Reese Campus

Course Syllabus

COURSE:	VNSG 1460 Clinical Level 2
SEMESTER:	Spring 2026
CLINICAL TIMES:	Monday, Tuesday; Times vary depending on clinical assignment.
INSTRUCTOR:	Course lead – Nina Castellanos BSN, RN
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Facebook:	https://www.facebook.com/SouthPlainsCollegeVocationalNursing

"South Plains College improves each student's life."

GENERAL COURSE INFORMATION

*It is the responsibility of each student to be familiar with the content and requirements listed in the course syllabus and SVN Handbook. *

Please Note: The COVID-19 crisis may change the clinical course and this syllabus. Please refer to the COVID POLICY.

Prerequisite courses: VNSG 1160
CO-requisite courses (concurrent): VNSG 1409, 1330, 1227, 2331

COURSE DESCRIPTION

A method of instruction providing detailed education, training and work-based experience and direct patient/client care, generally at a clinical site. On-site clinical instruction, supervision, evaluation and placement is the responsibility of college faculty. Clinical experiences are unpaid external learning experiences. "This course is designed to prepare students for the realities of clinical nursing practice. As such, course materials (including images, videos, and case studies) may depict **graphic content** related to injuries, diseases, medical procedures, and the human condition, including end-of-life scenarios. Students are expected to approach this material with **professionalism, sensitivity, and critical analysis**, as encountering such content is an inherent and essential part of the healthcare profession."

STUDENT LEARNING OUTCOMES

At the completion of the semester students will: (based on the Differentiated Essential Competencies of Texas Board of Nursing [DECS])
1. Become a Member of the Profession
2. Provider of Patient-Centered Care
3. Be a Patient Safety Advocate
4. Become a Member of the Health Care Team

COURSE OBJECTIVES - Outline form (C-5, C-6, C-7, C-8, C-15, C-16, C-17, C-18, C-19, C-20) (F-1, F-2, F-7, F-8, F-9, F-10, F-11, F-12)

At the completion of this course the student will:
• Apply the theory, concepts and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social and legal systems associated with Vocational Nursing
• Demonstrate legal and ethical behavior

• Demonstrate the ability to care for multiple patients in multiple patient-care situations
• Demonstrate safety practices within the health care setting
• Demonstrate interpersonal teamwork skills
• Communicates in the applicable language of health care
• Be prepared to practice within the legal, ethical and professional standards of vocational nursing as a health care team member in a variety of roles
• Exhibit an awareness of the changing roles of the nurse
• Utilize the nursing process as a basis for clinical judgment and action
• Accept responsibility for personal and professional growth
• Be present and punctual for all clinical assignments and lab with no more than 2 absences.

COURSE COMPETENCIES: To **successfully exit** this course, the student must:

- Have a 76 or better course average **AND**
- Pass departmental math exam by the third attempt with an "80" or better **AND**
- Must complete and turn in **all required clinical paperwork** EVEN IF the student missed the turn in deadline and receives a "0" on the assignment, the work must be turned in **AND**
- Maintain CPR and immunizations **AND**
- Complete all required labs and complete the self-evaluations **AND**
- Complete at least one of the sterile skill procedures (sterile dressing changes or Foley insertion) this semester **AND**
- Have NO MORE than TWO absences [absences must be made up] **AND**
- Complete the maternal-child rotation **AND**
- Practice within the student Scope of Practice

EVALUATION METHODS

Weekly clinical performance evaluations. May also include care maps, Case Studies, Care Plans, and other lab assignments with a final Summative Evaluation at the end of the semester.

ACADEMIC INTEGRITY

It is the aim of the faculty of South Plains College to foster a spirit of complete honesty and a high standard of integrity. The attempt of any student to present as his or her own any work which he or she has not honestly performed is regarded by the faculty and administration as a most serious offense and renders the offender liable to serious consequences, possibly suspension.

Cheating - Dishonesty of any kind on examinations or on written assignments, illegal possession of examinations, the use of unauthorized notes during an examination, obtaining information during an examination from the textbook or from the examination paper of another student, assisting others to cheat, alteration of grade records, illegal entry or unauthorized presence in the office are examples of cheating. Complete honesty is required of the student in the presentation of any and all phases of coursework. This applies to quizzes of whatever length, as well as final examinations, to daily reports and to term papers.

Plagiarism - Offering the work of another as one's own, without proper acknowledgment, is plagiarism; therefore, any student who fails to give credit for quotations or essentially identical expression of material taken from books, encyclopedias, magazines and other reference works, or from themes, reports or other writings of a fellow student, is guilty of plagiarism.

VERIFICATION OF WORKPLACE COMPETENCIES

Successful completion of this course and all required concurrent theory courses enables the student to enroll in VNSG 2461 and to continue on in the vocational nursing program.

BLACKBOARD

Blackboard is an e-Education platform designed to enable educational innovations everywhere by connecting people and technology. This educational tool will be used in this course throughout the semester as a reporting tool and communication too. Students should be aware that the "total" points noted on this education platform does not reflect the actual grade of the student because it does not take into consideration the percentages of each grade. Please calculate your grade according to the criteria in this syllabus.

FACEBOOK

The Vocational Nursing Program has a Facebook page at https://www.facebook.com/SouthPlainsCollegeVocationalNursingProgram in addition to the South Plains College website; this Facebook page will be used to keep students up-to-date on program activities, South Plains College announcements and will help with program recruitment. "Liking" the South Plains College Vocational Nursing Program Facebook page is not mandatory, nor are personal Facebook accounts, in order to access this page.

SCANS and FOUNDATION SKILLS

Refer also to Course Objectives. Scans and Foundation Skills attached

SPECIFIC COURSE INFORMATION

LEVEL 2 CLINICAL OBJECTIVES: (Based on the TBON DECs)

During the clinical course, the novice vocational nursing student progress to competent nurse through the following:

I. Member of the Profession
The student vocational nurse who exhibits behaviors that reflect commitment to the growth and development of the role and function of nursing consistent with state and national regulations and with ethical and professional standards; aspires to improve the discipline of nursing and its contribution to society; and values self-assessment, self-care, and the need for lifelong learning.
A. Function within the nurse's legal scope of practice and in accordance with the policies and procedures of the employing health care institution or practice setting.
1. Function within a directed scope of practice of the vocational nurse with appropriate supervision.
2. Assist in determination of predictable health care needs of patients to provide individualized, goal-directed nursing care.
3. a. Practice according to facility policies and procedures and provide input in the development of facility policies and procedures.
b. Question orders, policies, and procedures that may not be in the patient's best interest.
B. Assume responsibility and accountability for the quality of nursing care provided to patients and their families.
1. Practice according to the Texas laws and regulations, agency policies and SPC policies.
2. a. Provide nursing care within the parameters of vocational nursing knowledge, scope of practice, education, experience, and ethical/ legal standards of care.
b. Participate in evaluation of care administered by the interdisciplinary health care team.
3. a. Practice nursing in a caring, nonjudgmental, nondiscriminatory manner.
b. Provide culturally sensitive health care to patients and their families.
c. Provide holistic care that addresses the needs of diverse individuals across the lifespan.
4.a. Use performance and self-evaluation processes to improve individual nursing practice and professional growth.
5. a. Assume accountability for individual nursing practice.
b. Follow established evidence-based clinical practice guidelines.
6. a. Follow established policies and procedures.
b. Question orders, policies, and procedures that may not be in the patient's best interest.
c. Use nursing judgment to anticipate and prevent patient harm, including implementing Nursing Peer Review.

8. Use communication techniques to maintain professional boundaries in the nurse/ patient relationship.
9. Uphold professional behavior in nursing comportment and in following organizational standards and policies. Comply with professional appearance requirements according to organizational standards and policies.
C. Contribute to activities that promote the development and practice of vocational nursing.
1. Identify historical evolution of nursing practice and issues affecting the development and practice of vocational nursing.
2. Work collegially with members of the interdisciplinary health care team.
3. Participate in activities individually or in groups through organizations that promote a positive image of the vocational nursing role.
4. Recognize roles of vocational nursing organizations, regulatory agencies, and organizational committees.
5. Practice within the vocational nursing role and Scope of Practice.
D. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning
1. Participate in educational activities to maintain/improve competency, knowledge, and skills.
3. Use self-evaluation, reflection, peer evaluation, and feedback to modify and improve practice.
4. Demonstrate accountability to reassess and establish new competency when changing practice areas.
5. Demonstrate commitment to the value of lifelong learning.
6. Engage in self-care practices that promote work-life balance.
II. Provider of Patient-Centered Care
The student vocational nurse who, based on educational preparation and scope of practice, accepts responsibility for the quality of nursing care and provides safe, compassionate nursing care using a systematic process of assessment, analysis, planning, intervention, and evaluation that focuses on the needs and preferences of patients and their families. The student vocational nurse incorporates professional values and ethical principles into nursing practice. The patients for SVNs (LVNs) individual patients and their families.
1. Use problem-solving approach to make decisions regarding care of assigned patients.
2. a. Organize care for assigned patients based upon problem-solving and identified priorities.
b. Proactively manage priorities in patient care and follow-up on clinical problems that warrant investigation with consideration of anticipated risks.
c. recognize potential care needs of vulnerable patients
3. Identify and communicate patient physical and mental health care problems encountered in 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 from the vocational nursing program of study. of culturally, ethnically, and socially diverse patients and their families based on interpretation of health-related data.
1. Use structured assessment tool to obtain patient history.
2. Perform focused assessment to assist in identifying health status and monitoring change in patients.
3. Report and document focused patient assessment data.
4. Identify predictable and multiple health needs of patients and recognize signs of decompensation.
5. Share observations that assist members of the health care team in meeting patient needs.
7. Differentiate abnormal from normal health data of patients.
8. Recognize healthcare outcomes and report patient status.
9. a. Recognize that economic and family processes affect the health of patients.
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.
1. Integrate concepts from basic sciences and humanities to deliver safe and compassionate care in delivery of patient care.

2. Identify short-term goals and outcomes, select interventions considering cultural aspects, and establish priorities for care in collaboration with patients, their families, and the interdisciplinary team.
3. Participate in the development and modification of the nursing plan of care across the lifespan, Including end-of-life care.
4. Contribute to the plan of care by collaborating with interdisciplinary team members.
5. Assist in the discharge planning of selected patients.
7. Demonstrate basic knowledge of disease prevention and health promotion in delivery of care to patients and their families.
D. Provide safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.
1. Assume accountability and responsibility for nursing care through a directed scope of practice under the supervision of a registered nurse, advanced practice registered nurse, physician assistant, physician, podiatrist, or dentist using standards of care and aspects of professional character. professional values.
2. a. Identify priorities and make judgments concerning basic needs of multiple patients with predictable health care needs in order to organize care.
b. Manage multiple responsibilities.
c. Recognize changes in patient status.
d. Communicate changes in patient status to other providers.
3. a. Implement plans of care for multiple patients.
b. Collaborate with others to ensure that healthcare needs are met.
E. Implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors.
1. Implement individualized plan of care to assist patient to meet basic physical and psychosocial needs.
2. Implement nursing interventions to promote health, rehabilitation, and implement nursing care for clients with chronic physical and mental health problems and disabilities.
3. Initiate interventions in rapidly-changing and emergency patient situations.
4. Communicate accurately and completely and document responses of patients to prescription and nonprescription medications, treatments, and procedures to other health care professionals clearly and in a timely manner.
5. Foster coping mechanisms of patients and their families during alterations in health status and end of life.
6. a. Assist interdisciplinary health care team members with examinations and procedures.
b. Seek clarification as needed.
7. a. Inform patient of Patient Bill of Rights.
b. Encourage active engagement of patients and their families in care.
8. Communicate ethical and legal concerns through established channels of communication.
9. Use basic therapeutic communication skills when interacting with patients, their families, and other professionals.
10. Apply current technology and informatics to enhance direct patient care while maintaining patient confidentiality and promoting safety.
11. Facilitate maintenance of patient confidentiality.
12. a. Demonstrate accountability by providing nursing interventions safely and effectively using a directed score of practice
b. Provide nursing interventions safely and effectively using established evidence-based practice guidelines.
13. Provide direct patient care in disease prevention and health promotion and/or restoration.
F. Identify and report alterations in patient responses to therapeutic interventions in comparison to expected outcomes.
1. Report changes in assessment data.
2. Use standard references to compare expected and achieved outcomes of nursing care.
3. Communicate reasons for deviations from plan of care to supervisory health care team member.

4. Assist in modifying plan of care.
5. Report and document patient's responses to nursing interventions.
6. Assist in evaluating patient care delivery based on expected outcomes in plan of care and participate in revision of plan of care.
G. Implement teaching plans for patients and their families with common health problems and well-defined health learning needs.
1. Identify health-related learning needs of patients and their families.
2. Contribute to the development of an individualized teaching plan.
3. Implement aspects of an established teaching plan for patients and their families.
4. Assist in evaluation of learning outcomes using structured evaluation tools
5. Teach health promotion and maintenance and self-care to individuals from a designated teaching plan.
H. Assist in the coordination of human, information, and physical materiel resources in providing care for assigned patients and their families.
2.a. Report unsafe patient care environment and equipment.
2 b. Report threatening or violent behavior in the workplace
3. Implement established cost containment measures in direct patient care.
6. Assist with maintenance of standards of care.
III. Patient Safety Advocate
The student vocational nurse who promotes safety in the patient and family environment by: following scope and standards of nursing practice; practicing within the parameters of individual knowledge, skills, and abilities; identifying and reporting actual and potential unsafe practices; and implementing measures to prevent harm.
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
*1. Attain licensure through completion of these objectives in preparation to pass NCLEX and receive licensure**
2. Practice according to Texas Nursing Practice Act and Texas Board of Nursing rules.
3. Seek assistance if practice requires behaviors or judgments outside of individual knowledge and expertise.
4. Use standards of nursing practice to provide and evaluate patient care.
5. Recognize and report unsafe practices and contribute to quality improvement processes.
B. Implement measures to promote quality and a safe environment for patients, self, and others.
1. Promote a safe, effective caring environment conducive to the optimal health, safety, and dignity of the patients and their families, the health care team and others consistent with the principles of just culture.
2. Accurately identify patients
3. a. Safely perform preventive and therapeutic procedures and nursing measures including safe patient handling.
b. Safely administer medications and treatments.
4. Clarify any order or treatment regimen believed to be inaccurate, non-efficacious, contraindicated, or otherwise harmful to the patient.
5. Document and report reactions and untoward effects to medications, treatments, and procedures and clearly and accurately communicate the same to other health care professionals.
6. Report environmental and systems incidents and issues that affect quality and safety, and promote a culture of safety.
7. Use evidence-based information to contribute to development of interdisciplinary policies and procedures related to a safe environment including safe disposal of medications and hazardous materials.
8. Implement measures to prevent risk of patient harm resulting from errors and preventable occurrences.
9. Inform patients regarding their plans of care and encourage participation to ensure consistency and accuracy in their care.
C. Assist in the formulation of goals and outcomes to reduce patient risks.
1. Assist in the formulation of goals and outcomes to reduce patient risk of health care-associated infections

2. a. Implement measures to prevent exposure to infectious pathogens and communicable conditions.
b. Anticipate risk for the patient.
3. Implement established policies related to disease prevention and control.
D. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices.
1. Evaluate individual scope of practice and competency related to assigned task.
2. Seek orientation/ training for competency when encountering unfamiliar patient care situations.
3. Seek orientation/ training for competency when encountering new equipment and technology.
E. Comply with mandatory reporting requirements of the Texas Nursing Practice Act, SPC policies and agency policies.
1. Report unsafe practices of healthcare providers using appropriate channels of communication.
2. Understand nursing peer review rules Safe Harbor rules and implement when appropriate.
3. Report safety incidents and issues through the appropriate channels.
4. Implement established safety and risk management measures
*** F. Accept and make assignments that take into consideration patient safety and organizational policy.**
1. Accept only those assignments that fall within individual scope of practice based on experience and educational preparation.
IV. Member of the Health Care Team:
The student vocational nurse who provides patient-centered care by collaborating, coordinating, and/ or facilitating comprehensive care with an interdisciplinary/multidisciplinary health care team to determine and implement best practices for the patients and their families.
A. Communicate and collaborate 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.
1. Involve patients and their families with other interdisciplinary health care team members in decisions about patient care across the lifespan.
2. Cooperate and communicate to assist in planning and delivering interdisciplinary health care.
3. Participate in evidence-based practice in development of patient care policy with the interdisciplinary team to promote care of patients and their families.
B. Participate as an advocate in activities that focus on improving the health care of patients and their families
1. Respect the privacy and dignity of the patient.
2. Identify unmet health needs of patients.
3. Act as an advocate for patient's basic needs, including following established procedures for reporting and solving institutional care problems and chain of command.
C. Participate in the identification of patient needs for referral to resources that facilitate continuity of care, and ensure confidentiality.
1. a. Identify support systems of patients and their families.
b. Identify major community resources that can assist in meeting needs.
2. a. Communicate patient needs to the family and members of the health care team.
b. Maintain confidentiality according to HIPAA guidelines.
c. Promote system-wide verbal, written, and electronic confidentiality.
3. a. Advocate with other members of the interdisciplinary health care team on behalf of patients and families to procure resources for care.
b. Assist patient to communicate needs to their support systems and to other health care professionals.
4. Identify treatment modalities and cost of health care services for patients and their families.
D. Communicate patient data using technology to support decision making to improve patient care.
1. a. Identify, collect, process, and manage data in the delivery of patient care and in support of nursing practice and education.

b. Use recognized, credible sources of information, including internet sites.
c. Access, review, and use electronic data to support decision-making
2. a. Apply knowledge of facility regulations when accessing client records.
b. Protect confidentiality when using technology.
c. Intervene to protect patient confidentiality when violations occur.
3. a. Use current technology and informatics to enhance communication, support decision making, and promote improvement of patient care.
b. Advocate for availability of current technology.
4. Document electronic information accurately, completely, and in a timely manner.
G. Assist health care teams during local or global health emergencies or pandemics to promote health and safety, and prevent disease.
1. Recognize the impact and prepare to respond to an emergent global or local health issue in an assistant role
2. Guide patients, staff, and others in understanding the extent of the emergency and their response
3. Participate with the health care team to promote safety and maintain health during an emergency or pandemic
4. Include public health strategies in the care of individuals and communities that address resolution of a global or local crisis and promotion of health among the population.

**working toward but not achieve until licensure*

SPECIFIC LEVEL 2 CLINICAL UNIT OBJECTIVES:

MEDICAL-SURGICAL ROTATIONS

University Medical Center: Medical-Surgical Floor Objectives

Clinical Rotations are Monday, Tuesday, Wednesday 0800-1000

Unit	Location	Phone	Specialty
3 West	3rd floor west of patio	775-8909	Orthopedics: pre/post op care for joint replacements, amputations, arthroscopy or trauma. May also have overflow medical patients.
3 East	3rd floor east of patio	775-8903	Medical and Surgical patients such as pneumonia, GI bleeds, skin issues, pain
3 West Tower	3rd floor West Tower	775-9770	Geriatric trauma and supportive care. Supportive care manages pain, nausea, loss of appetites or other s/s caused by illness or medical treatments. Floor includes end-of-life care
4 East	4th floor East of patio	775-8959	Medical Surgical, Pre-operative and post-operative Cancer patients. Wound care, IV therapy, pain management, chest tubes, blood administration, chemo and radiation patients. There are six bone marrow transplant rooms.
4 West	4th floor West of patio	775-8945	Renal Telemetry. patients with such diseases as renal failure, diabetes, heart failure, strokes, kidney stones, bladder and prostate diseases. You will observe procedures, ie: peritoneal dialysis, bladder scans and irrigations, pre and post-operative patients. You may observe cardiac monitors, feeding tubes, strict I&O, daily weights,

			strict diets. You may observe code situations. This floor also gets overflow med-surg patients.
5 West	5th floor west of patio	775-9790	Medical or surgical patients and patients for "observation". Admissions & discharges are frequent
5 East	5th floor east of patio	775-9780	Medical/Surgical/Telemetry patients; includes pre/post op, cardiac procedures and medical problems.

General Guidelines for ALL Medical Surgical Rotations in Level 2

Criteria	Level 2
Number of patients	2
Medication administration with instructor supervision	After successful PSCCL
Documentation in Electronic Medical Record (MAR only during medication administration)	Yes
SPC Chart Pack	Yes
VS and brief assessment by 0730	Yes
Full assessment completed and documented by 0930	Yes
Staple removal with instructor supervision (after lab check-off)	Yes
Foley Catheter insertion (initially with instructor supervision)	Yes after successful lab check-off
Sterile Dressing change (initially with instructor supervision)	Yes after successful lab check-off
Follow Do and Don't List	Yes

****other clinical facilities may be assigned during the semester as they become available to students. If this occurs, additional clinical objectives will be posted on the VNSG 1460 Blackboard.**

Students MAY NOT

- bring course work to "study" during clinical rotations,
- complete clinical research
- research clinical information or other activities that distract from the clinical experience while on the units.
- ask class questions of instructors during clinical time; instead, the student who has questions about class work should make an appointment with the appropriate class instructor for that discussion.

Maternal Newborn Rotations

Please note: there is limited space availability in the maternal child areas. If a student misses a day in this rotation, the student may not be able to complete the required rotation, thus failing the clinical course. You must have 6 days of OB clinical experiences to complete this rotation

Family Birth Center (FBC) and Family Care Unit (FCU) at UMC
L&D and NICU 1st Floor / Post-Partum/Nursery 2nd Floor
OB Clinics

Guidelines:

STAY OUT OF THE BREAKROOM!!! Wait at the nurse's station for the Charge Nurse and check in with her.

FBC: **Students on floor by 0630 ready for report.** You will be assigned with a TPC nurse and her laboring patients each A.M. Complete your ISBAR entirely. Make all notes on the back of your ISBAR; ex: pitocin adjustments, position

changes, epidural procedure, etc. After your patient delivers, you will be assigned to another patient. If your patient is scheduled for a C-section, you will accompany your patient to the L&D O.R.

You will stay with the patient from delivery through the recovery stage. You will help your TPCN transfer the patient to the FCU unit, listen to nurse-to-nurse report, and then return to L&D with your TPCN.

The student should place a Foley while on the FBU, it's an excellent time to get that checked off. **Only in FBU (Labor and Delivery)**, once you have been checked off in the lab, you are then allowed to place a with your TPCN supervision. **This only applies to the FBU**. On other units, it is still required that Foley's be placed with your instructor.

With permission of the delivery nurse, the student who has passed PSCCL may pass PO medications with an instructor. The student may only pass the PO meds that are written out on their drug/med cards. You must have your drug card with you to administer it. You may not administer any other medications to the mother that you do not have complete written medication information on.

Students are *not* allowed to administer any medications to infants.

FCU:

Students on floor by 0630 ready for report. You will be assigned 1 couplet by the charge nurse. The patients on FCU only stay 24-48 hours post-delivery. You probably will not have the same patients for the 2 days you are there. **You must complete one chart pack for the mom and one chart pack for the baby.** (3 assessment pages and Braden). See Blackboard for appropriate paperwork.

During the FCU rotation, you will also do your Nursery Rotation. The baby(s) room in with the new mother—**this means that these nurses have two (2) patients at one time—the mother and the newborn**. **You will be responsible for the care of both the mother and infant**. (The newborn goes to the nursery for only a few hours. During this time, the baby will be assessed, blood sugar checked, and medications given.) If your patient has delivered a male child that is to be circumcised, then you can go to the nursery and observe this procedure. **You must document the care of each patient (mother and newborn!)**

The student who has passed PSCCL may pass PO medications with an instructor. The student may only pass the PO meds that are written out on their drug/med cards. You must have your drug card with you to administer it. You may not administer any other medications to the mother that you do not have complete written medication information on.

Students are *not* allowed to administer any medications to infants.

Bring your Nursing Skills and OB Skills Checklist with you during these rotations.

Items Required for this rotation: Postpartum, L&D ISBARs, infant ISBAR, NICU ISBARS, chart pack *Use Newborn Assessment Form for infants; DX/procedure and Med cards required by OB instructor, skills check off *Remember HIPPA when completing the forms and do not write any identifying data on paperwork.

Medication Administration Rotation

Please note: there is limited time available for medication administration rotation. If a student misses a day in this rotation, the student may not be able to complete the required rotation, thus failing the clinical course. You must have 4 days of direct, instructor supervised medication administration to complete this rotation.

PURPOSE: To ensure a safe medication administration rotation in a timely manner for vocational nursing students of South Plains College, Reese Center.

Prerequisite for assignment to PSCCL:

1. Successful passage of Departmental Math Exam at the beginning of the semester with 80 or better.

POLICY: All Vocational Nursing students will complete an intensive medication rotation as early as possible during the Level 2 semester to ensure adequate and safe medication administration by all routes excluding IV.

PROCEDURE:

1. All students will receive instruction on medication administration during Essentials of Medication Administration in VNSG 1227 during Level 2 and will demonstrate knowledge of drug classifications in Level 2.
2. This instruction will include IM injection lab in which students receive instruction on actual medication administration (lab.)
3. Students will receive an orientation on medication administration as part of this instruction during Level 2.
4. The lab will be available to students to practice medication administration.
5. Following the review, the Pharmacology Skills Critical Competency Lab will begin and all students must pass the PSCCL in three (3) attempts or less. ***If the student does not pass on the third (3rd) attempt, the student fails the Level 2 clinical course and is withdrawn from the VNP.***
7. Patients must be able to respond to the student during medication administration; therefore, comatose, dialysis patients or patients NPO for surgeries or tests are NOT appropriate patients for medication administration rotation.
8. **All students must pass medication rotation in order to graduate.**

IMPLEMENTATION: It is the responsibility of all students and faculty to ensure compliance with this policy.

Guidelines for Medication Administration during Clinical Medication Administration

THE STUDENT WILL:

1. Be assigned a floor and be assigned medication administration by the faculty.
2. Obtain all information on the patient regarding diagnosis and medications for the first clinical day and prepare all diagnosis and medication sheets on the patient and have everything prepared for the instructor on the second day.
3. Prepare drug sheet for the patient(s) that must include all active medications the patient is prescribed by the physician – scheduled meds, prn meds that the patient has had within the last three days, including IVPB medications.

Please Note: Information obtained from the Omnicell systems is incomplete and does not give the student enough information for safe drug administration; therefore, the student must have a completed drug sheet.

4. Be able to verbally tell the instructor and/or TPCN from memory or by reading drug sheet the following:
    a. medication name (trade and generic)
    b. classification
    c. effect (action)--reason patient is on medication (diagnosis)
    d. route ordered
    e. normal dose range for route ordered
    f. major common side effects (expect/report)
    g. nursing implications (V/S, lab, safety, etc.)
    h. patient teaching.

During Med Rotation; THE FIRST TIME THE STUDENT IS UNABLE TO GIVE THIS INFORMATION ON EACH MEDICATION FOR EACH ASSIGNED PATIENT, THE STUDENT WILL have points deducted from the clinical grade (This applies to

incomplete/missing RX information as well) AND will be placed on PROBATION. A second infraction will result in dismissal from the program. <u>This policy will carry over from medication rotation all the way through to graduation.</u>

5. Find all orders for all medications to be administered and know where orders are located in the patient(s) chart or on the computer.
6. Review medications with instructor and then administer medications only under the supervision of an instructor.

SHOULD A STUDENT ADMINISTER MEDICATIONS WITHOUT *<u>INSTRUCTOR</u>* SUPERVISION, THE STUDENT WILL BE PLACED ON PROBATION. A SECOND INFRACTION WILL RESULT IN THE STUDENT BEING WITHDRAWN FROM THE VOCATIONAL NURSING PROGRAM FOR UNSAFE PRACTICE. This policy is followed all the way through graduation!

7. Follow hospital policies which state that SVNs may give medications by all routes (*that have been checked off with a grade of 85 or better in EMA*); **EXCEPT IV** with supervision by the instructor. IV meds will not be given in the VN program.
8. Complete all other aspects of patient care.
9. Students may NOT print drug card information from the clinical facilities; this is theft of hospital property.
10. Should the student not have four (4) days of medication administration during the Level II semester, the student may fail the Level 2 clinical course, regardless of other grades. If medication rotation is not completed successfully, the student will not graduate.

MEDICATION ADMINISTRATION AFTER MED ROTATION

<u>Medication Administration by Student Vocational Nurses after successful medication rotation</u>

DECs: Member of a Profession, Provider of Patient-Centered Care, Patient Safety Advocate

POLICY: Student Vocational Nurses will administer medications following all guidelines and policies for safe, effective administration of medications.

STUDENT VOCATIONAL NURSES DO NOT ADMINISTER ANY MEDICATIONS UNTIL SUCCESSFUL PHARMACOLOGY CRITICAL COMPETENCY LAB in Level 2. See disciplinary action above!

Definition of Supervision: Instructor reviews medications, escorts student to the patient room, and supervises at all times during medication administration. This includes scheduled and prn medication administration. [Please note: the OB floors are an exception to this policy and will be discussed thoroughly by the OB instructor.]

VIOLATION: Unsafe Nursing Practice, Unprofessional Conduct

1. The student will follow the SPC/VNP and facility's policy and procedures on medication administration by the student vocational nurse.
2. The student will not pass medications without direct instructor supervision following hospital policy which states that the student vocational nurse may give medications by all routes EXCEPT IV (after successful check-off in EMA with an 85 or better; only oral and topical medications can be administered in pediatrics) with supervision by the instructor.
3. If the student has not administered a particular route and seeks the experience, the student must have complete medication information for that medication and call the instructor. The route will be documented on the Med/Surg checklist.
4. The student **must** have <u>complete medication information</u> prior to administering any medication. Failure to do so will result in disciplinary action. Students may administer herbal medicines and supplements with required

information for which a written physician's order is on the chart and the pharmacy has supplied for the patient. Supplements from home are not to be given by SVNs.

5. The student will be able to administer medication in the following areas:
   Short Stay — Post-Partum
   Rehabilitation — Med-Surg Floors
   Telemetry Floors **except Renal patients on Dialysis** — Long Term Care facilities
   Students may give meds to two or more patients.
6. Students should prepare to administer 0900 to 1500 medications by routes that have been successfully checked off with an 85 or better in EMA (except IV) on the day shift.
7. Students should communicate with the TPCN and notify them that they will be administering medications with their instructor for that patient. Please ask the TPCN to pull the medications from the PYXIS.
8. The student will be responsible for all patient care for assigned patients.
9. If a medication error is made, after assuring patient safety, the student will immediately notify the TPC nurse and instructor. The TPC nurse or instructor will notify the physician of the error, and an investigative report will be completed. The Medication Administration Error Quotient will be completed by the instructor and appropriate student action taken. See the example of the Quotient Form IN THE STUDENT HANDBOOK.
10. The student ***must have a completed med sheet on all medications (EXCEPT PRNs THAT HAVEN'T BEEN GIVEN IN THE LAST 3 DAYS***.
11. For new medication orders (orders written between nursing report and 0900):
    a. Look up the new medication in the drug book, review the information and mark the book.
    b. Give the medication per SPC policy following all nursing implications.
    c. Be prepared to show the instructor the new order and to discuss the new medication, including why it was ordered.
    d. **Complete the medication sheet and turn it in to the instructor the next classroom day**.
    e. Should the student fail to turn in the sheet on the following class day, the student will be subject to disciplinary action.
    f. This process should be the **EXCEPTION**, rather than the rule, meaning that this should only happen on occasion and not daily or weekly! This will be monitored and the student who consistently has to "look up" drugs will be subject to disciplinary action.

SHOULD A STUDENT ADMINISTER MEDICATIONS WITHOUT *INSTRUCTOR* SUPERVISION, THE STUDENT WILL BE PLACED ON PROBATION. A SECOND INFRACTION WILL RESULT IN THE STUDENT BEING WITHDRAWN FROM THE VOCATIONAL NURSING PROGRAM FOR UNSAFE PRACTICE. This policy is followed all the way through graduation!

THE SIMULATION EXPERIENCE

The Purpose: Simulation is a "strategy—not a technology— to mirror, anticipate, or amplify real situations with guided experiences in a fully interactive way." (http://www.ahrq.gov/)

When assigned, students will participate in simulated nursing care scenarios at the Center for Clinical Excellence located in Building 1 at the Reese Center.
Students can expect the following from simulation:

- The opportunity for independent critical-thinking, decision-making and delegation
- The opportunity to make and learn from mistakes
- The opportunity for deliberate nursing practice
- The opportunity for immediate feedback
- The opportunity to participate in experiential learning

During Simulation, students fulfill all roles of the nurse and are not restricted to student limitations. Students must treat the simulation experience as a REAL patient situation; if appropriate action is not taken by the student, the patient will

experience a negative outcome, including "death. On a rotating basis, students will be assigned roles for each scenario. All roles are important and all students have learning opportunities in any role.

RESEARCH: Students must be prepared for the simulation. Student prep materials are found on Black Board and should be reviewed the Sunday before the Simulation experience begins. Students are required to prepare for the clinical experience through review of materials, preparation of Dx, RX, procedure cards and other information that will be used during the experience**. Students are unprepared for the simulation experience due to lack of preparation may be sent home, accruing an absence.**

DEBRIEFING: occurs after the simulation concludes. During debriefing, the scenario is discussed and the student's nursing actions/decisions are examined. This is a great time for self-reflection. All students should participate in the debriefing process. Confidentiality is a must and students cannot share information with other classmates. **A Breach of Confidentiality in simulation is grounds for dismissal from the VNP.** While observing the scenario, students maintain a plus/delta sheet which allows the student to experientially learn and provide valuable feedback.

SIMULATION EVALUATION: Students will be evaluated during the experience. Adherence to SPC and CCE policies (including dress code), participating in the experience, adhering to safe nursing practice principals and competency of previously learned skills are part of the evaluation. Additionally, students reflect on their own learning through the reflection tool found on Blackboard.

SIMULATION ATTIRE: Students must be in full clinical uniform, including have stethoscope, penlight, scissors, ISBAR, Chart Pack, Dx and Rx cards. **If you do not have these items you are considered out of dress code**. ONLY Pencils may be used in the simulation rooms.

ATTENDANCE: This is a clinical experience. Full attendance is expected. Students who must be absent for any reason must follow call in guidelines by emailing Mrs. Castellanos by 0700; after 0700, the student is classified as a "No Show." Students are absent at 0800—**THERE ARE NO TARDIES**—this experience is already later than hospital experiences, so there is no reason to be late. Students must clock in by their student ID upon entering the Simulation Center.

LUNCH: The instructor will assign a lunch break during the day. You may bring your lunch or may leave the campus for lunch depending on the assigned time. I**f you return late from lunch, you are given an absence for the day.**

DO NOT BRING CELL PHONE INTO THE BUILDING!! Leave it in your car!

TEXT AND MATERIALS

Students should use current resources from theory textbooks such as the Williams & Hopper, Davis Drug Guide, etc. as tools to equip them for patient care. Websites that the student may use should end in ".org" ".gov" or ".edu". Wiki websites are not acceptable; neither are WebMD or Mayo Clinic [these websites are designed for laypeople—not professionals!]

Students are required to have the following items with them for the clinical experience:

- This syllabus with the Level 2 Clinical Objectives
- Specific unit objectives that are not included in this syllabus (found on Blackboard)
- Davis Drug Guide

ADDITIONAL CLINICAL ITEMS

Students should come to clinicals with all required research and chart pack. The student must be in full clinical uniform which includes the student badge, stethoscope, blood pressure cuff, penlight, bandage scissors, black ink pen and analog watch Refer to the Dress Code included in this syllabus.

ATTENDANCE POLICY (*READ CAREFULLY)

Clinical Attendance

Clinical experiences offer the student the opportunity to apply theory of nursing to actual nursing practice. Students are expected to attend all assigned clinical experiences, including Simulation. The student may be administratively withdrawn from the course when absences become excessive as defined in the course syllabus.

Absences are recorded for the whole day. A student who leaves before the end of the clinical period is marked as "absent" for the entire day. Since the majority of nursing work is done in the morning, students may not come in to the clinical setting in the afternoon.

Recognizing that sometimes students are ill or have ill children or have some other real reason to be absent, students may have TWO absences this semester—this includes any day the student is sent home for clinicals for a rules violation . **Any absence** will require a make-up in order to complete the required clinical hours(this includes Clinical, lab activities, Simulation, and post conference); Students will be assigned a virtual simulation that must be completed outside of regular class and clinical hours and submitted by the assigned due date. Because students cannot be evaluated if they are absent, points are deducted from the weekly clinical grade and replaced after make-up clinical.

ABSENCES MUST BE MADE UP BY THE END OF THE SEMESTER. Because students cannot be evaluated if they are absent, points are deducted from the weekly clinical grade***. Exceeding allowable clinical absences (2) may result in failure in the clinical course*.*** The student may be administratively withdrawn.

*If the student has a documented emergency that leads to exceeding 2 clinical absences, the student will be responsible for notifying the instructor. The student must present evidence to the course instructor and program coordinator regarding the reasons for all absences. The instructor and program coordinator will review and determine if a true emergency existed for each of the absences. Failure to plan (childcare, transportation, traffic, tardiness) is not an eligible emergency. There are absences available in each course in case one of these needs arises. However, exceeding absences is grounds for dismissal. Should you use an absence, please be aware that if you encounter a true emergency later in the semester and you have already used your absence for a non-emergency, the attendance policy will be upheld, and you may be dismissed from the VNP. The decision is final.

Clinical Times: (must be clocked in BEFORE the "Absent at" time; students are absent on the given time.

Facility	Clinical Time	Lunch	Absent at:	Call In Time	May leave floor at
University Medical Center	0630-1530	30 minutes	0631	0530	1515
Covenant Hospital	0630-1530	30 minutes	0631	0530	1515
Crown Point Medical Suites	0630-1430	30 minutes	0631	0530	1515
Simulation	0755-1600	Approx. 60 minutes	0801	0700	1600
EVENING SHIFTs if indicated at UMC	1400-2200	30 minutes	1345	1245	2200

Clinical time is "on the job" learning. Students are expected to be up and working throughout the entire shift. Students MAY NOT leave the assigned unit at the hospitals until 3:15 at the hospitals. This means that the student gives report, checks on the patients and participates in patient care until 3:15 and then gathers belongings, leaves the floor and clocks out. Students who leave the floor before 3:15 or students who clock out right at 3:15 (which means they had to leave early in order to get to the time clock by then) are given an absence for the entire day. The clock out time should be no earlier than 3:20!

PLEASE NOTE: The Time Clock located at UMC is the OFFICIAL clinical time. It is usually set to the Universal Time as found on digital media. Please set your analog watch to the time clock.

Simulation is considered a clinical experience. An absence in simulation is the same as for all other clinical experiences. A student that arrives late or unprepared for simulation will be given the option to stay and observe for the learning experience but will still be given a zero for the day and an absence.

At times, Students will be required to drive from hospitals to Reese and back during the clinical experience and should anticipate the need to drive back and forth.

Students who show up at the wrong facility will be counted as absent for the day. Students should verify their schedule on Sunday and make sure they understand the clinical assignment.

Absences in Short Rotations:

Maternal-child (L&D, PP, NSY or NICU) and medication administration rotations have limited clinical availability. Should there not be sufficient time or space in order to repeat this full clinical experience, the student will fail the clinical course. Absences in the medication administration rotation must be made up and the rotation will be extended as the clinical schedule allows. The student in a medication administration rotation making up absences may lose an external clinical experience.

Religious Holy Days Absence in the Clinical Setting:

In accordance with Section 51.911, Texas Education Code, South Plains College will allow a student who is absent from a clinical rotation for the observance of a religious holy day to complete an assignment scheduled for that day within seven (7) calendar days after the absence.

Students are required to file a written notification of absence with each instructor within the first fifteen (15) days of the beginning of the semester in which the absence will occur. Forms for this purpose are available in the office Student Services, along with instructions and procedures. "Religious holy days" means a holy day observed by a religion whose place of worship is exempt from property taxation under Section 11.20, Tax Code.

Students will be required to make up any clinical days missed if the student absence cap has not been exceeded.

How to Decide if you are Too Sick to Attend Clinical (verify with HCP note): Students should not come to the clinical setting for the following reasons:

* Fever > 100.4^{o} F
* Conjunctivitis (Pink Eye)
* Diarrhea lasting more than 12 hours
* Group A Strep—culture confirmed or physician diagnoses
* Jaundice—yellowing of the skin which might suggest viral hepatitis
* Cold Sores (herpes) that are weeping, open (not crusted over)
* Active measles, mumps, pertussis, rubella, chicken pox or shingles
* Upper respiratory infection (cold) with productive cough (green or yellow sputum)
* Tuberculosis and/or positive TB skin test
* Head lice
* Scabies (mites that burrow under the skin causing a rash)
* any draining wound such as an abscess or boil
* Impetigo
* Mononucleosis

Students who come to clinical contagious are sent home with an absence.

Students are officially enrolled in all courses for which they pay tuition and fees at the time of registration. Should a student, for any reason, delay in reporting to a class after official enrollment, absences will be attributed to the student from the first class meeting.

Students who enroll in a course but have "Never Attended" by the official census date, as reported by the faculty member, will be administratively dropped by the Office of Admissions and Records. A student who does not meet the attendance requirements of a class as stated in the course syllabus and does not officially withdraw from that course by the official census date of the semester, may be administratively withdrawn from that course and receive a grade of "X" or "F" as determined by the instructor. Instructors are responsible for clearly stating their administrative drop policy in the course syllabus, and it is the student's responsibility to be aware of that policy.

It is the student's responsibility to verify administrative drops for excessive absences through MySPC using his or her student online account. If it is determined that a student is awarded financial aid for a class or classes in which the student never attended or participated, the financial aid award will be adjusted in accordance with the classes in which the student did attend/participate and the student will owe any balance resulting from the adjustment.

(http://catalog.southplainscollege.edu/content.php?catoid=47&navoid=1229#Class_Attendance)

BREAKS and LUNCH during clinical rotations:

Break Process:

1. Students may take one 15-minute break in the morning *AFTER* completing a.m. patient care (student must complete assessments, vital signs, open charts). The student should not be in the break room or student room except for the one morning break. A student who takes a break without accomplishing any nursing activity is sent home as "absent."
2. Students may take one 15-minute break in the afternoon *BEFORE* 1400. The student should not be in the break room or student room except for the one afternoon break.
3. Between 1400-1515, the student should be completing documentation, doing last rounds on patients, completing I&Os and giving report to the TPCN. This is not the time for breaks.
5. Students may not divide the 15-minute break into three 5-minute breaks. The student only gets one morning and one afternoon break.
6. Students should remain on the assigned units for breaks.
7. Students taking prolonged breaks or leaving the floor during break times without notifying TPCN will be sent home with an absence, no matter what time of day the infraction is discovered.
8. Breaks are not guaranteed.

Lunch Process:

1. Unless otherwise specified in specialty rotation objectives, the student lunch is 30 minutes from the time the student reports off to the TPCN to the time the student returns and assumes patient care. If the student stands at the elevator for 15 minutes, that is 15 minutes out of the student lunch time.
2. Students may leave the clinical unit for lunch to go to the cafeteria.
3. Lunch is limited to the cafeteria or nurse's lounge on the specified unit. All other areas are considered "off premises", i.e., the parking lot, student car, etc.
4. Students lunch times should be assigned by the TPCN or the Charge Nurse.
5. Students taking prolonged lunches or found out in the parking lot will be subject to disciplinary action.
6. Students MAY NOT have visitors during the lunch period in the clinical setting (this includes family members who may be employed at a clinical facility). This protects the student from any accusation of improper behavior

CLOCKING IN/OUT: Clocking in/out for other students is PROHIBITED and is considered unprofessional conduct as dishonest behavior. All students involved are dismissed from the Vocational Nursing Program (please refer to the Student Handbook).

Time sheets are required at off-hospital rotations. Students who misrepresent themselves on the time sheet or forge a time sheet are deemed "unprofessional" and are dismissed from the program for unprofessional conduct (please refer to the Student Handbook).

NO SHOW POLICY

Professional behavior requires the student to call in any time he/she will be absent. When a student must be absent on a clinical day, the student must email Mrs. Castellanos by the **specified 0645** deadline. STUDENTS MUST EMAIL PRIOR TO THE SHIFT FOR THE ABSENCE TO NOT COUNT AS A 'NO SHOW"—ONCE THE SHIFT STARTS, IT IS A "NO SHOW" (so at 0645, the student is No Show if there has not been a call-in). Just not showing up is unprofessional and is detrimental to patient safety. No Shows apply to the entire clinical year as they would in employment; if a student has a No Show in the previous semester, it still is a part of the record and subsequent No Shows will be labeled as #2 or #3, depending on the actual number.

CONSEQUENCES of No Show:

1. Failure to email correctly prior to the start of the shift to report an absence results in being classified as NO SHOW.
2. The absence will have to be made up as with any other clinical absence; however, the grade for the missed day will remain the same (no points awarded for the NO SHOW.)
3. A second NO SHOW results in the same as in #2 and the student is placed on probation. Probation means that the student will not have any "off campus" rotations in the remainder of this Level and in Level 3
4. A third NO SHOW results in clinical failure, regardless of other grades, and the student is administratively withdrawn.

Cell Phones in the Clinical Setting

Cellular phones are not permitted in the clinical setting because they may interfere with electrical equipment within the facility. Additionally, cell phones are a distraction to patient care.

Cell phones are **prohibited at any time during the clinical experience** unless needed at the beginning of the shift to access the computer system and then may not be used in any location of the clinical setting during clinical hours. Students should not have cell phones on their person during clinicals.
Students who violate this policy and have their cell phone out or on their person during the clinical day *for any reason* outside of initial log in will be receive a zero for the day, no matter when the incident occurs.

Simulation is a clinical experience; this policy applies to simulation as well.

Clinical Affiliate Approval

Clinical affiliates have a right to deny clinical experiences to students based on that facility's policies and procedures.

1. If a student is a former employee of a facility and ineligible for rehire, that student may not be able to perform clinical rotations at that facility.
2. Should alternative experiences not be available, the student must withdraw from the VNP.
3. Clinical facilities may also request, in writing, a denial. Should a student be denied clinical experiences at a particular affiliate, the faculty will look for alternative experiences within the program's current affiliations. However, should a student be prohibited from a major facility in which BON required experiences occur, the student cannot meet the program objectives and must withdraw.
4. Clinical facilities may request student information prior to allowing students to participate in clinical experiences. At a minimum, the student name and SPC student ID is shared with facilities for clearance with their IT systems. Other information may be requested.

Clinical Probation

"Probation" is defined by Webster's New Collegiate Dictionary as "the subjection of an individual to a period of testing and trial to ascertain fitness…."

POLICY: During the course of each clinical rotation, the student will be evaluated by an instructor.

PROCESS: The instructor will complete a weekly clinical evaluation so that the student has many opportunities to improve performance.

1. Should a student have difficulty improving, that student may be placed on clinical probation.
2. A student who is not completing clinical paperwork may be placed on probation.
3. A student who is not completing the skills checklist may be placed on probation.
4. At the end of each clinical level, the summative evaluation tool will be completed by the Nursing Instructors.
5. The student on clinical probation who does not meet the clinical objectives will be withdrawn from the nursing program.
6. Students on probation at the beginning of Level III do not have off campus rotations.

CONFIDENTIALITY/HIPAA

Student Vocational Nurses will not divulge any protected patient information, clinical instructional information, or instructor-student conference information

In the Vocational Nurse's Pledge, we pledge:

"I will not reveal any confidential information that may come to my knowledge in the course of my work."

This statement makes it clear that any information gained by the nurse during examination, treatment, observation or conversation with the client or his/her family is confidential. Unless the nurse is authorized by the client to disclose the information or is ordered by a court to do so, she/he has a clear moral obligation to keep the information confidential.

The nurse may use the knowledge to improve the quality of client care, but she/he never shares information about the client with anyone not involved with his/her care. The student will direct all inquiries directly to the charge nurse.

Even when sharing with caregivers, the nurse must be extremely cautious. The information is not discussed in the cafeteria or around persons not involved with the patient's care. Students need to be **very aware** of confidentiality and be **extremely careful** with whom and where they discuss their assignments.

The Health Insurance Portability and Accountability Act (HIPAA) became effective April 14, 2003 for all health care providers in the United States. HIPAA established regulations for the use and disclosure of Protected Health Information (PHI). PHI is **any** information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. This means that NO information about a patient may be shared outside of those health care providers that "need to know" the information to properly care for the patient. Violation of HIPAA is a federal violation and is grounds for dismissal from the nurse program. This includes any information about a health care facility or individuals providing health care at a specific facility.

Students must always be aware of the private information that they have about patients and must protect that information. Even if a specific name is not mentioned, a violation can exist if there is enough information for other individuals to "connect the dots" and find out who the information is about. Students must be very cautious in discussing PHI – elevators, cafeterias, and even open nursing stations may be inappropriate places to discuss information.

All social networking sites are inappropriate areas to be discussing patient information. This includes Facebook, Instagram, Snap Chat, TikTok, Twitter, etc. HIPAA violations could also occur through the use of email or other computer programs. **Students who post inappropriate information or PHI on social media are dismissed from the program.**

Students should only share PHI with their instructors for the purpose of learning and with the other health care providers on the assigned unit who are participating in that individual patient's care. It is inappropriate to discuss situations with other classmates, family members, etc.

Students must also protect all student paperwork and may not leave these out where anyone can read them. Students should always secure any identifying information when leaving that information (don't leave information at the

nursing station unsecured, in patient rooms, etc.) ALWAYS LOG OFF of a computer system if you have used it! Press F4 when leaving the computer to close the chart.

Confidentiality also extends to the nursing report, facility in-services or other hospital/clinic meetings that the student nurse attends. Additionally, confidentiality is to be maintained in all student/instructor conferences and disciplinary actions.

Failure to maintain confidentiality is grounds for dismissal.

Additionally, confidentiality is to be maintained in all program situations including classroom discussions, student/instructor conferences and disciplinary actions. Student grades and clinical evaluations are confidential also.

Simulation scenarios should not be discussed with other classmates outside of the group assigned for a simulation. Sharing of information is CHEATING and violation of confidentiality. This is grounds for dismissal.

In observance of confidentiality, students who have family members or friends in the hospital MAY NOT review their charts or take them as patients. Family members who want to review documentation should follow the established hospital protocol. Students who violate confidentiality in this manner will be withdrawn from the VNP.

Students agree to protect confidentiality in the Student Contract at the end of this manual. A separate Confidentiality Agreement is required by some clinical affiliates prior to participating in clinical experiences at those facilities.

Contacting the Clinical Instructor

Instructors often rotate between floors for student instruction. The clinical instructor is the student's BEST clinical resource and should be contacted by the student ANY TIME the student has a clinical question or concern. Should the instructor be on another floor, the student should do the following to contact the instructor:

1. Obtain instructor's contact number from the clinical schedule.
2. Using a phone at the nurse's station (auxiliary stations do not have an outside return number), dial the instructor contact number.
3. The instructor may be with another student or assisting another student with a procedure; please leave a brief but detailed message and your contact number. The instructor will call you back as soon as possible.
4. **STAY BY THE PHONE!!!** If you must leave, be sure that you have a classmate that can wait for your return call; the staff are not responsible for making sure your message is delivered.
6. If you don't receive a return phone call within 10 minutes, please call again. The instructor may be supervising a procedure and may not be able to call right away.

When Students Should Contact the Clinical Instructor:

The clinical instructor should be contacted:

1. When there is a personnel issue on the clinical unit.
2. When there is a patient care issue on the clinical unit.
3. Any time a patient refuses an essential element of care, such as a bed bath or assessment.
4. When there is any patient or student-related incident.
5. For all sterile procedures.

Dress Code for Clinical Experiences

Looking professional is an obligation a nurse has for the patient; a well-groomed nurse inspires confidence to patients and staff. Students are expected to follow the clinical dress code ANY time students are in clinical uniform for any clinical situation.

1. Uniform:
   a. Teal scrub top, black pant or knee-length, A-line skirt. All tops must have "SPC" embroidered logo and Vocational Nursing Student patch on the left upper sleeve.

b. Must have appropriate underwear with the uniform. Bras and underpants are required for females. Underpants are required for males. White socks or white hose are required. Underwear may NOT have writing on them that shows through the scrub top/bottom. Women wearing skirts must wear a slip and white hose. Bras should be skin colored and should not be visible through the neck of the clinical uniform.

c. The uniform must be clean and pressed (ironed). Wrinkled uniforms look unprofessional and may result in the student being sent home as absent. To avoid ironing, remove uniforms immediately from the dryer and hang the uniform up. There are commercial sprays you can use to help remove wrinkles as well.

d. The uniform must be worn to the hospital or other health care facility each clinical day, even during specialty rotations. This rule also applies to any special events such as honor lunches or breakfasts. If a student is at a rotation where street clothes are allowed, such as day care, the student MUST dress in the clinical uniform when participating in ANY school event.

e. A closed-toe, closed-heel *mostly* white or black (leather or other material that is fluid and puncture resistant athletic) shoe should be worn in ALL clinical settings, including day care. Shoestrings must match the shoe color and be clean. Shoes should be cleaned/polished regularly. Crocs and clogs or any other plastic shoes are unsafe and unacceptable.

f. A teal jacket may be worn (optional). If worn, it must have the "SPC" embroidered logo and Vocational Nursing Student patch on the left upper sleeve. It must be clean and pressed <u>DAILY</u>. Cold-natured students should purchase this item. Other jackets and coats—even during lunch—may not be worn with the student uniform. (Be advised that there is limited space to hang coats/jackets during the winter months. Expensive coats should not be worn to the hospital where they could be stolen)

g. A teal or black t-shirt may be worn under the scrub top for warmth. Teal or black are the only acceptable colors. A t-shirt, if worn, must be cleaned daily and must have no writing that shows through the scrub top. T-shirts must be tucked in and Not hanging out under the uniform

h. IF a uniform is too little (as purchased) or IF it becomes too small so that it rides up over the buttocks, the student is sent home "absent" and cannot return to the clinical setting until a new uniform that fits correctly is purchased.

2. Sweaters <u>must not</u> be worn with the uniform.
3. No jewelry may be worn when in uniform other than a watch with a second hand {SMART watches are prohibited} and one flat WEDDING BAND without stones. Stones in rings may be damaged or may injure a patient. No body areas may be jeweled, including earrings, and tongue, nose, eyebrow, or chin studs. Plastic spacers may be worn if they are clear and flush with the skin. *Jewelry policy applies Even if they are covered when wearing a mask.
4. No pins or other decorations may be worn on the uniform, except those approved by the faculty.
5. Tattoos:
    - Facial tattoos must not be visible. If a student has a facial tattoo, love bites; it must be covered with dermablend or another brand of tattoo concealer.
    - Tattoos on the upper extremities down to the wrist must be covered with clothing (Scrub undershirt in Teal or Black) or bandages.
    - Tattoos in other areas may be left uncovered (hands, wrist, neck, chest, behind the ears) unless the words or images convey profanity, violence, discrimination, sexually explicit content or anything deemed offensive by fellow students, instructors, faculty, patients, patient family or hospital staff.
6. Hair must be kept clean, washed frequently, neatly arranged, and professional in appearance.
    a. Extreme coiffures (bushy, mohawks, extreme shavings, pompadours or other hairstyles determined by faculty as extreme) are inappropriate with the uniform. Extreme hair colors (blue, pink, bright orange, purple, green, gold, silver, maroon, bright yellow or glitter, or those that call attention to self) are not allowed. **A student should be known for good nursing skill rather than hairstyle!**
    b. Long hair must be worn in a neat and confined bun (NO MESSY BUNS). Swinging ponytails are not allowed. Long hair extensions must also be worn in a bun.

c. No loose bangs, tendrils and/or wings or braids are permitted. If hair falls forward when bending over, it must be secured away from the face and shoulders. A thin headband the same color as student hair may be worn. Long bangs should be pinned back.
d. Decorative items such as ribbons, flowers, combs, barrettes, headbands, bandanas, head scarves, head-dress of any kind, beads, feathers, or "fad" items etc. must not be worn in the hair while in uniform. *Plain claw hair clamps may be worn by students to hold long hair back. These claw hair clips can only be in the following colors: black, brown, teal, or the student's own natural hair color.*
e. Head scarves/coverings or Hijabs worn for religious purposes must be black or teal and may not have adornments on them.
f. Ponytail holders must be black, brown, teal, or the student's own natural hair color.
g. Sideburns, beards and mustaches must be neatly trimmed and/or according to hospital policy.
h. The above guidelines and specific clinical affiliate grooming policies will be adhered to during the time the student is in uniform, including touring off-campus facilities.

6. Nail polish (even clear) may NOT be worn with the uniform because polish of any kind can harbor infectious microorganisms.
   a. Fingernails must be clean and well-shaped.
   b. Fingernails must be kept filed to the edges of the fingers to eliminate the danger of scratching or injuring the patient or self.
   c. NO artificial/sculptured nails may be worn.
7. Scented body powder, cologne, toilet water, aftershave lotion, perfume and hairspray may not be worn while on duty. Even pleasant scents can cause vomiting for a nauseous patient.
8. Personal and oral hygiene are a must for the nurse. Deodorant and antiperspirant must be used daily and must be sufficient to control personal body odors. Teeth should be brushed. No bejeweled teeth. Daily bathing is a must. Certain foods, such as garlic, curry, etc. may cause the body to have a peculiar odor and consumption of these foods may require more frequent bathing and washing of the uniform. Please be cautious when consuming these foods.
9. Make-up should be minimal and natural in appearance (no glitter, bright colors). No false eyelashes are allowed.
10. NO chewing gum is allowed. Breath mints may be consumed after meals and smoking.
11. No tobacco products are allowed on person during the clinical setting. Smoking is allowed only in designated areas for staff (not visitor smoking areas). There are no smoking areas at UMC.
12. The student badge must be visible above the waist at all times. No decorative badge holders other than the "SPC" badge holder may be worn. The ID badge must be worn at all times when in a clinical rotation**; <u>students without their badges are sent home, accruing absences.</u>** The PICTURE must always be visible.
13. The student badge and/or clinical uniform signifies that a student is a nurse or a student at SPC and must be worn with critical thought when the student is out in public. Sports bars, pubs or any place where the behavior could be questioned are inappropriate places to wear the student uniform for the following reasons:
    a. Once identified as a nurse or nursing student, the individual becomes *obligated* to provide emergency care at that location should it be necessary. The student is held *legally liable* for all care rendered during this situation. <u>Additionally, a student who has imbibed alcohol, even only one drink, could be charged with practicing nursing while under the influence. Drinking alcohol when in uniform is grounds for immediate termination.</u>
    b. The SPC VN logo is a professional standard and the public expectations of nurses is in conflict with the expectation of a person at a bar, even if the student is not partaking of alcohol beverages (guilt by association.) This situation can render the student susceptible to complaint and public humiliation.

c. Students who wear SPC insignia inappropriately or in a compromising situation (i.e. drinking alcohol) are dismissed from the VNP.

CLINICAL PREPARATION

Each student is expected to prepare for clinical practice in such a way that makes the student a safe, effective care giver. Not understanding the disease process and the expected care is equal to unsafe nursing practice. Preparing for clinical practice is a DUTY of the student vocational nurse and leads to SAFE NURSING PRACTICE. The student is required to

prepare for clinical in such a way as to understand the medical diagnoses and medications, the implications of labs and diagnostics, the potential complications and how to prevent them, and the required nursing care. **Adequate preparation is a must**. The student should plan on a *minimum* of two hours of prep time per day for each clinical experience

Prepare" is the **intentional** effort on our part—to fix, establish and set. This means that the student must intentional spend time and effort to fix, establish and "set" in the student mind the disease processes of the patient and the care required. The student will be expected to demonstrate this understanding through the care of the patient, as well as discuss this understanding with the instructor.

Medical Surgical Unit Requirements:

1. Utilize Computer Checklist.
2. Upon arriving to the Unit, allow charge nurse to assign TPCN. Provide note to TPCN, choose patients (2-3} patients)
3. First day of clinicals: **After *assessment and AM care is completed and documented***, the student may access the patient's medical record for approximately **30 minutes** to gather information. This information should include
    a. Patient's medical and surgical history
    b. Current diagnoses
    c. Medications
    d. Labs and Diagnostics
4. Prior to leaving for the day, the student may verify with the instructor what information is important for research. **NO RESEARCH IS TO BE DONE ON THE UNIT!**
5. After clinical clock-out, the student should begin the preparation process so that there is enough time to research and organize the student's prepared work.
6. The student should organize the information and be ready to present the information to the instructor. If this patient(s) has been dismissed, the student may still discuss the current information.

Research Requirements:

1. For each patient, the student must complete the Note to Nurse, ISBAR, page 1 & 2 (assessment and narrative), flowsheet page 3, braden page 4. For primary patient also include Thin Thinking, Labs/rationales, and all medication (given to patient in last 72 hours), .
2. On the primary patient, the student must complete the medication sheet and lab list as well and gather information to complete the research and Thin Thinking Template.
3. The student will demonstrate understanding of the patient's diagnosis(es) through knowledgeable discussion of the diagnosis, risk factors, s/s, treatments, nursing interventions and rationales, and patient teaching.
    a. In addition to the chart pack and thin thinking template, the student may add written information in any form the student chooses, i.e., diagnosis sheets or diagnosis cards
    b. Students are encouraged to have this information written so that when the student becomes nervous, there is a reference for the student to use during discussion; however, a written pathophysiology form is not required *if* the student can discuss the information in a logical, organized, reasonable manner.
    c. Students unable to discuss this information will receive a clinical deduction and may be instructed to have written information on subsequent clinical experiences.
4. The student will demonstrate understanding of the patient's medications through knowledgeable discussion of the medication, its action, its indication, the dosage and times of administration, possible side effects/adverse reactions, and applicable nursing indicators and patient teaching.
    a. The Medication List is to be thoroughly completed for the primary patient. There is a deduction for any incomplete Med List
    b. Students unable to discuss the medications will receive a clinical deduction and may be instructed to write additional information on medications.
    c. For students with poor discussion of medications or for incomplete med list, med administration may be forfeited, with additional point deductions.
5. The student will demonstrate an understanding of the patient's laboratory status through discussion of the lab, the normal values, the abnormal values, and the indicators of the lab values.

a. The Lab Sheet is to be completed for the primary patient.
b. Students who are unable to discuss the laboratory values will receive a clinical deduction and may be instructed to do additional written work on labs.
c. There is a deduction for incomplete lab data.

THIN Thinking:

Utilize the Thin Thinking Template to demonstrate appropriate clinical judgment. Fill in each area as it applies to your patient. Your clinical instructor will determine which patient you use to complete the Thin Thinking template. It is possible that it will not be the same patient that you are administering medications to.

Thin Thinking is a "compass" used to assist the student in developing clinical judgement. Clinical Judgement is the "doing that happens with critical thinking—the decision-making, problem-solving aspect of nursing."

T—top three priority needs: what are the top 3 needs of this patient? What are the top 3 concepts of this patient, diagnosis, etc. What are the top 3 questions we should ask (about this patient, about this disease, about this med, about this lab?) Are these problems chronic? Stable? Or are they acute? Unstable?

This step helps identify what information is relevant/irrelevant? What information is most important? What information is of immediate concern?

Choosing the top 3 is helping to analyze cues. What conditions are consistent with the cues? Are there inconsistencies? Why are these a concern?

H--Help quick! What can the nurse do RIGHT NOW? What is best for the patient right now? What do I as the nurse need to do immediately? Later? Eventually? This is the greatest area of "failure to rescue" and usually relates back to fundamentals of nursing. Interventions should be between 4 to 5.

This step addresses the highest priorities with appropriate nursing actions. How should the intervention be accomplished (performed, requested, administered, communicated, taught, documented, etc). Who should be involved in the action?

I--Identify greatest risk of safety for the patient—are there s/s showing that could indicate an increasing problem? Is there a medication that is indicating a problem or could be a problem? Are there family dynamics that could be a problem? Risk should have minimum of 4.

This step helps identify risks to the patient based on s/s, on age, location, medication, disease process—not just "fall risk".

N--Nursing Process/clinical judgement-do I have enough information to act? What do I need to assess? What do I need to implement—do? Who do I need to inform? Minimum of 4 assess/reassess, what you don't know and need to know.

This step compares the actual outcome to the desired outcome. What signs point to improving/declining/unchanged status? Were the interventions effective? What needs to be changed or continued? Is there something more effective that could be done?

See Blackboard for the Thin Thinking Rubric

- IF PATIENTS are dismissed prior to 2pm on Day 1, the student is expected to pick a new patient and begin the research process again.
- IF PATIENTS are dismissed after 3:15pm on Day 1, the student is expected to pick new patients upon arrival to the unit on Day 2 and complete an ISBAR, assessment, and flowsheet for the new patients on Day 2. The student must provide care during the clinical day but is not required to complete clinical research on the new patients that evening.

- IF PATIENTS are dismissed after 10am on Day 2, the student is expected to assist the TPCN and fellow classmates with patient care.

CHART PACK:

In all medical-surgical rotations, the student must complete individual research: the chart pack and Thin Thinking. The Chart Pack is the student's practice documentation and is considered a legal document (it may be subpoenaed for evidence); therefore, the Chart Pack should be treated with respect and completed up to the point the student relinquishes care of the patient.

The completed Chart Packs and research/thin thinking template should be turned in for REVIEW on Wednesdays by 0800 via Blackboard. Failure to turn in the chart pack with research and thin thinking by 0800 will result in a 25-point deduction from the clinical grade, with a 20-point deduction each day thereafter. Additional points may be taken from the clinical grade if work is incomplete (such as I&O not completed, no closing note, etc.)

Students should retain a photocopy or computer-accessible file of all assignments turned in. Always have a backup copy.

Assignments are not accepted by email. If the assignment is to be submitted via ATI or via Blackboard it is your responsibility, as the student, to make sure that you do not upload blank documents and that your document can be opened on a PC, because not all Mac files are able to convert. If you submit a blank document or a file that cannot be opened, it will not be accepted, unless informing instructor a minimum of two hours prior to deadline. If within this timeframe, instructor can clear the previous attempt and allow student to resubmit before the deadline, otherwise, the grade will be recorded as a zero

Instructions for Completing the Chart Pack

Documentation of patient care is an integral part of care and is a necessary skill for the student to develop. ***Student Nurse Documentation is one way that the student demonstrated clinical judgment/critical thinking***! It also has legal implications. The student must make every effort to provide thorough and effective documentation throughout the shift and must complete the documentation on the student work sheets.

Remember: ***Your chart pack is your form of patient documentation and is considered a LEGAL document; therefore, you should treat your Chart Pack as a legal document. ONLY black ink should be used to document and you must complete all documentation. All writing must be legible. You should store your papers in a secure place at home.***

1. Each patient should have the ISBAR completed because this is your communication tool. You use one (1) ISBAR for the patient for all dates of care. There is room in the "assessment" area to write in your report information or you may use the back of the page. [If you must get a new patient, you need a new ISBAR]. THE ISBAR MUST BE VALIDATED BY THE INSTRUCTOR.
    a. Write your name in the Introduction area.
    b. In the R area, you should identify immediate nursing concerns for this patient and you identify/start discharge planning. Both of these should have further documentation in your nursing narrative.
2. From Blackboard, print the "chart pack"; you will need a new chart pack each day for each patient.
3. Assessment Page 1: write your name, patient initials, room number and date of the assessment across the top. At the bottom of the page is a place to document the time of the assessment. This format is basically a CHECKLIST of important assessment areas. It is to help you remember what to assess and then to document the assessment. You should complete it at the bedside. KEEP IT NEAT! *Use Newborn assessment form if in NICU or FCU. See Blackboard.
    a. Go through each assessment area, placing a check mark (√) in all areas that apply to this patient and completing all blanks as necessary as you complete your patient assessment—**BE WARY OF THE TEMPTATION TO COPY FROM DAY-TO-DAY! This is unprofessional, illegal and unethical.**
    b. If your patient has diabetic checks (accudatas), be sure to get that information for breakfast) on your assessment page. If that check is covered by insulin, be sure and document that. YOU SHOULD ALWAYS

KNOW YOUR PATIENT'S LATEST BLOOD SUGAR (diabetic patients). Also, be sure to inspect the diabetic patient's feet

c. Be sure that you document your initial safety check on the checklist. You will also document this in your FLOW SHEET, but this is your FIRST check.
d. Under skin, describe the color—using descriptive terms but not "NORMAL FOR RACE" or a similar statement. Actually, describe the color.
    i. The Braden scale should be done on each patient, using your scale to make that determination. Write in the Braden Score on Page 1.
e. Be sure under "musculoskeletal" that you appropriately mark the pulses on the stick figure.
f. If something does not apply to your patient, leave it blank
g. Some areas indicate that they must be described in the narrative.
h. ANY unusual finding should be marked with an asterisk* and then detailed in the narrative. This is a patient problem.

4. Assessment Page 2: Write your name, patient initials, room number and date across the top. There is a Narrative charting checklist provided for you at the top of the page to remind you of what you should include. This is the NARRATIVE NOTE. "Narrative" means story—this is the story of the patient that you will write for the day. You must write in BLACK ink and your writing MUST BE LEGIBLE! Please note the following basic rules:
    a. This is considered "legal"—your records could be subpoenaed, so remember that when you document! ONLY factual information should be put in the patient's record.
    b. Writing must be clear. Correct spelling and punctuation are essential! Misspelled words could be used to indicate poor nursing care!
    c. This story is about THE PATIENT. Therefore, the *subject understood* of each sentence is "the patient" unless you change the subject. You do not need to write "the patient" every time—it is acceptable to start the sentence with the verb, realizing that "the patient" could be placed in front of the verb.
        i. You must be cautious with this—if you fail to change the subject of the sentence, it could be read and interpreted as if the patient was doing his/her own care. For example, if you write "gave bed bath", it legally reads "the patient gave bed bath"—as if the patient gave his own bed bath. To write this, you would change the subject to "bed bath" and then you would write "bed bath given." Now, it clearly reads that you were the one giving the bed bath.
        ii. Because this story is about the patient, you NEVER use personal pronouns in your narrative "I" "me" "we" . . . it is NOT about you. It is about the patient, the care given to the patient, and the patient's response to that care!
        iii. If you document care given by others, use their name and credential as much as possible so that it is clear who the care giver was. "TPCN" may be easy for you to write, but is unclear in the documentation.
    d. NEVER cross out, white out, erase or use any other method to remove an error. If there is an error made in the charting, use ONE line to cross through the error, and place your initials above that line [follow this same rule for all papers written in the VNP]. Any attempt to obliterate documentation indicates that something is being hidden. Do not write the word "error" anywhere on the chart—this could be used against you in a court of law, indicating nursing errors.
    e. If you forget to document something that you did at an earlier time, write in the current time that you remembered, and then in the narrative write "Late entry for _____ (the time you took action), then complete the documentation. *Eventually as a licensed nurse, you will document on a computer which automatically times each entry—therefore, it is important that you correctly learn to write a late entry.*
    f. Your student paperwork is CONFIDENTIAL. Always be aware of where you leave your papers. For all of your student paperwork, please only identify your patient by initials. Do not leave your papers out where anyone can read them.
    g. Be FACTUAL—only document what you observe or do or what the patient tells you, using direct quotes if necessary. Do not make a judgmental statement, but instead describe the behavior. For example, do

not write “patient is angry.” Instead describe the behavior “yelling, cursing, and throwing urinal at staff” is more specific and allows the reader to determine the patient’s state of mind. You could even quote the patient’s yells or curses to give a more accurate picture of the patient.

h. Use only APPROVED abbreviations. The national trend is to use fewer and fewer abbreviations so that there is clarity in the documentation.
i. The left column is the Time column. Please write—in military time—each time you are noting the care given. In the right column, is where you write your notes.
j. NEVER leave blank spaces in the narrative chart. Always draw a single line through any empty space to prevent subsequent entries from being made in your documentation by another person.
k. To begin your documentation, “open” your chart.
    i. The OPENING statement should include the following:
        1. report was received
        2. care was assumed
        3. of the patient by sex and age
        4. the diagnosis and the physician—this shows that you are taking care of the patient and that you know who the patient is and why they are there.
    ii. The next statement should be how you found the patient when you first went into the patient room. Is the patient (in bed? What position was the patient in? Was the patient breathing? Is the patient safe?)
        1. *Position:* chickens “lay” and people “lie” [lying]—patients in bed are in a position: supine, prone, left lateral, right lateral, High-fowler’s etc. Do not say “the patient was laying in bed” or “lying in bed”!
        2. *Breathing:* the patient should be breathing! You need to note that you saw that their respirations were present, regular, etc.
            a. You cannot say the patient is “sleeping”—how do you know they are sleeping? The only way to know for sure is if you wake the patient up.
            b. Their eyes may be closed. This is what you observe. This is why you document their breathing.
        3. Describe what safety features are present.
    iii. Other items that must be described:
        1. Pain—rating on a scale, location, intensity, duration
            a. What is done about the pain
            b. Follow-up—did whatever was done about the pain, change the pain?
        2. Wounds—must be described, including location, dressings, care, etc.
        3. IV/INT: the IV/INT site, dressing, condition should be described. If it is an IV, the solution, rate, amount should also be described—this is for primary solutions, not IVPBs. You must know the difference.
    iv. Asterisk items from assessment page must also be described in narrative and what was done about those items.
    v. Any unusual assessments or specific nursing actions should be addressed in the narrative. The narrative should show that care was given to the patient and that the patient needs were addressed. If the patient doesn’t need nursing care, why are they still here?
    vi. IF A PATIENT ***REFUSES*** any care, it must be documented
        1. The REFUSAL must also be reported to the TPCN and the instructor WHO WILL VERIFY THE REFUSAL. Document your reporting the refusal in the chart: *“Refused bath; refusal reported to TPCN Cindy and Instructor Backus.”*
    vii. If the patient leaves the unit for any reason, the reason should be documented, how they left and with whom they left with. Their time of returning to the unit should also be documented, along with a quick assessment to make sure the patient is okay. *“To x-ray via w/c accompanied*

by transportation assistant. Returned to room, assist to bed; resp even and reg. denies needs at this time."

viii. Who is with the patient? Do they have needs? Questions?

ix. Discharge Planning: discharge planning begins on admission; what needs are identified? How can those needs be met? What resources might the patient need?

x. Ambulation: how far did they walk? Did they use equipment? How many nurses had to assist? What type of assistance? What therapy? "*Ambulate 20 feet to nurses station and back. Up to chair, call light within reach, overbed table at chairside."*

xi. "Close" the chart at the end of the shift. The closing statement should indicate that report about the patient was given to another nurse and that care for that patient was relinquished to the nurse. The narrative must be signed by your LEGAL signature, your first initial, last name, nursing credential "SVN SPC-R". The signature must be legible.

5. Page 3: FLOW SHEET—This is your every 2-hour documentation!
    a. ALL **bold face** items must be documented every 2 hours throughout the shift:
        i. Pt position: what position is the patient in: B (back), R (right side) L (left side) P (prone), is the patient independent in turning = I. If the patient gets up to the chair = U; if the patient dangles on the bedside, "D." Write in the appropriate letter every 2 hours. If there is something that happens and is not here, write this in the narrative.
        ii. Check armband and allergy band every 2 hours and initial. If there is a change or a loss, write this in the narrative.
        iii. What position is the bed in? Use the arrows to indicate this. If something unusual happens with the bed, write this in the narrative.
        iv. Where is the call light? Initial that you have checked its availability every two hours. If something happens unusual, write it in the narrative.
        v. Are the bed brakes locked? Initial every two hours that you know the brakes are locked. If something unusual happens, write it in the narrative.
        vi. Are the siderails up at the head of the bed? Initial that you have checked every two hours. If there is something unusual happening or if the lower rails are also raised, write this in the narrative, explaining why the lower rails are raised. You would also need to narrate more information about assisting the patient out of bed or other safety measures if the lower rails are up.
        vii. The IV/INT site should be inspected at least every 2 hours and you should note if it is Clean (C), Dry (D) and intact (I). You should write CDI at each time it is checked. If the IV infiltrates or other problems develop, those should be noted in the narrative. If the IV is DC'd or restarted, it should be documented in the narrative.
        viii. Oxygen therapy should be noted via the device (write in the blank) and the Liters completed. Initial each time it is checked. If the Oxygen is DC'd or changed, it should be noted in the narrative. You should also note how the change in order has affected the patient's respiratory function.
        ix. Initial every time the Incentive Spirometer (IS) is used by the patient. If the patient is not using IS, leave this area blank. If the patient is having respiratory issues, you should evaluate the need for IS.
        x. Initial every time you have the patient TCDB. If the patient's care does not require TCDB, leave this blank. If the patient is having respiratory issues or has had any anesthesia, or if the patient is having respiratory issues, nurses should automatically introduce TCDB to the patient.
        xi. Is there family present? Indicate the number of family members present by writing in the number. Specific family questions, requests, or problems should be documented in the narrative.

xii. Is toileting offered? This is especially important for patient with mobility or voiding problems and should be offered. Note the offer with your initials. If there are issues with toileting, these should be described in the narrative. If the patient is independent in toileting, leave this area blank.

b. Routine AM Care:
   i. Write in the type of bath the patient takes. Initial when this occurs. If the patient refuses a bath, this should be (1) reported to TPCN, (2) reported to instructor, and (3) documented in the narrative with the explanation of why the bath is refused.
   ii. Initial the time when the following are done: oral care, skin care, peri care, Foley care, linen change, ROM exercises and when TED/AE or PP are on. If the patient is independent in these activities or if the patient does not have a Foley, TED/AE or PP, leave those blank. If the dependent patient refuses an area of care, this should be documented in the narrative.

c. INTAKE and OUTPUT:
   i. INTAKE: Record all of the patient's intake for the day. Be sure that you note the difference between an IV solution and IVPBs! At 2 p.m. (1400), you should total all of the day's intake in each category, then add them all together for the grand total intake. You should be concerned if the patient has NO intake all day**! In addition to getting a total and documenting it, you should report the intake to your TPCN when you relinquish care**.
   ii. OUTPUT: write in output in each category for the time throughout the day. ***An output that is less than 30 mL an hour MUST BE IMMMEDIATELY reported to the TPCN/CN! This is an emergency***. You should be concerned if there is no output! At the end of the day, total each category, then total all categories for the grand total. **In addition to documenting the output, you should report the output to the TPCN when you relinquish care.**

d. Vital Signs—record the vital signs and the time. If frequent VS are required (like a post-op patient), there is space to write them. ***Any abnormal VS should be discussed in the narrative, along with what was done about the abnormality. As a reminder to you, if there are extremes, there are reminders that these need to be reported IMMEDIATELY***. IF the patient has a high temperature, you must check the WBCs and document them.

e. Glasgow Score should be completed on all neuro patients or on patients that have an order for neuro checks. *Routine med-surg patients usually do not need this*.

f. Nutrition: Write in the diet ordered, then record the percentage consumed of each meal. If the patient has a snack during the day, this should be documented in the narrative. If the patient is refusing to eat, (1) report and (2) document this in the narrative. Also write in the narrative what else was offered to the patient in the way of nutrition.

g. For diabetic patients, record the AC lunch accudatas and amount of insulin given is appropriate. You should always be aware of your patient's blood sugar. If there is an unusual occurrence, document this in the narrative.

h. INCISIONS, WOUNDS, Pressure ULCERS: for each wound, please write in the location (i.e. midline abd), the type of wound (i.e. surgical, pressure) a brief description and the dressing type—can use OTA if the wound is open to air. If there are more than 4 wounds or if there is great drainage or dehiscence, etc., then describe this in the narrative as well as the care given.

LEVEL 2 AND LEVEL 3:

6. Medication Form: **AFTER** you have completed your assessment and a.m. care, go the patient's medical record and list your medications on this form. You should include the dose, the route, the frequency, and the times the medication is to be administered.
   a. MONDAY NIGHT RESEARCH:
      i. Write in both the GENERIC and TRADE name of the medication
      ii. Therapeutic Class and Drug Class: find this in the drug book: *classification* of each

medication

iii. How it works: Look at *Action* in the drug book.
iv. Why is YOUR pt taking it? Write the *indication* for THIS patient— "My patient is taking this because. . ." Many times, the patient takes a medication for a different reason than that of its classification. An example is Aspirin. Aspirin is classified as an antipyretic or pain reliever. However, for an adult, 81 mg or 325 mg dose will not do either of those things. In this case, the patient is taking this as an antiplatelet/anticoagulant, NOT for fever. KNOW THE REASON!
v. Why is this med usually given: Look at *indications* in the drug book.
vi. Pt Dose: Write in the ordered dose (noting if this is a correct dose when you research) and the route; Also complete the Normal Dose Range
vii. Pt. Route: PO, IM, IV, etc.; Also Possible Routes
viii. Times: Write in the frequency of the medication AND the time— "daily" is not a time— not all meds ordered daily are at 0900, so you must write in the time the medication is to be administered.
ix. Side Effects: Identify 3 major *side effects* or adverse reactions (if you write a comprehensive term like *Steven Johnson Syndrome* you better be able to explain what that is [hint: write it on a stickie note])
x. Nursing considerations: Identify 3 (can include labs, VS needed prior to administering this medication (Look at Nursing Implications and Implementation in Drug Book)
xi. Patient Teaching: 3 things to teach your patient about this med.
xii. Citation: Correctly site the drug book with page number.
xiii. Write therapeutic level, antidote, max dose in 24hrs as applicable. Onset and Peak for all insulin

b. Review your medications and think about the relationship to the diagnosis, the expected effect of the medication and how each works in the body so that you can effectively discuss these on Tuesday with your instructor.

7. LAB DATA: **AFTER** you have completed your a.m. care, go to the patient's medical record and pull up lab and diagnostic information. You should write in all labs <u>from the date of admission,</u> then current labs for dates of care. **PLEASE NOTE: agency values may be slightly different based on each agency's equipment. If the agency calls something "abnormal" and its value is a little different, please go with the agency determination**
    a. ROUTINE LABS: There are some labs that almost all patients have and these are listed on the lab sheet, along with "normal" adult values as found in Van Leeuwen & Bladh, 2019. Highlight in YELLOW all abnormal labs for this patient.
    b. RESEARCH: Monday night (and then note any changes on Tuesday night), research why the patient's values are abnormal—you are looking for Rationales/REASONS, not diagnoses. Use Laboratory Diagnostic test handbook, Nurse Pocket guide to help with these rationales.
    c. PATIENT SPECIFIC LABS: there are blank spaces in the lab form you to use to write labs that are specific to this patient. There is a suggestion box to use to help you think about what to look for. There is also a table in the back of your lab manual that has labs listed by diagnoses that you can use to help you. THIS AREA SHOWS YOUR CRITICAL THINKING when you determine that the lab is important to your patient and write it down or when you determine a lab is needed and request it to be ordered! Students who either cannot recognize important labs and have them written or who want to skip this will find deductions taken from the clinical evaluation!
        i. Patient specific labs that are abnormal should also be highlighted in YELLOW
        ii. Patient specific labs should also be researched to determine why it is abnormal
    d. Students are expected to discuss all labs as part of the student discussion with instructors.

8. Look at diagnostic studies (x-rays, etc.). Write in the dates they were ordered, and the "impression" from the radiologist under patient results. Determine why you think these were ordered.

Clinic Required Research

To prepare for the Outpatient Clinics:

General rules:

1. Each clinic has specific requirements of preparation that the student MUST do PRIOR to the rotation. Please see the table below.
2. Each clinic will require the following daily, both of which should be turned in to the clinical instructor by 0800 Wednesdays
    a. Clinic Note
    b. Med Log (if no meds are administered, please write "No meds administered" and submit)
    c. Med Sheet from chart pack completely filled out for that clinic
    d. Diagnosis Sheets as indicated by the clinic objectives
    e. Completed time sheet
3. Each student will submit a signed time sheet for the clinic rotation turned to the clinical instructor.
4. Additional clinical deductions will be taken for failure to turn the above documents in completed and on time.
5. Students who get placed on probation will forfeit all further clinic rotations so that greater instructor supervision is available to assist the probated student
6. Students at the clinics must follow all SPC guidelines.
7. The Clinic Notes and Medication Log are posted on Blackboard

Students in the clinics work with all staff including nurses and physicians in providing outpatient care. Students should anticipate that they will assist staff with calling patients back, taking vital signs, completing focused assessments, assisting with procedures, as well as assisting with all phases of nursing care.

Assignment for each clinic: Complete the Clinic Notes posted on Black Board and follow those instructions.

Clinic	Required Research PRIOR to rotation
OB-GYN	Med sheets for Hormones, Immunizations, Antibiotics Childhood Diseases Diagnosis Sheets: Chickenpox, Measles, Mumps, Rubella, RSV,

Guidelines for Writing a Narrative Note in the Vocational Nursing Program

Although modern technology has done away with much of the written head-to-toe assessment in actual patient documentation, the ability to put such an assessment together with clarity and detail enhances a student vocational nurse's critical thinking about the patient assessment process.

The following guidelines are to be used in writing the narrative note.

General Writing Rules:

1. Write on one side of the Narrative Note only. If you need more than one sheet of paper, continue writing on a second sheet, not on the back.
2. Handwriting must be legible—if it cannot be read, it has no value.
3. Treat this work as a LEGAL document—this means that it could be used in a court of law. Your Chart Pack could be subpoenaed.

4. This writing is about the patient—the focus is the patient and how the patient is, what the patient needs, does, wants, etc. The nurse signature indicates that the nurse is the one providing the care unless the nurse indicates in the writing that someone else provided care, so the writing must be clear.
    a. If a sentence starts with a verb, then the subject *understood* is the patient.

    Example:

    Gave bed bath. Reported pain. *These legally read "The patient gave bed bath. The patient reported pain."*

    b. If the subject of the sentence is not the patient, then the subject should be clearly identified.

    Example:

    Bed bath given. (Bed Bath is the subject). Pain reported to TPCN. (Pain is the subject of that sentence).

    c. Personal pronouns, *I, we, me, you, us*, should not be used in the narrative assessment.
    d. What the student thinks, feels, does, is not important in this writing except to write what happens to the patient as a result of the care given.
5. The date and time must initiate the writing, flush left of the page.
    a. Each new entry should have the time
    b. Military time should be used; therefore, no colon should be used in between the hour and minutes.

    Example:

    Incorrect: 07:10 Report received, care assumed. . ..

    Correct: 0710 Report received, care assumed. . ..

    c. If a new page is started, re-write the date and time continued with that entry.
6. At the end of an entry, the student's first initial of the student's *legal* name and the full last name, along with the credential "SVN" must accompany the entry.
    a. If the entire note is written as one entry, only the last line must be signed.
    b. If the entry ends at the end of a page, sign off that entry on that page. Sign off the last entry on the new page.
7. If an entry ends midway through a line, <u>line out</u> the rest of the line to prevent someone else from coming after and writing in additional words.
8. If an error is made in writing, place one line through the error and write the student initials above the line, then continue with the writing. If there is not room to write the correction, place a line through the entire sentence and re-write the entire sentence.
    a. DO NOT blacken out the writing—this indicates something to hide
    b. DO NOT use white out—again, indicates something to hide
    c. DO NOT write over—besides being sloppy, this indicates something to hide
9. Punctuation must be used. Periods must end sentences, commas must separate clauses.
10. This is written in narrative style, meaning a story. Therefore, you do not write a section, colon and then describe. You write the whole section as a story.

    Example:

    Incorrect: Eyes: PERRLA. Ears: clear. Skin: warm and dry.

    Correct: PERRLA. Ears clear. Skin warm and dry.

11. Use only approved abbreviations in this writing. The ampersand "&" is **NOT** an approved abbreviation for "and."
12. Spelling is important. You must be able to spell words, especially common words!
    a. Most common errors include the use i" and "e" such as in receive.

    "I" before "e" except when it comes after "c" or when it sounds like "a" as in "neighbor" or "weigh."

    b. The patient has *bowel* sounds, not *bowl* sounds.

Specific Writing Criteria:

1. The documentation needs to be "opened" or started with the initial opening statement that tells (a) how the nurse took over care, (b) identifies who the patient is and why the patient is there, and (c) tells how the nurse first found the patient.
   Example:
   0700 Report received and care assumed of a 74-year-old male with diabetes, (L) BKA, weakness for Dr. Rabbit, supine in bed with eyes closed, respirations even and regular. *N. Nurse, SVN.*
   In this example, "report" and "care" are the subjects that start this sentence. The age is given to identify the patient as well as the diagnoses and physician. The patient was apparently sleeping, as indicated by stating that the eyes were closed and the respirations were even and regular (as opposed to dead with no respirations). The statement would have been incorrect to say "sleeping" because the only way to be sure the patient was asleep would be to wake the patient up.
2. The patient position should be clear. People "lie" and chickens "lay"—patients are in positions: supine, left or right lateral, Fowler's, prone, etc.
3. Complete Vital Signs should be written because they are "vital" to the patient.
4. Orientation should be specific—to say "x 3" is incorrect because there are many questions that could be asked to determine orientation.
   a. The correct word is "oriented." **Orient** as a verb means to "find direction" or "give direction." The noun form of this kind of orienting is **orientation.**
   b. Sometimes people in their speech will form an imagined verb from **orientation** and say **orientate** or make it a verb as **orientated.** At best, **orientate** is a back-formation used humorously to make the speaker sound pompous.
   c. The correct word is the verb **orient.**
   d. **Orientate** is more widely accepted in the U.K. than in the U.S.A., but <u>it should be avoided</u> in any formal or standard writing.
5. Describe what you see. Don't say "natural" or "normal" for skin color—unless you have seen the patient prior to the hospitalization, how do you know what is natural or normal?
6. Avoid using the word "normal"—who determines "normal"? Instead use the descriptive terms
   a. Lung sounds are clear, adventitious, wheezes, rhonchi, rales, congested
   b. Bowel sounds are present, normoactive, hypoactive, hyperactive, absent
   c. Skin is pink, brown, tan, pale, ruddy.
7. If the patient says something that is important to document, use quotation marks to show that that information came directly from the patient.
8. Don't assume—if you find the patient on the floor, describe it but don't assume the patient fell (they have been known to deliberately get on the floor). Don't assume there is a bruise because of an injection.
9. Intravenous (IV) access can be through a peripheral vein such as those found in the arms or legs, a subclavian vein or a jugular vein. In most instances on a med-surg floor, the access is peripherally, usually in the lower arms. IVs can be continuous, meaning that they usually have 500-1000 mL bag of solution running continuously throughout care, OR IV access can be *intermittent, meaning* that the vein has an IV port, but solutions do not run all the time—usually for about 30 minutes several times a day for medications, only. Documentation of the IV access must be clear. For a CONTINUOUS IV, termed as "IV," there should be documentation of the solution, the amount, the rate, the pump being used (or if it is by gravity), and the site of the IV access with the access site described as to location, condition and dressing. An intermittent access is termed "INT". For the INT, the site should be described as to location, condition and dressing. When either is DC'd, the description of the removal and of the site should be included, as well as the dressing applied and instructions given to the patient about the DC.
10. If there is an *abnormal* condition or assessment, describe it and include what nursing actions were taken, including who was notified about the abnormality. If the patient reports pain, don't just document the pain. You must also document who you reported the pain to and what was done about it. The documentation should also indicate that you verified pain relief. If there is abnormal skin turgor, you must also include who was informed

about it. If the IV infiltrates or develops phlebitis, you should document that it was DC'd (and by whom if it was not you), if it was restarted, and what was done about the injured vessel.

11. Describe wounds and/or dressings. Don't just say there is a wound present.
12. Decubitus prone areas—the back, the buttocks, the heels—should be specifically addressed.
13. If a Foley catheter is present, the size and type of catheter, amount and color or urine should be clearly indicated. If the Foley is connected to a Continuous Drainage Unit (CDU), that must be stated. The location of the CDU should be stated as well to show that the safety of the catheter was maintained.
14. Safety is a major issue in the hospital. All safety care should be noted in the documentation: ID bands, safety bands, allergy bands, restraint devices, side rails, call light, bed position, brakes, and any alarms. Sitters should be noted if they are part of the safety device. If family have been instructed to not leave the patient alone, family must be noted as part of the safety information.

Remember: the information that is documented must be RELEVANT to the patient care. Social conversations, TV shows, political/social views & opinions are ONLY relevant if they impact patient care! What YOU think, feel, believe, etc. is NOT relevant to this documentation.
Your documentation should reflect the focus of nursing care—what patient problems you are doing something about!

Organization and Specific information:

Organization of the material is important—it helps the nurse remember what all to assess as well as helps the reader understand the assessment. Be logical in your writing; try to cover all of the same body system together rather than jumping around.

SPECIFIC information:

1. The Head: includes mentation, orientation, communication, following instructions, eyes, ears, nose and throat, jugular vein distention, and swallowing.
2. The Chest: includes heart and lung sounds, apical pulse, respiratory effort, chest symmetry.
    a. Lung sounds include bilaterally anteriorly and posteriorly, laterally. The student can choose to do the posterior lung sounds when the patient is turned for the posterior assessment, but can still write them all together. In a "normal" patient, there are 5 lobes of the lungs (not 4 quadrants).
    b. The respiratory effort must also be noted as part of the assessment of the chest.
    c. While cardiologists and expert nurses assess all of the heart value sounds, our program only requires that you assess S1 and S2 and the apical pulse rate.
3. The abdomen: You should listen for bowel sounds in all quadrants—you do not use the word "four" and "quadrant" together because this is redundant. Bowel sounds are either normoactive, hypoactive, hyperactive or absent. You also assess the softness and condition of the abdomen. You want to know when the last bowel movement was and get a description.
4. Extremities: This includes the skin condition, the turgor, capillary refill of both upper and lower extremities, pulses bilaterally, Homan's sign bilaterally in lower extremities and/or strength test in lower extremities. The medical term for the lower legs is "lower extremities"—not calf or calves (that is laymen's terms).
5. Perineum: You may not always assess the peri area if the patient has no problems and is a legally consenting adult. You may just ask the patient if there are any problems and check on when the patient is voiding, color and how much. If there is a Foley catheter, you must assess the area. If there are any problems, you need to assess the area.
6. Back: Once the patient rolls over you can assess the back, buttocks and heels. You can listen for posterior lung sounds and note any problems in this area.

ASSIGNMENT POLICY—Clinicals

All assignments must be completed by the assigned due date and time. Late and/or incomplete work will not be accepted and a grade of zero will be recorded. Work submitted incorrectly will not be graded and a "0" recorded; the student must submit according to the instructions of the assignment.

It is the responsibility of the student to be informed of class progress and assignments and to come to clinical prepared to participate in patient care, to turn in any assignments due, and/or take the quiz or test scheduled for that day. Students will be required to write Care Plans and Case Studies as part of the clinical experience. Information about the assignments will be posted to Blackboard.

Plagiarism - Offering the work of another as one's own, without proper acknowledgment, is plagiarism. Any student who fails to give credit for quotations or essentially identical expression of material taken from books, encyclopedias, magazines, websites such as: blogs, journals, or articles, other referenced works, from themes, reports, and/or other writings of a fellow student, is guilty of plagiarism. If there is any suspicion of work completed by Artificial Intelligence (A.I.), the student and their work may be questioned, and if proven that A.I. was used will be considered guilty of plagiarism.

COMPUTER USAGE

Clinical Computer Usage: Computer systems at the clinical sites are for the purposes of clinical work. Students may only use the agency computer systems for accessing important patient data the student needs for safe and effective patient care. Students MAY NOT use the agency computer for personal usages such as checking emails (even SPC or instructor-sent emails are prohibited on agency computers), Black Board, websites (including drug or diagnoses websites) or other personal usage. **No "research" is to be done during the clinical period**. Students who engage in inappropriate computer usage will be placed on probation for the first offense and dismissed from the VNP for a subsequent offense. Refer to the Student Vocational Nurse Handbook. The student should not be on the computer if (1) each assessment is not completed, (2) each assessment is documented, and (3) a.m. care is completed for each patient. Students found on the facility computer will be asked for these records and deductions will be taken if they are not complete.

As computer technology in the field of health occupations continues to become more popular, computers may be used in this course for Case Studies and Care Plans if the student chooses to use them. All students have access to computers and printers on the South Plains College campus. All registered students are supplied with a working email account from South Plains College.

ALL STUDENTS ARE EXPECTED TO KNOW THEIR SPC STUDENT USER NAME AND PASSWORD.

Use of TikTok on any SPC device or while using SPC Wi-Fi is prohibited. TikTok may not be used for any assignment.

Computer Checklist

History and Physical

Go to Clinical Notes -> Hospital -> Physician -> History and Physical

- If History and Physical does not show up at this time, you may need to change your search dates.
- Right click on the Dates that are displayed and click change search criteria. Click on Admission to Current. This should make the history and physical accessible.

If you are still unable to find the history and physical, you need to call your instructor!

- Utilize the H&P to fill in your ISBAR with information you did not receive from your nurse or patient.
- Be sure to READ all the way to the bottom. You can skip over any lab and radiology results as you will be looking at that later under the Lab section.
- At the bottom of the H&P is the Impression and Plan. This is where Physicians write what they believe is going on and will write the plan for treatment.

The H&P is documented within 24hrs of admission so be aware that these diagnoses can change and more may be added. This is why you will be looking next at your Progress notes for changes that have occurred since admission.

Progress Notes

Clinical Notes -> Hospital -> Physician -> Progress Notes

- There is typically a progress note for every day of their stay during this admission. You should read at least the first and last progress note. If, when reading the progress note, you do not know how all of the sudden several diagnoses have changed or been added, you can skip back and read more of the progress notes.

- Again, you must read all the way to the bottom. At the bottom, you will find the Impression and Plan.

Use this information to fill in your ISBAR with current and past medical diagnoses. Also, fill in what is happening now. You can also see if they are planning discharge.

MAR

1. Get your White Medication Sheet from the chart pack.
2. Fill in the medication name, route, dose, frequency and times.

This is not the time to fill in classification, indication, side effects, and V/S needed- that is for research.

3. For Scheduled medications you will need to right click on the medication -> Order Info -> Additional Information. This should show you the times that the medication is scheduled. Be aware that if the med is BID- you are looking for 2 times, TID- 3 times, etc.…
4. You only need to fill in frequency for PRN medications, not times because they are not scheduled at set times.

Example of Scheduled vs. PRN:

Medication	Classification	Indication	Dose/route	Frequency/time	Side effects	v/s
Furosemide (Lasix)			20 mg PO	Daily 0900		
Acetaminophen (Tylenol)			500mg PO	Q4h PRN		

Orders

- Click on orders tab on left hand side of the screen.
- Be sure to note any wound care, Ted Hose, SCDs, Oxygen, IV fluids, Blood sugar monitoring, Diet, Fluid Restriction, Weight bearing restrictions, etc.…

Flowsheets (Labs, Radiology, Nursing Plan of Care)

Click on Flowsheets tab on left hand side of the screen. This will bring up a chart that looks similar to:

	Labs 48 hours	Lab	Radiology	Nursing plan of care
Complete blood count				
complete metabolic panel				
Point of Care				

- Skip over the 48-hour labs and Click on the tab labeled Lab. This will show you the most recent labs.
- You will need to look at your patient's admission date and get your lab sheet from your chart pack. Fill in the labs from the date of admission.
- Then look at the most current labs and fill those labs in on the next column. You need to write this information in black ink.
- DO NOT write in the normal values or draw your high or low arrows in blue or red at this time. This is for you to do at home as research.
- Be sure to look at the left-hand column (Complete Blood Count, Complete metabolic panel, etc.) You can toggle through the labs using this column.
- Make sure to note any Microbiology. This is where you will find cultures such as blood cultures, urine cultures, wound cultures.
- If your patient has accudatas, you will find them under Point of Care glucose.
- Next Click the Radiology Tab.
    - Get your Diagnostics paper from your chart pack and fill in any x-rays, MRI, US, results from the current admission

COMPUTER LAB USAGE

The computer lab(s) on any campus may be used by students during scheduled open hours or as assigned by an instructor. The computer lab is open to students. Printer paper will not be provided for students to print materials but students may seek assistance from faculty or staff to request lab paper from the college if needed. Lack of computer lab paper is not an excuse for not completing assignments. Waiting to print at the last minute and then not being able to do so is no excuse either. *Please remember that NO FOOD or DRINK is allowed in the computer lab.*

GRADING POLICY

Students must earn an overall grade of 76 or better in this course to pass this course, but have some specific grading criteria:

Final semester grades will be based on the following:

A. **Departmental Math Exam—**the student must pass the semester's departmental math exam by the third testing with an 80 or better on the exam. Students will not pass medications until this exam is passed. Students who do not achieve an 80 by the third testing fail the clinical course and are administratively withdrawn at that time, regardless of other grades.

B. **Weekly clinical evaluation**—students will receive a weekly clinical evaluation based on the student's individual clinical performance, research-paperwork, and preparedness to practice nursing. The weekly ratings are averaged together for the length of the course. The student must have a 76-performance average in order to complete the course, and if not, fails the clinical course, regardless of other clinical grades.

C. **Written Work:** students should strive for a grade greater than a 76 average on all required written work. ALL work must be turned in complete by the deadline according to the schedule. If work is not turned in, The grade is a "0"; however, the work must still be completed and turned in in order for the student to exit this course. Students who do not turn in an assignment will fail the clinical course, regardless of other grades. This includes, but is not limited to, Thin Thinking assignments/activities, ATI, pathos, care plans, clinical care maps, case studies, worksheets, etc. as assigned.

D. **Skills Checklist and Performance of at least one sterile skill:** Students must continue to complete the skills checklist and must score 80% on the checklist or above. At least one of the sterile skills (Foley catheter or sterile dressing) must be completed this semester.

E. **CPR and Immunizations—**CPR and immunizations must be kept current. If CPR expires or if an immunization booster/update is required, the student may not attend clinicals, accruing absences. Should this put the student over the allowable absences, the student will fail the clinical course, regardless of other grades. If the student misses one day due to an expired CPR or immunization, that student will have to make up that day in the clinical setting. IT IS THE RESPONSIBILITY OF THE STUDENT TO MAINTAIN CPR AND IMMUNZATIONS.

F. **Summative Evaluation—**at the end of the semester, the student will have a summative evaluation that states if the student met all expectations of the clinical experience. The student must have completed all assignments, remediation, clinical experiences and make up days in order to have a successful summary.

GRADING SCALE:

90-100 = A
80-89 = B
76-79 = C
. 70-75 = D
<70 = F

Please note: clinical grades are reported as whole numbers; decimals are dropped and are not rounded up.

GRADE BREAKDOWN

Weekly Clinical Evaluations/Paperwork: 90%
Quizzes and other written assignments: 10%

COMMUNICATION POLICY

Electronic communication between instructor and students in this course will utilize the South Plains College Blackboard and email systems. The instructor will not initiate communication using private email accounts. Students are encouraged to check SPC email on a regular basis. Students will also have access to assignments, web-links, handouts, and other vital material which will be delivered via Blackboard. Any student having difficulty accessing the Blackboard or their email should immediately contact the help

Email Policy:

A. Students are expected to read and, if needed, respond in a timely manner to college e-mails. It is suggested that students check college e-mail daily to avoid missing time-sensitive or important college messages. Students may forward college e-mails to alternate e-mail addresses; however, SPC will not be held responsible for e-mails forwarded to alternate addresses.

B. A student's failure to receive or read official communications sent to the student's assigned e-mail address in a timely manner does not absolve the student from knowing and complying with the content of the official communication.

C. The official college e-mail address assigned to students can be revoked if it is determined the student is utilizing it inappropriately. College e-mail must not be used to send offensive or disruptive messages nor to display messages that violate state or federal law

D. Instructors make every attempt to respond to student emails *during regular college business hours* when faculty are on campus. Instructors *are not* required to answer emails after hours or on weekends.

E. Students who use email inappropriately to faculty, students, staff or others will be placed on probation for the first offense; dismissed from the program for a second offense.

F. When contact faculty via email, please use the SPC email and NOT the message system on Blackboard.

Texting Faculty: Students should not text faculty via the faculty cell phone. Written communication should be by email, office phone, or personal notes. The faculty cell phone is for contact during the clinical hours ONLY and should not be used outside the clinical experience. Students who text faculty will be placed on probation for the first offense and dismissed from the program for the second offense.

Incidents/Investigative Reports/Generic Screens; for our purposes, the words Incident Report will be used.

An Incident Report shall be completed for the following:

a. All injuries that occur to a student during clinical experience.
b. Any patient occurrence.

In the event of unusual occurrences involving students, employees of the clinical facility, patients and/or visitors, the following procedure should be followed:

a. Notify the program coordinator or instructor.
b. Notify nurse in charge of the clinical area where the incident occurred.
c. Complete the clinical form with the assistance of an instructor and/or TPCN.
d. Complete the SPC incident report form documenting the event for SPC records.

1. An unusual occurrence includes but is not limited to incidents such as medication error, patient injury witnessed by a student, and student injury.
2. Students who become ill or get injured should contact the instructor immediately.
3. Students who choose to use the facility's emergency services will be required to pay for Emergency Room services and then file with SPC insurance and/or their own insurance carrier.
3. Students who are injured to the extent that they cannot meet clinical objectives must withdraw from the VNP and apply for readmission once the injury has healed and the student can meet the objectives.
4. Student Exposure Incidents: Should a student of the VNP at Reese have an exposure to blood or body fluids through needle stick or other means, the student should do the following:

a. Wash wound with warm, soapy water immediately. If splash is to eyes, the eyes should be rinsed with clear water or normal saline. Every area has an eyewash station, and the SVN is responsible for knowing where these are located.
b. Notify the instructor as soon as possible.
c. Call the facility's Employee Health department and give the following information. (The instructor should assist with this phone call.)
    1) name, room number and medical record number of sources of exposure
    2) physician's name
    3) state "I have had an exposure through…."
    4) phone number of students

5. Student Vocational Nurses DO NOT report to the facility's employee health (we are not employees).

Laboratory Experiences

All lab rules apply (dress code, hair, hails, etc.) The student is expected to be in uniform for the competency labs.

Proficiency Labs: Students must remain proficient in all nursing skills.

During the first weeks of Level II and before the end of Level III, all students may be required to pass a clinical skills competency lab in order to exit the clinical course to assure that all skills remain at the appropriate proficiency level.

Leaving the Clinical Unit

To avoid the charge/appearance of patient abandonment, students leaving the clinical setting will follow the rules of good conduct expected of Vocational Nurses:

If the student must leave the unit for any reason (including end of the shift), the student must:

1. Notify the nurse in charge or other designated licensed nurse and give report to the nurse.
2. Contact the Vocational Nursing instructor when it is necessary to leave the hospital before the assigned hour to leave.
3. Not visit patients (this includes relatives) or other students on other units while in clinical practice. *Students who visit friends/relatives <u>after</u> clinical should be out of uniform.*
4. Students who leave the floor without authorization and without reporting off appropriately will come under full disciplinary action which could include dismissal from the VNP.

Limitations for Students in the Clinical Setting (Do's and Don'ts List)

Students are expected to know and follow the Scope of Practice for LVNs as well as for SVNS and facility policies. There are some skills and procedures that are dictated by facilities as to who can perform them and under what circumstances. Students will be able to perform additional skills in this level and in Level 3.

Vocational Nursing Students **<u>CANNOT</u>** perform the following procedures:

1. Start an IV, prepare or administer IV medications such as IV piggyback, IV push, or chemotherapy drugs, blood or blood products.
2. Perform IV site care or change IV dressings on central lines.
3. Take report on patients transferred from critical care areas or the recovery room.
4. Remove or shorten surgical drains.
5. Take physician's orders verbally or on the telephone. This includes pre-op orders from surgery.
6. Take CVP readings.
7. Adjust the angle of flexion or CPM apparatus.
8. Remove hemovac, JP, or T-tube.
9. Remove a fecal impaction.

11. DC chest tubes or central line
12. Insert NG tube
13. Photocopy ANY part of the patient record!!!

Once students have completed the specific classroom course AND/OR lab, they **CAN** do the following procedures with a written physician's order and always with supervision:

1. Prime a peripheral IV bottle or bag after successful completion of IV Therapy lab.
2. Discontinue peripheral IVs after successful completion of IV therapy lab.
3. Perform venipuncture after venipuncture lab at Arthritis Associates or Cardiology Clinic at TTUHSC (not at UMC or CHS facilities) if they meet the IV therapy course criteria and have faculty approval.
4. Administer medications or do procedures involving medications after satisfactory completion of medication administration rotation. This includes suppositories, eye and ear instillations, and tube feedings which have medications in the formula.
5. Discontinue N/G tube after skills lab with TPCN supervision.
6. Remove staples after skills lab *always with instructor supervision.*
7. Perform tracheotomy suctioning and care after successful completion of skills lab in ICU with TPCN supervision.
8. N/G irrigation and tube feedings after skills with TPCN supervision.
9. Perform bladder irrigation and bladder scans.
11. Perform wet-to-dry dressings (but NO packing)
12. Perform fingerstick blood glucose tests at Ambulatory Clinics ONLY (not at UMC or CHS facilities)
13. Remove sutures at Ambulatory Clinics ONLY (not at UMC or CHS facilities) always with nurse supervision
14. Perform EKGs at Ambulatory Clinics
15. Other skills as noted on specific clinical objectives.

It is the student's responsibility to assure that there is adequate supervision for these skills!

Safe Clinical Practice

Students are expected to demonstrate growth in clinical practice through application of knowledge and skills (SCOPE OF PRACTICE_ from previous and concurrent courses, to demonstrate growth in clinical practice as they progress through courses and to meet clinical expectations outlined in this syllabus, and to prepare for clinical practice in order to provide safe, competent care

The purpose of this educational program is to make safe, effective vocational nurses. This aim is achieved through the various theory, lab, simulation and clinical experiences. Clinical supervision is provided by professional nursing educators to assure as much safety for the patient as possible.

Students who engage in unsafe nursing practice, either by omission or commission of acts, may be withdrawn from the nursing program, whether or not actual harm to a patient occurred, depending on the situation. The determination will be made by the Clinical Coordinator and Class Instructor. It is the potential harm to the patient from a student's action or inaction that is the basis for this determination. In most cases, students are given opportunities to improve; however, **a deliberate act of unsafe nursing practice (such as lying about patient care practices) is grounds for immediate dismissal.**

Smoking in Clinical Setting

There is NO SMOKING for students while at UMC! All smoking areas at UMC are for patients and visitors only!
Violation of the smoking policy is grounds for dismissal from the VNP.

Telephone Calls in the Clinical Setting

PROCEDURE:

1. If an emergency arises, the student's family MUST call the SPC Vocational Nursing Office at 806-716-4626. A message will be relayed to the student in clinicals. **However, there may be times that no one is available to take the emergency message. Students should arrange with other adults to act on behalf of the student for emergencies!**
3. **It is the student's responsibility to inform family members and assure that this policy is followed.** The clinical facilities do not have access to your records or schedules and will not be able to assist your family member in locating you!
4. When answering the phone on a unit, be courteous at all times. When you answer the phone, you must identify the unit, your name, and your title.
   Example: "East 5, Sue Smith, Student Vocational Nurse."
5. If you are able to answer the request, please indicate to the caller that you will do the request and complete that request as soon as possible.
6. If you are unable to answer a request, refer the matter to the charge nurse. Be sure to explain any delays to the person calling.
7. **NEVER** give out patient information over the phone, take a doctor's order, lab reports, reports from critical care or surgery, pre-op orders from surgery. **NEVER** phone the physician for orders or to give lab results. (Remember HIPAA.)

Unprepared Students (for Nursing Care)

Students must research patient care information prior to the clinical experience and during the clinical experience to assure safe and therapeutic patient-centered care.

Unprepared Criteria:

1. A student who does NOT have clinical objectives, syllabus and student handbook with him/her is unprepared. These documents assist the student in knowing clinical expectations, school policies, etc.

Unprepared and Unsafe Criteria:

2. A student is not prepared who:
   a. cannot discuss the nursing report.
   b. has not assessed his/her patient and begun giving care.
   c. is not assisting a TPC nurse with patient care.
   d. is not ready to perform procedures on the unit.
   e. cannot discuss the plan of care and/or
   f. does not have required research
   g. has not read the unit objectives and knows what to do on that unit
3. A student who fails to follow up with instructor instructions in the clinical setting is unprepared. For example, if an instructor tells the student to add more information to the student research, and the student chooses not to add the information, then the student is unprepared.
4. A student who does not meet previous level objectives is unprepared.

As a student progresses, he/she is expected to understand and relate more of the data to the disease process. For example, a student in the second semester who could not perform and discuss the assessment (a first semester skill) would be considered unprepared.

A student is evaluated with the same expectations as other students at the same level.
**Students who have these things but have difficulty understanding them are not considered "unprepared." The student should ask for assistance in understanding this information.

Students who are unprepared and **are sent home with an absence.**

Time Management of Clinical Day

Clinical Day 1

Time Frame:	**Task/Skill/Activity**
0645-0715	Go with Assigned Nurse for Report a) Note: Head to toe assessment, Name, age, physician, diagnoses, safety level, allergies, code status, voiding/BM status, activity, diet, oxygen, incisions/wounds/drains, IV sites-solutions, rates; Ordered tests, results from previous tests, Accudatas on diabetics Choose Patient(s) a) Decide which patient(s) you will care for and note it on the yellow student assignment sheet in the breakroom. b) Introduce yourself and identify your role as a student vocational nurse and let them know what care you will be providing. (will change depending on semester) c) Make beginning entry in nurses' narrative ex. - Report received, Care assumed of ____year old _____ (gender) admitted with _____ (diagnoses) under the care of Dr. ____ (physician's name). Resting in bed, eyes closed, respirations even and unlabored. (a note to show that you actually saw the patient(s) at this time and that they are alive)
0715-0900	Assessment, AM Care a) Complete Head to toe assessment b) Inform TPCN and PCA of vital signs c) Inform TPCN of any abnormalities noted in the assessment d) Document Head to toe assessment e) Start the Activity/I&O sheet f) Complete the ISBAR with information gathered from report - IF you did not receive certain information in report that is needed to complete the ISBAR, you need to ask the patient. - You should be talking to your patients as you are performing the head to toe assessment. g) Set up meal tray for patient(s) and assist with breakfast if applicable h) Once your patient is taken care of, you may help out on the unit by answering call lights and helping other students and nurses. *** Be aware that if you are standing around at the nurse's station, you will be required to answer the call lights. It is recommended that you document your assessment in the patient's room so that it will be complete by 0930. i) Complete AM care- oral care, bathing, grooming, ROM, linen change j) Get on computer to look up History and Physical in order to complete any missing information of the ISBAR that you were unable to collect from the nurse or the patient ***This is not the time to gather information for Research! ***Assessment must be completed and documented prior to getting on the computer.
0900-0930	Seek instructor to present information a) The following must be completed by 0930: Head to toe assessment documented Braden Scale Completed ISBAR completed

Activity and I&O sheet initiated

b) Be prepared to give report about your patient(s)

***If instructor is busy with another student, you should give the required materials to the instructor so that they can see that the information is completed even though they may not be able to go over it with you at this time. It is not the responsibility of the instructor to come and find you in order to get your information.

c) Update Charts (must chart at least every 2 hours in nurse's narrative and Activity Sheet)

d) Look at orders: Note orders that will affect your care.

Ex.- TEDs, SCDs, Dressing changes, Diet, Fluid Restrictions, Accudatas…

1000-1100	Finish up AM care Follow the nurse Assist with other patient care activities Update Charts
1100-1130	Take vital signs and report them to the TPCN and PCA If patient lunch is available, help set up or assist with lunch as needed
1130 (time may vary due to patient care responsibilities)	Lunch- 30 Minutes total time. Report to TPCN before leaving to lunch
1200-1300	Check on patient(s), update charts, activity and I&O sheet Assist with patient activity
1300-1330	Get on the computer and gather information for research.

***Patient care is priority. This should take no longer than 30 minutes. This time is only for gathering information from the chart. Medication sheet: Medication, dose, route, frequency, times; Labs: only the lab results, do not fill in normal ranges, analysis, write in black pen. At home, you complete the rest for research. See Computer checklist.

1330-1430	Answer call lights Follow nurse Be sure room is clean Fresh water is given if pt. isn't NPO You should do a check on your patient(s) at least every 2 hours for pain, toileting, positioning, and safety checks Ask TPCN to sign off on any completed skills *For level 2 and 3, after PSCCL- Do medication teaching with patient.
1430-1500	Empty Foleys, make sure patient is clean and dry, room is clean, trash cans are not full, fresh water available, Update activity sheets and total I&Os, Report off to TPCN and make "Care Relinquished" ending note in narrative.
1515	Leave the unit and go clock out *Do not leave the unit until 1515. Do not camp out in the breakroom with your backpacks on waiting for the clock to turn 1515.

Clinical Day 2

Time Frame:	**Task/Skill/Activity**
0645-0715	Go with Assigned Nurse for Report

b) Note: Name, age, physician, diagnoses, safety level, allergies, code status, voiding/BM status, activity, diet, oxygen, incisions/wounds/drains, IV sites-solutions, rates; Ordered tests, results from previous tests, Accudatas on diabetics (any changes from day 1?)

Choose Patient(s) if your patient went home:

a) Decide which patient(s) you will care for and note it on the yellow student assignment sheet in the breakroom.

b) Introduce yourself and identify your role as a student vocational nurse and let them know what care you will be providing. (will change depending on semester)

c) Make beginning entry in nurses' narrative

ex. - Report received, Care assumed of ____year old _____ (gender) admitted with _____ (diagnoses) under the care of Dr. ____ (physician's name). Resting in bed, eyes closed, respirations even and unlabored. (a note to show that you actually saw the patient(s) at this time and that they are alive)

0715-0900 Assessment, AM Care

a) Complete Head to toe assessment

b) Inform TPCN and PCA of vital signs

c) Inform TPCN of any abnormalities noted in the assessment

d) Document Head to toe assessment

e) Start the Activity/I&O sheet

f) Complete the ISBAR with information gathered from report

- IF you did not receive certain information in report that is needed to complete the ISBAR, you need to ask the patient.

- You should be talking to your patients as you are performing the head to toe assessment.

g) Set up meal tray for patient(s) and assist with breakfast if applicable

h) Once your patient is taken care of, you may help out on the unit by answering call lights and helping other students and nurses.

*** Be aware that if you are standing around at the nurse's station, you will be required to answer the call lights. It is recommended that you document your assessment in the patient's room so that it will be complete by 0930.

j) Complete AM care- oral care, bathing, grooming, ROM, linens

k) Get on computer to look up History and Physical and progress notes in order to complete any missing information of the ISBAR that you were unable to collect from the nurse or the patient

***This is not the time to gather information for Research!

***Assessment must be completed and documented prior to getting on the computer.

<u>If giving meds</u>:
Inform TPCN and ask her to pull your medications from the pyxis. Check the chart to find any new med orders and any labs that are needed for meds you are giving. Seek out instructor to let them know when you are ready to give your meds. Communicate with your instructor in advance so meds can be given on time. Assessment should still be complete and documented prior to giving your medications. For further instruction see PSCCL folder on Blackboard.

0900-0930 Seek instructor to present information

a) The following must be completed by 0930:

Head to toe assessment documented
Braden Scale Completed
ISBAR completed
Activity and I&O sheet initiated

b) Be prepared to give report about your patient(s)

***If instructor is busy with another student, you should give the required materials to the instructor so that they can see that the information is completed even though they may not be able to go over it with you at this time. It is not the responsibility of the instructor to come and find you in order to get your information.

c) Update Charts (must chart at least every 2 hours in nurse's narrative and Activity Sheet)
d) Look at orders: Note orders that will affect your care.
Ex.- TEDs, SCDs, Dressing changes, Diet, Fluid Restrictions, Accudatas

1000-1100	Finish up AM care Follow the nurse Assist with other patient care activities Update Charts
1100-1130	Take vital signs and report them to the TPCN and PCA If patient lunch is available, help set up or assist with lunch as needed
1130 (time may vary due to patient care responsibilities)	Lunch- 30 Minutes total time. Report to TPCN before leaving to lunch
1200-1300	Check on patient(s), update charts, activity and I&O sheet Assist with patient activity
1300-1430	Answer call lights Follow nurse Be sure room is clean Fresh water is given if pt. isn't NPO You should do a check on your patient(s) at least every 2 hours for pain, toileting, positioning, and safety checks Ask TPCN to sign off on any completed skills
1430-1500	Empty Foleys, make sure patient is clean and dry, room is clean, trash cans are not full, fresh water available, Update activity sheets and total I&Os, Report off to TPCN and make "Care Relinquished" ending note in nurse's narrative.
1515	Leave the unit and go clock out. **Do not leave the unit until 1515.** Students who leave the floor BEFORE 1515 are marked ABSENT for the entire day!

Witnessing Documents

Student Vocational Nurses do not witness any legal documents, such as a surgical permit, blood permit, etc. While the student may be present during the discussion, the student must make clear to physicians and staff that the student will NOT be able to sign the legal document as a witness.

Additionally, Student Vocational Nurses cannot interpret for the purpose of informed consent for any legal document. Informed consent (surgical permits, blood permits, etc.) require that the patient fully understand and agree to the procedure based on the explanation of the physician. Because there is room for error in translation from one language to another, only certified interpreters should perform this service and not students. It is acceptable practice to interpret during routine nursing procedures, but not for legal purposes.

STUDENT CONDUCT—Please refer to the Student Vocational Nursing Handbook for all Program Rules & Policies

Rules and regulations relating to the students at South Plains College are made with the view of protecting the best interests of the individual, the general welfare of the entire student body and the educational objectives of the college. As in any segment of society, a college community must be guided by standards that are stringent enough to prevent disorder, yet moderate enough to provide an atmosphere conducive to intellectual and personal development.
A high standard of conduct is expected of all students. When a student enrolls at South Plains College, it is assumed that the student accepts the obligations of performance and behavior imposed by the college relevant to its lawful missions,

processes and functions. Obedience to the law, respect for properly constituted authority, personal honor, integrity and common sense guide the actions of each member of the college community both in and out of the classroom.
Students are subject to federal, state and local laws, as well as South Plains College rules and regulations. A student is not entitled to greater immunities or privileges before the law than those enjoyed by other citizens. Students are subject to such reasonable disciplinary action as the administration of the college may consider appropriate, including suspension and expulsion in appropriate cases for breach of federal, state or local laws, or college rules and regulations. This principle extends to conduct off-campus which is likely to have adverse effects on the college or on the educational process which identifies the offender as an unfit associate for fellow students.
Any student who fails to perform according to expected standards may be asked to withdraw.
Rules and regulations regarding student conduct appear in the current Student Guide and in the Vocational Nursing Student Handbook.

ACCOMMODATIONS

For college policy statements related to Intellectual Exchange Statements, Disabilities Statements, Non-Discrimination Statements, Title IX Pregnancy Accommodations Statements, CARE, Campus Concealed Carry Statements, COVID-19, or the use of AI-Artificial Intelligence, visit: https://www.southplainscollege.edu/syllabusstatements/.

Be aware you must still hold a LTC to carry on our campus. Also, there is a NO Carry Policy at all within ANY clinical facility.

FOUNDATION SKILLS

BASIC SKILLS–Reads, Writes, Performs Arithmetic and Mathematical Operations, Listens and Speaks
F-1 Reading–locates, understands, and interprets written information in prose and in documents such as manuals, graphs, and schedules.
F-2 Writing–communicates thoughts, ideas, information and messages in writing and creates documents such as letters, directions, manuals, reports, graphs, and flow charts.
F-3 Arithmetic–performs basic computations; uses basic numerical concepts such as whole numbers, etc.
F-4 Mathematics–approaches practical problems by choosing appropriately from a variety of mathematical techniques.
F-5 Listening–receives, attends to, interprets, and responds to verbal messages and other cues.
F-6 Speaking–organizes ideas and communicates orally.

THINKING SKILLS–Thinks Creatively, Makes Decisions, Solves Problems, Visualizes and Knows How to Learn and Reason
F-7 Creative Thinking–generates new ideas.
F-8 Decision-Making–specifies goals and constraints, generates alternatives, considers risks, evaluates and chooses best alternative.
F-9 Problem Solving–recognizes problems, devises and implements plan of action.
F-10 Seeing Things in the Mind's Eye–organizes and processes symbols, pictures, graphs, objects, and other information.
F-11 Knowing How to Learn–uses efficient learning techniques to acquire and apply new knowledge and skills.
F-12 Reasoning–discovers a rule or principle underlying the relationship between two or more objects and applies it when solving a problem.

PERSONAL QUALITIES–Displays Responsibility, Self-Esteem, Sociability, Self-Management, Integrity and Honesty
F-13 Responsibility–exerts a high level of effort and perseveres towards goal attainment.
F-14 Self-Esteem–believes in own self-worth and maintains a positive view of self.
F-15 Sociability–demonstrates understanding, friendliness, adaptability, empathy and politeness in group settings.
F-16 Self-Management–assesses self accurately, sets personal goals, monitors progress and exhibits self-control.
F-17 Integrity/Honesty–chooses ethical courses of action.

SCANS COMPETENCIES

C-1 **TIME** - Selects goal - relevant activities, ranks them, allocates time, prepares and follows schedules.

C-2 **MONEY** - Uses or prepares budgets, makes forecasts, keeps records and makes adjustments to meet objectives.
C-3 **MATERIALS AND FACILITIES** - Acquires, stores, allocates, and uses materials or space efficiently.
C-4 **HUMAN RESOURCES** - Assesses skills and distributes work accordingly, evaluates performances and provides feedback.

INFORMATION - Acquires and Uses Information
C-5 Acquires and evaluates information.
C-6 Organizes and maintains information.
C-7 Interprets and communicates information.
C-8 Uses computers to process information.

INTERPERSONAL–Works With Others
C-9 Participates as a member of a team and contributes to group effort.
C-10 Teaches others new skills.
C-11 Serves Clients/Customers–works to satisfy customer's expectations.
C-12 Exercises Leadership–communicates ideas to justify position, persuades and convinces others, responsibly challenges existing procedures and policies.
C-13 Negotiates-works toward agreements involving exchanges of resources; resolves divergent interests.
C-14 Works With Diversity–works well with men and women from diverse backgrounds.

SYSTEMS–Understands Complex Interrelationships
C-15 Understands Systems–knows how social, organizational, and technological systems work and operates effectively with them.
C-16 Monitors and Corrects Performance–distinguishes trends, predicts impacts on system operations, diagnoses systems performance and corrects malfunctions.
C-17 Improves or Designs Systems–suggests modifications to existing systems and develops new or alternative systems to improve performance.

TECHNOLOGY–Works with a Variety of Technologies
C-18 Selects Technology–chooses procedures, tools, or equipment, including computers and related technologies.
C-19 Applies Technology to Task–understands overall intent and proper procedures for setup and operation of equipment.
C-20 Maintains and Troubleshoots Equipment–prevents, identifies, or solves problems with equipment, including computers and other technologies.

Clinical Course Schedule—placed on Black Board *Subject to change.

VNSG 1460 SYLLABUS CONTRACT

This contract must be submitted prior to the student attending clinical practice

PRINT NAME: _____

I have read the VSNG 1460 syllabus and understand the course requirements and all that I will need to do in order to become a successful, safe and therapeutic nurse.

- *I understand that this clinical syllabus has been updated from the student handbook and that the policies in this syllabus supersede the handbook.*
- *I understand that I am required to have this syllabus with me in clinical rotations*
- *I have had the opportunity to ask questions.*
- *I can comply with all requirements found in this syllabus and the Student Vocational Nurse Handbook and Clinical Handbook.*

Signed: _____ *Date:* _____