

5. Did you notice any "common mistakes" made? If any, describe.

6. Describe your reaction to this rotation.

Review the attached information in this packet before management rotation. Answer the above six questions. (This will be your assignment to turn in). You may bring your lunch or go eat out.

Section 6.13 NICU/ICU/CCU

NICU/ICU/CCU

1. Describe the role of the nurse in this area.

2. Describe one client/family teaching aspect during this rotation. Teaching needs to be specific.

3. List and describe the function of 3 types of special equipment used in this unit.

4. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.14 Nursery

Nursery

1. Describe the role of the nursery nurse.

2. Complete the newborn assessment/database on one newborn.

3. Define:
    a. Moro reflex
    b. Tonic neck reflex
    c. Dancing reflex
    d. Rooting reflex
    e. Sucking reflex
    f. Babinski reflex
    g. Describe other reflexes that may be seen on the newborn.

4. Describe four methods of maintaining body heat in a newborn.

5. Describe basic newborn care.

6. Describe Ballard Assessment

7. What medications was the newborn administered. Complete drug cards.

8. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.14.01 Newborn Assessment Database

Name:					
Birth date:	Time:		Adm. Time		
APGAR:	/	Del type:			
Membranes ruptured at:					
Maternal history:					
GMS.	lbs.	ozs.			
T.	HR.	R.R.	B.P. /	Map	
Head:	Chest:	Length:	Accucheck:	Time:	
MEC. ⌈	Void ⌈				
Suction: ⌈	⌈ DELEE	⌈ Catheter			

I. General Appearance	
Color:	⌈ pink ⌈ pale ⌈ flushed ⌈ acrocyanosis ⌈ general cyanosis ⌈ gray ⌈ jaundiced ⌈ mottled ⌈ Mec. Stained ⌈ foul odor
Cry:	⌈ strong, lusty ⌈ weak ⌈ no cry ⌈ hoarse ⌈ high pitched
Activity:	⌈ active, spontaneous ⌈ hyperactive response to stimulation ⌈ slow response to stimulation ⌈ no response to stimulation ⌈ flaccid ⌈ jittery
Reflexes:	⌈ no abnormality notes ⌈ moro ⌈ root ⌈ grasp ⌈ sucking
Skin:	⌈ smooth ⌈ dry, peeling ⌈ warm, dry ⌈ cold, clammy ⌈ cold, dry ⌈ cool, extremities ⌈ parchment like ⌈ perspiring ⌈ edema ⌈ lanugo ⌈ mec stained ⌈ petechaie
Birthmark:	⌈ no ⌈ yes location:_____ description:_____
Vernix:	⌈ none ⌈ LT. ⌈ MOD ⌈ heavy
II. Head	
Head & Face:	⌈ symmetrical ⌈ asymmetrical ⌈ caput ⌈ molding ⌈ bruising ⌈ lacerations ⌈ forcep marks ⌈ cranial tabes ⌈ cephalohematoma ⌈ widely sep. suturess
Fontanelles:	⌈ soft ⌈ flat ⌈ small ⌈ large ⌈ bulging ⌈ depressed ⌈ pulsating
Eyes:	⌈ no abnormality noted ⌈ opacities ⌈ drainage ⌈ swollen ⌈ trauma ⌈ other
Ears:	⌈ no abnormality noted ⌈ low set ⌈ abnormal ⌈ skin tags ⌈ deep sinuses
Mouth:	⌈ no abnormality notes ⌈ circumoral cyanosis ⌈ protruding tongue ⌈ cleft lip ⌈ cleft palate ⌈ teeth ⌈ cysts
Nose:	⌈ nasal congestion ⌈ nares patent ⌈ nasal flaring ⌈ symmetrical
Neck:	⌈ no abnormality noted ⌈ nares patent ⌈ webbing ⌈ mass ⌈ sinus ⌈ fat pad ⌈ clavicle asymmetrical ⌈ right ⌈ left
III. Chest	
Breath sounds:	⌈ clear/equal ⌈ crackles ⌈ shallow ⌈ coarse
Respirations:	⌈ unlabored ⌈ grunting ⌈ nasal flaring ⌈ irregular ⌈ tachypnea 80 ⌈ bradypnea 30
Retractions:	⌈ none ⌈ subcostal ⌈ substernal ⌈ intercostal ⌈ suprasternal
Shape:	⌈ symmetrical ⌈ asymmetrical ⌈ barreled
Breast:	⌈ no visible bud ⌈ visible bud ⌈ stripled areola ⌈ breast tissue ⌈ engorged ⌈ skin tags
IV. Heart Sounds	
⌈ between left nipple and sternum ⌈ to right of sternum ⌈ to left of left nipple ⌈ faint, distant ⌈ Bounding ⌈ Murmur _____ ⌈ regular ⌈ irregular	
Pulse:	⌈ palpable femoral ⌈ Brachial ⌈ capillary refill time _____
V. Body and Extremities	
Abdomen:	⌈ symmetrical ⌈ asymmetrical ⌈ scaphoid, sunken ⌈ distended, soft ⌈ distended, firm ⌈ mass, location _____
Back:	⌈ no abnormality noted ⌈ mongolian spots ⌈ myelomeningocele ⌈ sacral dimple ⌈ skin tags ⌈ hair tufts
Umbilical Cord:	⌈ no abnormality noted ⌈ small ⌈ large ⌈ pulsating ⌈ meconium stained ⌈ oozing ⌈ umbilical hernia ⌈ number of vessels _____
Hands & Arms:	⌈ no abnormality noted ⌈ abnormal shape ⌈ RT ⌈ LT ⌈ no movement ⌈ RT ⌈ LT ⌈ Palmar simian creases ⌈ abnormal shape ⌈ RT ⌈ LT
Legs & Feet:	⌈ no abnormality noted ⌈ extra digits ⌈ RT ⌈ LT ⌈ bruising ⌈ abnormal shape ⌈ RT ⌈ LT ⌈ positional deformity ⌈ assym. Gluteal folds ⌈ sole creases to heal 2/3 ⌈ hip abduction normal ⌈ sole creases involving heal 3/3
Genitalia & Rectum:	⌈ no abnormality noted ⌈ imperforated anus ⌈ term ⌈ preterm ⌈ male ⌈ female ⌈ no abnormality noted ⌈ hypospadius testes: ⌈ descended ⌈ undecended ⌈ bruising ⌈ edema ⌈ abnormal

Section 6.15 OB/GYN – Clinic

OB/GYN – Clinic

3. Describe the role of the obstetrical nurse. What are his/her responsibilities?

4. Select two patients during this rotation, one OB and one GYN) and answer the following questions?
    a. Is patient pregnant or gynecological patient? If pregnant, how many weeks gestation? If gynecological, what is the reason for Doctor visit?
    b. Signs and Symptoms, if any, presented by patients.
    c. Nursing care given including areas assessed.
    d. Medical care given.
    e. Medications prescribed or already taking (attach drug cards)

5. Describe one client/family teaching aspect noted during this rotation.

6. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.16 Observation Unit

Observation Unit

1. What is the role of the Observation Nurse?

2. Prepare a list of the patients you observe on this rotation and include the following:
    a. Initials only
    b. Signs and symptoms experience
    c. Diagnosis
    d. Treatment received
    e. Complications (if any)
    f. Medications
    g. Lab results
    h. Patient teaching

3. Prepare drug cards for a patient in the patient list for all prescribed medications.

Section 6.17 Outpatient/Day surgery/Endoscopy

Outpatient/Day Surgery/Endoscopy

1. Describe the role of the nurse in the endoscopy lab.

2. Make a log of client/patient you observed.
    a. Patient diagnosis.
    b. Type of endoscopy needed.
    c. What kind of prep did this patient receive and why.
    d. What type of anesthesia was used?
    e. Teaching to family or patient.

3. State why someone would come to outpatient/day surgery area instead of being an inpatient?

4. What medications were given to the patient? Complete drug cards.

5. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.18 Cook Children's or Pediatrician Office

Pediatrician

1. Describe the role of the pediatric clinic nurse. What are his/her responsibilities?

2. Select one patient and answer the following questions.
    a. Diagnosis with textbook definition
    b. Signs and symptoms (both textbook and those presented by the patient)
    c. Nursing care (out-patient) (both textbook and what you observed)
    d. Medical care (out-patient) (both textbook and what you observed)
    e. Medications prescribed (attach drug cards)
    f. Has this patient had all required immunizations? (list with dates)

3. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.19 Physical Therapy/OT/ST

Physical Therapy/OT/ST

1. Describe the role of the nurse/therapist in these areas.

2. Make a log of 5 clients/patients seen during this rotation and include:
    a. Diagnosis
    b. Therapy given and why (describe)
    c. Any devices used
    d. Teaching

3. Describe the proper use and function for:
    a. Trochanter roll
    b. Hand roll
    c. Trapeze bar
    d. Transfer belt

4. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.20 Radiology

X-Ray

1. Define the following terms:
    a. Roentgen
    b. Roentgenogram
    c. Fluoroscopy
    d. Contrast medium

2. Define and describe prep for the following test:
    a. KUB
    b. Upper GI
    c. BE
    d. Cholecystography
    e. IVP
    f. Angiography
    g. CAT
    h. Sonogram
    i. Bronchoscopy
    j. Proctoscopy
    k. Sigmoidscopy
    l. Cystoscopy
    m. MBS (Modified Barium Swallow)

3. State the nurses' role in assisting in the X-ray dept.

Section 6.21 Recovery Room

Recovery Room

1. Describe the role of the nurse in this department.

2. Describe 3 different client-patients seen in this area.

    A. Surgical procedure.
    B. Condition upon arrival in recovery.
    C. Any equipment used and why.
    D. Any medications administered during recovery and why.
    E. Condition upon discharge from recovery
    F. Discharge to (home, another unit, etc.)

3. Describe your reactions to this rotation. Would you make any recommendations or changes?

Section 6.22 Respiratory Therapy

Respiratory Therapy

1. Describe the role of the nurse/therapist in this area.

2. Make a log of the patients you observed
    a. Medical diagnosis
    b. Treatment/Meds used
    c. Medications given in emergency
    b. Teaching

3. List and describe devices used to deliver O2. What % of O2 do they deliver? What flow of O2 do these devices require?

4. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.23 School Nurse

School Nurse

1. Describe the role of the school nurse for Elementary, Intermediate, or High School.

2. Make a log of children seen by the school nurse (up to 5)
    a. Reason seen (complaint)
    b. Treatment
    c. Medication given

3. Any instructions given to the child or parent

4. Describe any tests given the day you were there:
    a. Vision screening
    b. Hearing screening

5. List 3 common problems the school nurse addresses every year.

6. Complete One pathcare map for the week besides the information on the school nurse objectives. Each day with the school nurse requires objectives to be completed individually.

7. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.24 Surgery

Surgery Objectives

1. Describe the role of the circulating nurse.

2. Describe the role of the scrub nurse.

3. Describe three different surgeries you observed.
    a. How was patient prepared?
    b. What type of anesthesia was used?
    c. Should tell a story of what happened from your point of view according to what you saw.

4. List and describe the use of three types of special equipment used in the operating room. (ex: suctioning, oxygen, automated B/P monitor, O2 saturation monitor, etc.)

5. What medications were administered and why? Complete drug cards.

6. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.25 WIC Women's, Infants, Children's Clinic

WIC OBJECTIVES

1. What does WIC mean?
2. What services does WIC provide?
3. Describe the role of the nurse in this area.
4. What did the nurse assess with each patient and family?
5. Describe one patient/family teaching aspect during this rotation.
6. Discuss the impact that having this resource for the family and child or children.
7. Describe your reaction to this rotation. Would you make any recommendations or changes?

Section 6.26 Erickson's Psychosocial Stages of Development

Erickson's psychosocial stages of development

Infancy:	Trust/mistrust Getting Tolerating frustration in small doses Recognizing mother as distinct from others and self
Early Childhood:	Autonomy/shame and doubt Trying out own powers of speech Beginning acceptance of reality versus pleasure principle
Late Childhood:	Initiative/guilt Questioning Exploring own body and environment Differentiation of sexes
School age:	Industry/inferiority Learning to win recognition by producing things Exploring, collecting Learning to relate to own sex
Adolescence:	Identity/role diffusion Moving toward heterosexuality Selecting vocation Beginning separation from family Integrating personality (e.g., altruism)

Section 6.27 Team Leader

During the Level III Clinical Rotation, the student will participate in team leading. The student will act as a member of the health care delivery team by functioning as a student team leader under the direct supervision of the clinical instructor and during the team leader rotation, the student will:

1. Supervise and evaluate team members' patient care, including, but not limited to: activities of daily living, treatments, medications, etc.
2. Communicate with other team members of the health care delivery system.

Hill College Vocational Nursing Team Leader Objectives

1. **What is the role of the team leader?**
2. **Discuss the different types of leadership.**
3. **Discuss therapeutic communication that is necessary for the team leader.**
4. **What is the most difficult part of this rotation?**
5. **Discuss how this role had made you aware of leadership and management.**
6. **Discuss how you assisted the team members and what you could have done differently to make this an easier process.**
7. **Complete a pathophysiology and care map for the rotation on one of the patients seen today.**
8. **What did you learn from this rotation?**

Hill College Vocational Nursing
Leadership or Charge Nurse Rotation

1. Describe the role of the charge nurse or ADON/DON.

2. From the handout on leadership, list the characteristics that you observed in your charge nurse or

   ADON, and describe the action he/she displayed.

3. What type of management system did the charge nurse of ADON display?

4. List six concepts used in leadership and management. Which one did you observe in the charge nurse/ADON?

5. Did you notice any “common mistakes” made? If any, describe.

6. Describe your reaction to this rotation.

Section 6.28 Bioterrorism Objectives

Student Name		Clinical Date	

Fill in the information in the white areas of the form

1. Define bioterrorism using 3 reputable sources including your text. (Cite each source)

2. List and describe the biological agents. Also include clinical manifestation and treatments of these agents. (Add more lines as needed)

Agent	Description	Clinical Manifestation	Treatments

3. Define Triage and explain how patients are processed in bioterrorism events.

4. Summarize the CDC recommendations for responding to an incident of bioterrorism.

5. Describe "best practices" for hospitals faced with a bioterrorism event.

6. Outline a method for reporting an incident of bioterrorism.

Textbook references for interventions/rationales:

Book	Author	Page#	Year

Note: If you need to add a line if you hover over the left edge, the add line button will appear, click on it to add a line.

Section 6.29 Process Reading

The interaction between the nurse and the patient, as you recall, is recorded and examined in the Process Reading- that is, a record of the on-going interaction, the process of the two people relating with each other. The recording includes a description of the patient's nonverbal and verbal behaviors, the nurse's response, identification of the therapeutic technique used by the nurse, and an explanation of the nurse's evaluation and interpretation of the interaction.

The major elements of the process recording are reviewed here:

Patient's Nonverbal Behavior:

First, notice the patient's nonverbal behavior because it often speaks so much more loudly than the patient's actual words. Look at the patient's appearance: Is clothing appropriate to the weather, the activity, and the place? Are jewelry and make-up likewise appropriate? Is the patient neat, clean, free of odors, etc?

Next, look at the patient's body language: Is he smiling, laughing, crying, or maintaining a tense facial expression? Is his posture erect, stooped, or slouched? Does he walk rapidly, shuffling, or not move at all? Are his body movement's slow, fast/jerky? What are his motor activities (kicking his foot against a chair, falling asleep during a conversation, etc.)? Is the patient able to establish eye contact with you? Does talking about certain topics cause the eye contact to increase or decrease? Are there signs of anxiety (moist palms, restlessness)?

Based on these observations, you may assess the patient's affect (of feeling tone- a reflection of mood): Is he happy, sad, lonely, apathetic, cheerful, angry, etc.? Is his feeling tone appropriate to the situation and recent events?

You may make many more observations of nonverbal behavior and include them in your Process Recording. The behaviors mentioned here are only to serve as a guide, a brief outline to help you gather your ideas together.

Patient's Verbal Behavior:

Now consider the patient's actual conversation with you. While you are talking with the patient, think about the following points and include them in your assessment.

1. Notice the patient's tone of voice- is it soft, harsh, commanding, or frightened?
2. Are the patient's conversations appropriate to the person he's with and the situations he's in: for example, in the midst of a baseball game does he begin to cry and talk about his rejection by his mother?
3. Are his moods expressed appropriately- that is, does he laugh or cry in response to hearing a very sad story?
4. Are his thoughts and ideas connected and following a logical order, or disconnected, hard to follow, etc.?
5. Does his conversation demonstrate that he is reality-oriented (in touch with reality) and therefore aware of who he is, where he is, who other people are, and what month and year it is? What does the patient actually say?

Once again, consider these verbal behaviors here assessed to be a mere guide for you. Please do not be restricted by the guide, for you may have many more verbal behaviors of your patient that you wish to record. But remember, the more accurate you record the patient's actual words, the easier you will find it to understand the communication.

Nurse's Response:

An interaction, as you recall from your experience with therapeutic communication, by its nature, is a two-sided event. For example, the patient may seem to exhibit certain nonverbal and verbal behaviors when alone. However, these behaviors are in actuality a response to nonverbal and/or verbal stimuli in the environment! These influences can include such things as rules and regulation, punishments or rewards for behavior and very important, the verbal and nonverbal behavior of you, the nurse.
As your self-awareness increases (and it will!!):
You will probably find yourself reflecting on your own behavior in specific situations, and wondering why you responded to your patient in this way or that. Also, why your patient responded to you in this way or that.
You may want to remember what you said in response to your patient's verbalizations.
You may also want to know what nonverbal cues you gave to the patient. While you told the patient that you were glad to see him, did your voice sound strained or did you begin to wring your hands anxiously? These verbal and nonverbal responses, objectively described, and whether they actually "match" or agree with each other, will give you and your instructor important information to assess your progression in using therapeutic communication techniques.

Therapeutic Technique:

Throughout your nursing program, you have been learning how to interact therapeutically with your patient. Learning better and more helpful ways to communicate is (and will be) a never-ending process in your nursing career.

You started studying about communication, including those techniques which are therapeutic and those which block communication in your first nursing course. At this point, you may want to review those techniques and blocks.

For example, your patient may speak to you in a way that is illogical and confusing. You want to stop his flow of conversation to ask him to explain and clarify in greater detail. The therapeutic technique used in this interaction would be "asking for clarification".

In another situation, your patient may begin to reveal some of his deepest feelings. If you became anxious and couldn't tolerate what he was saying, you might interrupt by changing the subject. Changing the subject in this particular situation would probably lower your own anxiety, but most likely "block" further communication with your patient.

Remember, the Process Recording is a learning experience for you. It would be most helpful to you if you honestly record the therapeutic techniques and those techniques you used which blocked communication.

Evaluation and Interpretations:

As you write your Process Recording, certain thoughts may come to your mind. You may want to state why you did or said a particular thing, or why you neglected to do or say something. You may wish to comment on what a particular flow of behavior means, as you interpret it. You may want to suggest another therapeutic action that might have been more helpful than the one you chose. By practicing in making interpretations of your own and the patient's behavior, you will develop new ways of looking at events and new insights into behavior.

Article 7 Clinical Evaluations

Section 7.01 Clinical Evaluation Tool Level 1

Rate yourself in the following areas (check the appropriate box)	Pass	Needs improvement	Fail
Attends and reports promptly for clinical			
Professional appearance and attitude			
Follows rules and guidelines			
Identifies limits and responsibilities			
Maintains confidentiality			
Properly communicates ethical/legal concerns			
Requires minimal supervision			
Maintains skills checklist			
Utilizes constructive criticism			
Understands CEU requirements			
General knowledge of LVVN organizations			
Correlates assessment with disease process			
Uses assessments to monitor change			
Records legible (correct spelling and terminology			
Reports abnormal change in clients			
Reports off appropriately			
Identifies and prioritizes needs			
Gathers information independently			
Uses multiple resources			
Assists in discharge			

Maintains safety			
Provides direct care to multiple patients			
Maintains standard precautions			
Maintains sterile technique			
Formulates and implements teaching plan			
Utilizes problem solving			
Utilizes resource within work settings			
Identifies others who assist in client care			
Works with other health care team members			
Follows protocols and policies			
Identifies available community resources			
Communicates client needs			
Identifies cost-containment measures			
Comments:			

Student Signature_____ Date_____

Section 7.02 Clinical Evaluation Tool Level 2

Clinical Self Evaluation Tool All Levels

List two accomplishments achieved in this rotation.

List two areas you could improve on performance in the future rotations.

I will concentrate on improving performance in these areas because:

List two areas in which you could have made rotations better.

List ways in which you participated as a member of the healthcare team this semester.

Article 11 Differentiated Essential Competencies of Graduates of Texas Nursing Program

Section 11.01 Competency Statements for Vocational Nurse Graduates

The curriculum for vocational nursing (VN) education is delivered as a certificate program of approximately one year in length offered by a college, university, or career school or college, or in a hospital or military setting. Texas Board of Nursing (BON or Board) Rule 214 for Vocational Nursing Education requires didactic and clinical learning experiences designed to prepare graduates to practice as safe, competent nurses who are able to demonstrate the competencies outlined in the DECs.

The BON approved curriculum incudes requirements for instruction in the five basic areas of nursing care: (1) children; (2) mothers and newborns; (3) elderly; (4) adults; and (5) individuals with mental health problems. The initial clinical instruction takes place in the skills and simulation laboratories, progressing to faculty supervised, hands-on clinical experiences with actual patients in health care settings. Clinical experiences in psychiatric nursing are optional, but the mental status of patients should be considered in all clinical settings.

Required nursing and support courses provide instruction in nursing roles; biological, physical, social, behavioral, and nursing sciences, including body structure and function, microbiology, pharmacology, nutrition, signs of emotional health, human growth and development; vocational nursing scope of practice, and nursing skills. Content may be integrated within the core nursing curriculum or may be taken as stand-alone courses. With advances of education and practice, programs may include content in the use of technology and informatics through learning experiences in the clinical practice arena, simulated practice, and skills laboratories.

All levels of prelicensure nursing education prepare graduates to demonstrate the DECs and the competencies for each educational level are based upon the preparation in the program of study. Graduates of VN nursing education programs who have qualified and completed all aspects of the application to take the NCLEX-PN® will receive a temporary authorization to practice under direct supervision up to 75 days while awaiting testing and licensure.

The entry-level graduate of a VN program provides nursing care within a directed scope of practice under appropriate supervision. The vocational nurse uses a systematic problem-solving process in the care of multiple patients with predictable health care needs to provide individualized, goal-directed nursing care. The vocational nurse contributes to the plan of care by collaborating with interdisciplinary team members and with the patient's family. The new graduate can readily integrate technical skills and use of computers and equipment into practice.

Educational opportunities exist for Licensed Vocational Nurses (LVNs) to articulate into professional nursing education programs. Vocational nursing represents the beginning level of the nursing practice continuum in the roles of Member of the Profession, Provider of PatientCentered Care, Patient Safety

Advocate, and Member of the Health Care Team. The entry-level competencies of the VN graduate are listed on the following pages

Section 7.03 Exit Competencies

ESSENTIAL COMPETENCIES OF GRADUATES OF TEXAS
VOCATIONAL NURSING EDUCATIONAL PROGRAMS
SEMESTER I

I. Member of the Profession:

A. Function within the nurse's legal scope of practice and in accordance with regulation and the policies and procedures of the employing health care institution or practice setting.
B. Assume responsibility and accountability for the quality of nursing care provided to patients and their families.
C. Contribute to activities that promote the development and practice of vocational nursing.
D. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning.

II. Provider of Patient-Centered Care:

A. Use clinical reasoning and knowledge based on the vocational nursing program of study and established evidence-based practice as the basis for decision-making in nursing practice.
B. Assist in determining the physical and mental health status, needs, and preferences influenced by culture, spirituality, ethnicity, identity, and social diversity of patients and their families, and in interpreting health-related data based on knowledge derived from the vocational nursing program of study.
C. Report data to assist in the identification of problems and formulation of goals/outcomes and patient-centered plans of care in collaboration with patients, their families, and the interdisciplinary health care team.
D. Provide safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.
E. Implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors.
F. Identify and report alterations in patient responses to therapeutic interventions in comparison to expected outcomes.

III. Patient Safety Advocate

A. Demonstrate knowledge of the Texas Nursing Practice Act and the Texas Board of Nursing Rules that emphasize safety, as well as all federal, state, and local government and accreditation organization safety requirements and standards.
B. Implement measures to promote quality and a safe environment for patients, self, and others.
C. Assist in the formulation of goals and outcomes to reduce patient risks.
D. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices.
E. Comply with mandatory reporting requirements of the Texas Nursing Practice Act.

IV. Member of the Health Care Team

A. Communicate and collaborate in a timely manner with patients, their families, and the interdisciplinary health care team to assist in the planning, delivery, and coordination of patient- centered care to assigned patients.
B. Participate as an advocate in activities that focus on improving the health care of patients and their families.
C. Participate in the identification of patient needs for referral to resources that facilitate continuity of care, and ensure confidentiality.
D. Communicate patient data using technology to support decision-making to improve patient care.

SEMESTER II

I. Member of the Profession:

A. Function within the nurse's legal scope of practice and in accordance with regulation and the policies and procedures of the employing health care institution or practice setting.
B. Assume responsibility and accountability for the quality of nursing care provided to patients and their families.
C. Contribute to activities that promote the development and practice of vocational nursing.
D. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning.

II. Provider of Patient-Centered Care:

A. Use clinical reasoning and knowledge based on the vocational nursing program of study and established evidence-based practice as the basis for decision-making in nursing practice.
B. Assist in determining the physical and mental health status, needs, and preferences influenced by culture, spirituality, ethnicity, identity, and social diversity of patients and their families, and in interpreting health-related data based on knowledge derived from the vocational nursing program of study.
C. Report data to assist in the identification of problems and formulation of goals/outcomes and patient-centered plans of care in collaboration with patients, their families, and the interdisciplinary health care team.
D. Provide safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.

E. Implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors.
F. Identify and report alterations in patient responses to therapeutic interventions in comparison to expected outcomes.
G. Implement teaching plans for patients and their families with common health problems and well-defined health learning needs.

III. Patient Safety Advocate

A. Demonstrate knowledge of the Texas Nursing Practice Act and the Texas Board of Nursing Rules that emphasize safety, as well as all federal, state, and local government and accreditation organization safety requirements and standards.
B. Implement measures to promote quality and a safe environment for patients, self, and others.
C. Assist in the formulation of goals and outcomes to reduce patient risks.
D. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices.
E. Comply with mandatory reporting requirements of the Texas Nursing Practice Act.

IV. Member of the Health Care Team

A. Communicate and collaborate in a timely manner with patients, their families, and the interdisciplinary health care team to assist in the planning, delivery, and coordination of patient-centered care to assigned patients.
B. Participate as an advocate in activities that focus on improving the health care of patients and their families.
C. Participate in the identification of patient needs for referral to resources that facilitate continuity of care, and ensure confidentiality.
D. Communicate patient data using technology to support decision-making to improve patient care.
E. Assign nursing activities to LVNs or unlicensed personnel based upon an analysis of patient or work place need.

SEMESTER III

I. Member of the Profession:

A. Function within the nurse's legal scope of practice and in accordance with regulation and the policies and procedures of the employing health care institution or practice setting.
B. Assume responsibility and accountability for the quality of nursing care provided to patients and their families.
C. Contribute to activities that promote the development and practice of vocational nursing.
D. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning.

II. Provider of Patient-Centered Care:

A. Use clinical reasoning and knowledge based on the vocational nursing program of study and established evidence-based practice as the basis for decision-making in nursing practice.
B. Assist in determining the physical and mental health status, needs, and preferences influenced by culture, spirituality, ethnicity, identity, and social diversity of patients and their families, and in interpreting health-related data based on knowledge derived from the vocational nursing program of study.
C. Report data to assist in the identification of problems and formulation of goals/outcomes and patient-centered plans of care in collaboration with patients, their families, and the interdisciplinary health care team.
D. Provide safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.
E. Implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors.
F. Identify and report alterations in patient responses to therapeutic interventions in comparison to expected outcomes.
G. Implement teaching plans for patients and their families with common health problems and well-defined health learning needs.
H. Assist in the coordination of human, information, and physical resources in providing care for assigned patients and their families.

III. Patient Safety Advocate

A. Demonstrate knowledge of the Texas Nursing Practice Act and the Texas Board of Nursing Rules that emphasize safety, as well as all federal, state, and local government and accreditation organization safety requirements and standards.
B. Implement measures to promote quality and a safe environment for patients, self, and others.
C. Assist in the formulation of goals and outcomes to reduce patient risks.
D. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices.
E. Comply with mandatory reporting requirements of the Texas Nursing Practice Act.
F. Accept and make assignments that take into consideration patient safety and organizational policy.

IV. Member of the Health Care Team

A. Communicate and collaborate in a timely manner with patients, their families, and the Interdisciplinary health care team to assist in the planning, delivery, and coordination of patient-centered care to assigned patients.
B. Participate as an advocate in activities that focus on improving the health care of patients and their families.
C. Participate in the identification of patient needs for referral to resources that facilitate continuity of care, and ensure confidentiality.
D. Communicate patient data using technology to support decision-making to improve patient care.
E. Assign nursing activities to LVNs or unlicensed personnel based upon an analysis of patient or work place need.
F. Supervise nursing care by others for whom the nurse is responsible. G. Assist health care teams during local or global health emergencies or pandemics to promote health and safety, and prevent disease.

The Board approved the 2020 Revision of the DECs in January 2021 and recommending a start date for January 2022.

1. **The new concepts are included in the curriculum:**
   Civility
   Community readiness for emergencies, crises
   Culture of safety
   Global health
   Just culture
   Nursing Peer Review
   Self-care
   Service excellence
   Social determinants of health
   Social justice
   Vulnerable patients/populations
   Workplace violence

2. **Major concepts under each core competency in the curriculum:**
   - **I.** Member of the Profession
     - **A. Legal scope of practice**
     - **B. Accountability for nursing care**
     - **C. Professionalism**
     - **D. Personal professional growth (competencies)**
   - **II.** Provider of Patient-Centered Care
     - **A. Clinical reasoning and decision-making**
     - **B. Patient assessment**
     - **C. Analysis of patient assessment**
     - **D. Goals for plan of care**
     - **E. Safe and competent nursing care**
     - **F. Evaluation of patient responses**

G. Patient teaching
H. Coordination of care

III. Patient Safety Advocate
A. Regulations
B. Quality and safety of patient care
C. Reduction of patient risk
D. Seek instruction/training
E. Mandatory reporting
F. Delegation and assignment

IV. Member of the Health Care Team
A. Communication and collaboration
B. Advocacy
C. Continuity of care
D. Use of technology
E. Delegation and assignment
F. Supervision
G. Global health – NEW

Matrix Identifying Texas Board of Nursing Differential Essential Competencies in the Current Hill College Vocational Nursing Program 2021-2022									
	VNSG 1500	VNSG 1360	VNSG 1509	VNSG 1461	VNSG 1334	VNSG 2510	VNSG 1462	VNSG 1330	VNSG 1331
Civility	X	X	X	X	X	X	X	X	X
Community readiness for emergencies, crises	X		X		X	X			
Culture of Safety	X	X	X	X	X	X	X	X	X
Global Health	X		X			X			
Just Culture	X		X			X			
Nursing Peer Review						X	X		
Self-Care						X	X		
Service Excellence						X	X		
Social Determinants of Health	X		X		X	X		X	
Social Justice	X		X		X			X	
Vulnerable patients/populations	X		X		X			X	
Workplace violance	X		X			X			

Vocational Nursing Marketable Skills

- Cultural Competency
- Critical Thinking
- Adaptability
- Communication
- Teamwork

Section 7.04 Grading Rubric for Clinical Evaluation Tool (all Levels)

	95%-90%	Near-mastery of objectives. Consistently exceeds expectations.	**Proficient**. Proactive. Coordinated and confident. Overall good efficiency. Consistent. Accountable. Requires NO prompting. Continues to update and use instructor guidance with growing independence.
	80-85%	Performs at expected level and frequently exceeds expectations.	**Supervised**. Requires minimum prompting and support. Demonstrates steady improvement in efficiency, coordination, and confidence. Clarifies and ask questions, and uses instructor guidance and supervision appropriately.
	80%	Performs at expected level.	**Assisted**. Performance meets expected level criteria with moderate prompting and support. Performance demonstrates problems with efficiency and coordination but remains safe.
	75%	Some concerns, but not unsafe or unethical.	**Requires frequent assistance**. Performance meets level specific criteria with frequent prompting and support. Performance demonstrates repeated problems with efficiency and coordination needs close monitoring for safety.
	70%	Significant concerns.	**Dependent**. Performance below level specific criteria even with instructor prompting and support. Inefficient. Lacks confidence and coordination. Inaccurate or infrequent communication with instructor. Poor accountability for own practice.
	60%	Unsafe behavior or unethical conduct.	
	0%	Unsafe behavior and unethical conduct.	

Article 13: Forms

The forms on the following pages need to be printed out, signed, and turned in on the 1st class day.

Community Service form and Verification are for use when completing your community service.

Student Agreement

To all Vocational Nursing students, this handbook is being provided to you for your clinical rotation. Enclosed you will find the objectives/evaluations you will be using during your Clinical I Practical Nurse, Clinical II Practical Nurse, and Clinical III Practical Nurse rotations.

You will find the following clinical paperwork enclosed in this book (you will need to make more than one copy as needed):

1. Format for Pathophysiology
2. Nursing process priorities
3. Care Map
4. Drug Cards
5. Process for teaching plans
6. Nursing Assessment Clinical Data Sheet
7. Adult Database
8. Weekly Skin Assessment
9. Labor Assessment Data Base
10. Pediatric Assessment Data Base
11. Newborn Assessment Data Base
12. Postpartum Assessment Data Base

You will find the following objectives enclosed in this book:

1. Autopsy
2. Cardiac Cath Lab
3. Daycare
4. Dialysis
5. Emergency Department
6. Family Medicine/Physician clinic
7. Home Health/Hospice
8. Infection Control
9. Jail/Correctional Objectives
10. Labor/Delivery
11. Laboratory
12. Leadership
13. NICU/ICU/CCU
14. Nursery
15. OB/GYN – Clinic
16. Observation Unit
17. Outpatient/Day surgery /Endoscopy
18. Pediatrician Office
19. Physical Therapy/OT/ST
20. Radiology
21. Recovery Room
22. Respiratory Therapy
23. School Nurse
24. Surgery
25. WIC Women's, Infants, Children's Clinic

You will find the following general clinical information enclosed in this book:

1. Unsafe Students
2. Process reading
3. Communication Tools and Blocks
4. Therapeutic Communication
5. Supervision of Medication Administration/IV Medications
6. Procedure of Heparin lock insertion and Medication Administration
7. Potential of Actual Medication Error form
8. Descriptive terms commonly used in charting
9. Skills allowed to perform in clinical setting
10. Attendance Verification Sheet (copy and use for Specialty area rotations)
11. Semester I Exit Competencies
12. Semester II Exit Competencies
13. Semester III Exit Competencies

I have read the above and have received a copy of this student agreement. I acknowledge that it will be my responsibility to read and familiarize myself with this clinical handbook and bring it with me when I attend clinical as required. I acknowledge that I must complete the exit competencies for each semester before being allowed to progress to the next level. I further acknowledge that I must have copies of clinical paperwork as needed.

Student Signature _____ Date _____

Clinical Information Acknowledgement

1. All students will be scheduled for a clinical evaluation at the end of each semester. If the student is not present for his/her scheduled clinical evaluation or fails to sign the form he/she will be given an incomplete and will not be able to progress to the next level.

2. All students need to be aware it is part of their responsibility, as student vocational nurses, to seek out new learning potentials in the clinical areas. The student vocational nurse must recognize their own strengths and weaknesses to improve or enhance their potential to learn from the experiences at all clinical sites and all clinical instructors.

3. Clinical grading rule:

   90-100% - superior completion of clinical objectives
   80-89% - above average completion of clinical objectives
   75-79% - average completion of clinical objectives
   <75% - failure to meet minimal clinical requirements

4. The Hill College nursing department strives to maintain consistency in the material used so students learn all information needed to be competent student nurses', however; the student needs to be aware that not all instructors grade exactly the same. In the clinical setting there are different requirements for the various facilities i.e. Med/Surg related paperwork would not be exactly the same as OB or Pedi. Each facility will have different rules and regulations regarding what they require in the charts, it will enhance your learning experience to be exposed to the various ways of charting or the required paperwork assigned for that particular area.

5. If the student is going to be absent it is the students' responsibility to call in appropriately. The process for calling in appropriately is as follows:
   Call Mrs. Grimland before 6AM 2542051611.
   If unable to call either of the above call the Hill College Nursing Department (817) 760-5921 before 6:00 am or 254-659-7920 and leave a voice mail message

I acknowledge that I have read and understand the above information. I have received a copy of this form.

_____ _____
Student Signature Date

Addendum to Clinical/Classroom Rule

All incoming calls involving students will come through the nursing faculty and will be handled by them. Only emergency calls will be accepted.

The following are not allowed within any clinical facility:

1. Cell phones
2. Incoming or outgoing personal phone calls unless emergency
3. Use of patients' telephone for personal use

Cell phones are only allowed in the nursing classroom at the instructor's direction.

Students may only use cell phones on class days on class breaks but must have the phone off in class unless being directed for use.

Emergency calls can be directed to the director of the program to allow quick notification to the student.

I, _____, acknowledge that I have read and understand the above rule. I further acknowledge that I have received a copy of this document.

_____ _____

Student Signature Date

Unsafe Student Acknowledgement

Unsafe Students or Students with Unethical Issues

Maintaining client safety is the overriding principle in clinical practice. Nursing faculty has the responsibility to ensure that students are providing safe care. Nursing students must function at the expected clinical level as stated in the course objectives and clinical evaluation forms. Unsafe behavior is the failure to perform in the manner that any prudent student nurse, at the same level of preparation, would perform in a particular clinical situation. Nursing faculty have the responsibility to identify student conduct and performance in the academic and/or clinical area that are unsafe, unethical, and/or unprofessional, take immediate corrective action, and provide remediation contracts, if appropriate. Any faculty that perceives a student is unsafe will take immediate corrective action, document the incident fully, and refer the student to the program director and the Incident Review Committee (which will consist of: 1 faculty member from each VN program, EMS director, 1 academic faculty and the VN coordinator, ADN coordinator, Director of Nursing) for evaluation. The Incident Review Committee will then review all documentation, including student's comments, to make a determination on possible remediation contract or dismissal from the nursing program.

Unsafe behavior includes, but is not limited to:

- Being under the influence of drugs or alcohol.
- Failure to use Standard precautions at all times.
- Failure to apply basic safety rules, such as leaving side rails down on beds and cribs.
- Failing to report an abnormal finding.
- Being unable to make sound judgments due to adversely affected thought processes and decision-making.
- Attending clinical with a possibly communicable infectious process.
- Failure to follow the five rights while administering medications.
- And any other action or failure to act that would jeopardize client safety.

Duty of the Nurse to Report

Nursing Educational Programs have the duty to report:

- Impairment or likely impairment of the student's practice by chemical dependency.
- Impairment or likely impairment of the student's practice by mental illness.
- Information related to criminal convictions.

I have read the above and have received a copy of the rule for unsafe students. I acknowledge that by my signature below understand the above rule and will abide by it. I further acknowledge that the above rule applies to all three levels of the Clinical Practicum in the vocational nursing curriculum.

_____ _____

Student Date

SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING

***Supervised by instructor each time ** At instructors discretion * Can perform independently

Skills	Write in the date and have clinical instructor initial. EX: 1-4 / KC											
1. NGT/Enteral tubes												
Feeding **												
Insertion ***												
2. Bedmaking *												
3. Handwashing *												
4. Gowning/Gloving ***												
5. ROM *												
6. Restraints **												
7. Bath/Personal Care *												
8. Pt. Positioning/Transfer *												
9. CPR *												
10. VS/Neuro Signs *												
11. Documentation ***												
12. I & O *												
13. Urinary Cath Insertion ***												
14. Urinary Collection												
DC Foley**												
Clean Catch*												
Catheter**												
I & O*												
15. Bowel Elim.												
Fecal Impaction**												
Enemas**												
Occult Blood Test*												
Ostomy												
Bag Changes**												
Emptying**												
16. Pt. Physical Assessment*												
FSBS **												

SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING

***Supervised by instructor each time ** At instructors discretion * Can perform independently

17. Wound Care												
Dressing Changes **												
18. Nasopharynix Suction **												
19. Trach												
Care **												
Suctioning **												
20. Drains												
Emptying & Removal **												
Hemovac												
J-P												
Penrose												
21. Chest Tubes												
Monitoring **												
Milking **												
22. Sutures												
Monitoring/Removal **												
Staples												
23. Packing												
Monitoring/Removal **												
Wound												
Vaginal												
Rectal												
24. SCD / AV Boots												
CPM Application **												
25. Medication Admin.												
Oral **												
Rectal												
SL												
Vaginal												
Inhalers												
Nasal												

SKILLS ALLOWED TO PERFORM IN CLINICAL SETTING

***Supervised by instructor each time ** At instructors discretion * Can perform independently

Eye												
Ear												
Patches												
NGT												
Parenteral												
ID												
SQ												
IM												
IV/PIGs												
Insertion ***												
Changing Bags **												
Changing Tubing **												
Pump/Monitor **												
IV to SL **												
IV to DCSL**												
Inhalation Therapy **												
Perform Leopold Maneuver**												
Assess FHT **												
NB Assessment **												
NB Care												
Cord**												
Circumcision **												
Vitamin K ***												
Eye Care **												
Measure/Weigh**												
Bath**												
Bulb-Syringe Suction**												
26. Observed												
Vag delivery												
C-sect delivery												

Patient Documentation

Pt. Initials ____Room ____Primary Nurse ____Dr. ____Student Nurse _____

Dx: _____

Allergies: _____

Medications	Times

Vital Signs:	T	P	R	BP
	T	P	R	BP

AM Shift
Report:_____
_____
_____
_____
_____
_____

Meds Ck MAR & DO		Read Pt chart last 24 hr	
General Ck Pt		VS	
Notify Nurse of Assign		Listen to report	
Meal served fed Pt		Bath/ADL's	
Linen changed		Head to toe assess	
Soap note check		I&O Complete	
IV check Q2 Hr		Treatment complete	
Complete Soap Note		Report to Nurse	

Soap notes

Appearance Rule Acknowledgment

The following statement must be signed, dated and returned.

By my signature below, I acknowledge that I have received, read and understand the requirements set forth by the **Appearance Rule**. I also confirm by my signature that I agree to comply with the Hill College Standards for Personal Appearance.

_____
Potential Student Signature

_____
Printed Name

_____
Date

Uniform Rule Violations – Written Warning

Student Name (printed) _____

You are hereby given a written warning for uniform rule violations for the following reason(s). Continued violation of the uniform rule will result in probation.

Circle the number of all that apply:

1. Hair down in face or inappropriate colors
2. Excessive makeup
3. Tattoos exposed
4. Excessive/inappropriate jewelry
5. Pant length (touching floor)
6. Inappropriate/visible or no undergarments
7. Uniforms dirty/wrinkled
8. Inappropriate/dirty shoes
9. School patch loosely secured or no patch.
10. Inappropriate or missing watch
11. Missing ID badge
12. Excessive scents (perfume, lotions, colognes, body odors)
13. Sagging pants
14. Uniform too small
15. Inappropriate or no socks
16. Dangling Earrings/tongue rings/or other visible piercings
17. Acrylic nails or nail polish

Student comments:

Instructor Comments:

Students Signature _____ Date _____

Instructor Signature _____ Date _____

Rules and Regulation Agreement

The College student is considered a responsible adult. The conduct of students on the premises of Hill College must not interfere with the orderly processes and governance of the College. The student's enrollment in the College District indicates acceptance of those standards of conduct. I have read the Hill College Vocational Nursing Program Student Handbook and I understand that it is my responsibility to be knowledgeable of and to comply with the contents and provisions of Hill College Policy, rules and regulations stated within. In addition, I certify that the said rules and regulations have been verbally explained to me.

I am aware that it is my responsibility to read the Hill College Catalog and the Hill College Student Handbook and to abide by all policies, procedures, rules and regulations set forth in those documents.

I understand that completion of the Hill College Vocational Nursing Program will not assure my passing any state board examination for licensure.

_____

Signature of Student

_____

Date

Infectious / Communicable Disease Exposure Rule

I understand that in my role as a student vocational nurse I may be exposed to infectious / communicable diseases. I understand I will be taught Standard Precautions (formerly known as Universal Precautions or Body Substance Isolation) and Transmission Based Precautions as recommended by Centers of Communicable Diseases (CDC) and OSHA. Knowledge regarding Standard Precautions procedures will be implemented when caring for all patients regardless of their infectious status. Applying the knowledge of Standard Precautions and Transmission – Based Precautions reduce the potential for transmitting blood – borne, airborne, droplet, or contact pathogens and those from moist body substances and fluid. This involves all contagious disease processes.

The Standard Precautions are followed whenever there is potential for contact with:

- Blood
- All body fluids, secretions, and excretions regardless of whether they contain visible blood
- Non intact skin
- Mucous membranes

The Transmission Based Precautions are followed for pathogens that are:

- Airborne
- Droplet
- Contact

_____
Signature of Student

_____
Date

Texas Board of Nursing
Texas Administrative Code (TAC) Acknowledgment
Vocational Nursing

The following Texas Administrative Code rules are included in this section:

Rule:	§213.27	Good Professional Character
	§213.28	Licensure of Persons with Criminal Convictions
	§213.29	Criteria and Procedure Regarding Intemperate Use and Lack of Fitness in Eligibility and Disciplinary Matters
	§213.30	Declaratory Order of Eligibility for Licensure
	§214.8	Students
	§217.11	Standards of Nursing Practice
	§217.12	Unprofessional Conduct

I, _____, acknowledge that I have received a copy of the Texas Administrative Code that pertains to the Hill College Vocational Nursing Program. I acknowledge that the above rules have been explained to me. I understand it is my responsibility to seek further clarification regarding the contents of the above rules if needed and can be found on the following website: http://www.bon.texas.gov/nursinglaw/pdfs/bon-rr.pdf

_____ _____

Signature Date

Texas Board of Nursing

Texas Occupation Code (TOC) Acknowledgement

Vocational Nursing

The following Texas Occupation Code rules are included in this section:

Rule: §301.252	License Application
Rule: §301.257	Declaratory Order of License Eligibility
Rule: §301.452	Grounds for Disciplinary Action
Rule: §301.4521	Physical and Psychological Evaluation
Rule: §301.453	Disciplinary Authority of Board; Methods of Discipline
Rule: §301.4535	Required Suspension, Revocation, or Refusal of License for Certain Offenses
Rule: §301.454	Notice and Hearing
Rule: §301.455	Temporary License Suspension or Restriction
Rule: §301.4551	Temporary License Suspension for Drug or Alcohol Use
Rule: §301.456	Evidence
Rule: §301.457	Complaint and Investigation
Rule: §301.458	Initiation of Formal Charges; Discovery
Rule: §301.459	Formal Hearing
Rule: §301.460	Access of Information
Rule: §301.461	Assessment of Costs
Rule: §301.462	Voluntary Surrender of License
Rule: §301.463	Agreed Disposition
Rule: §301.464	Informal Proceedings
Rule: §301.465	Subpoenas; Request for Information
Rule: §301.466	Confidentiality
Rule: §301.467	Reinstatement
Rule: §301.468	Probation
Rule: §301.469	Notice of Final Action

I, _____, acknowledge that I have received a copy of the Texas Administrative Code that pertains to the Hill College Vocational Nursing Program. I acknowledge that the above rules have been explained to me. I understand it is my responsibility to seek further clarification regarding the contents of the above rules if needed and can be found on the following website: http://www.bon.texas.gov/nursinglaw/pdfs/npa2011.pdf

_____ _____

Signature of Student Date

Potential or Actual Incident Report

To be filled out by instructor:

Date: _____ Clinical area_____

Student's name: _____

Nature of error: _____

Description of Incident: (To be filled out by the Student)

_____

_____

_____

_____

_____

_____

How can I prevent a recurrence?

_____

_____

_____

_____

_____

_____

_____

_____ _____

Student Signature Date

_____ _____

Instructor Signature Date

Hill College is accredited by the Southern Association of Colleges and Schools Commission on Colleges to award the associate degree. Contact the Southern Association of Colleges and Schools Commission on Colleges at 1866 Southern Lane, Decatur, Georgia 30033-4097 or call 404-679-4500 for questions about the accreditation of Hill College.