Reese Campus

**Course Syllabus**

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| COURSE: | VNSG 2661 Clinicals Level 2 |
| SEMESTER: | Spring 2021 |
| CLINICAL TIMES: | Monday, Tuesday and Fridays; Times vary depending on clinical assignment |
| INSTRUCTOR: | All instructors under the direction of Korbi Berryhill |
| OFFICE: | Reese Center, Building 5 |
| OFFICE HOURS: | by appointment only |
| OFFICE PHONE: | 806-716-4719 |
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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.* This syllabus should be placed at the front of the student handbook!

*Please Note:* **The COVID-19 crisis may change the clinical course and this syllabus. Please refer to the 2021 Student Handbook for the complete COVID POLICY.**

**Prerequisite courses: VNSG 1260**
**CO-requisite courses (concurrent): VNSG 1409, 1330, 1171**

### FACE COVERING COURSE SYLLABUS STATEMENT

It is the policy of South Plains College for the Spring 2021 semester that as a condition of on-campus enrollment, all students are required to engage in safe behaviors to avoid the spread of COVID-19 in the SPC community. Such behaviors specifically include the requirement that all students properly wear CDC-compliant face coverings while in SPC buildings including in classrooms, labs, hallways, and restrooms. Failure to comply with this policy may result in dismissal from the current class session. If the student refuses to leave the classroom or lab after being dismissed, the student may be referred to the Dean of Students on the Levelland campus or the Dean/Director of external centers for Student Code of Conduct Violation.

### 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.

### STUDENT LEARNING OUTCOMES

| At the completion of the semester students will: (based on the Differentiated Essential Competencies of Texas Board of Nursing [DECS]) |
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| 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: |
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| • Apply the theory, concepts and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economical, environmental, social and legal systems associated with Vocational Nursing |

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| • 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 3 absences. |

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

- Have a 75 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**
- Pass PSCCL by the third attempt **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 change or foley insertion) this semester **AND**
- Have NO MORE than two absences **AND**
- Complete the maternal-child rotation **AND**
- Practice within the student Scope of Practice

**EVALUATION METHODS**

Weekly clinical performance evaluations, care maps, Case Studies, Care Plans, and vSims, and other 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. ***This includes your Concept Map, Drug Cards, Diagnosis information and vSim Pathophysiology!***

**VARIFICATION OF WORKPLACE COMPETENCIES**

Successful completion of this course and all required concurrent theory courses enables the student to enroll in VNSG 2662 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 in to 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 (SVN) 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 and the need for lifelong learning.***

**A. Functions within the SVN's legal scope of practice and in accordance with the policies and procedures of South Plains College and the clinical agencies.**

1. Provides nursing care within student limits & nursing standards (follows VNP policies) [Functions within a directed scope of practice of the SVN with appropriate supervision.]
2. Follows SPC Student Dress Code
3. Follows Attendance Policy and is on time.
4. Assists in determination of predictable health care needs of a patient to provide individualized, goal-directed nursing care.
5. a. Practices according to facility policies and procedures
   b. Questions orders, policies, and procedures that may not be in the patient's best interest.

**B. Assumes responsibility and accountability for the quality of nursing care provided to patients and their families.**

1. Provides nursing care within the parameters of SVN knowledge, scope of practice, education, experience, and ethical/legal standards of care at this level.
2. a. Practices nursing in a caring, nonjudgmental, nondiscriminatory manner.
   b. Provides culturally sensitive health care to patients and their families
   c. Provides holistic care that addresses the needs of diverse individuals across the lifespan.
3. Uses performance and self-evaluation processes to improve individual nursing practice and professional growth
4. Assumes accountability for individual nursing practice
5. a. Follows established policies and procedures
   b. Uses nursing judgment to anticipate and prevent patient harm
6. Uses communication techniques to maintain professional boundaries in the nurse/ patient relationship
7. Complies with professional appearance (dress code) requirements according to SPC policies.

**C. Contributes to activities that promote the development and practice of vocational nursing.**

1. Identifies historical evolution of nursing practice and issues affecting the development and practice of vocational nursing.
2. Works collegially with members of the interdisciplinary health care team.

**D. Demonstrates responsibility for continued competence in nursing practice, and develops insight through reflection, self-analysis, self care, and lifelong learning.**

1. Uses self-evaluation, reflection, instructor evaluation and feedback to modify and improve practice. [does not keep making same mistake]
2. Demonstrates accountability to reassess and establish new competency when changing practice areas. [able to follow unit objectives]

**II. PROVIDER OF PATIENT CENTERED CARE:** ***The SVN 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 nurse incorporates professional values and ethical principles into nursing practice and provides care to individual patients and their families.***

**A. Uses clinical reasoning and established evidence-based policies as the basis for decision making in nursing practice.**

1. Is prepared for clinical practice [appropriate patients, appropriate research]
2. Uses problem-solving approach to make decisions regarding care of assigned patient.
3. a. Organizes care for assigned patient based upon problem-solving and identified priorities
   b. proactively manages priorities in patient care and follow-up on clinical problems that warrant investigation with consideration of anticipated risks.
3. Identifies and communicates patient physical and mental health care problems encountered in practice.

**B. Assists in determining the physical and mental health status, needs, and preferences of culturally, ethnically, and socially divers patients and their families based on interpretation of health-related data.**

1. Identifies health care needs (Uses structured assessment tool to obtain patient history)
   a. assesses patient needs appropriately & timely with appropriate documentation
   b. completes assessment in a timely manner
2. Performs focused assessment to assist in identifying health status and monitoring change in patient.
3. Reports and documents focused patient assessment data.
   a. reports abnormals appropriately and timely
   b. maintains documentation throughout the shift
4. Identifies predictable and multiple health needs of patient and recognizes signs of decompensation.
5. Shares observations that assist health care team (HCT) members in meeting patient needs.
6. Differentiates abnormal from normal health data of patient.
7. Recognizes healthcare outcomes and reports patient status.

**C. Reports 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 HCT.**

1. Relates meds/diagnostics/treatments to medical diagnoses and is able to discuss them (Integrates concepts from basic sciences and humanities to deliver safe and compassionate care in delivery of patient care).
2. Evaluates, documents care, modifies plan of care with Health Care Team (Identifies short-term goals and outcomes, selects interventions considering cultural aspects, and establishes priorities for care in collaboration with patients, their families, and the interdisciplinary team.)
3. Identifies priorities & makes judgments re: basic needs of multiple patients & manages time to provide care for these patients. (Participates in the development and modification of the nursing plan of care across the lifespan, including end-of-life care)
4. Contributes to the plan of care (POC) by collaborating with interdisciplinary HCT.
5. Demonstrates basic knowledge of disease prevention and health promotion in delivery of care to patients and their families.

**D. Provides safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.**

1. Meets basic physiological needs of the patient [bed bath/shower, a.m. care, linen change]
2. Assumes accountability and responsibility for nursing care through a directed scope of practice under the supervision of the instructor or licensed nurse, using standards of care and professional values
3. a. identifies priorities and makes judgements concerning basic needs of one patient with predictable health care needs in order to organize care.
   b. recognizes changes in patient status.
   c. communicates changes in patient status to other providers

**E. Implements aspects of the plan of care (POC) within legal, ethical, and regulatory parameters and in consideration of patient factors.**

1. implements individualized POC to assist patient to meet basic physical and psychosocial needs
2. Implements nursing interventions to promote health, rehabilitation, and implements nursing care for clients with chronic physical and mental health problems and disabilities. [ROM activities, activity, ambulation, up to chair, positioning, etc]. Promotes psychological, spiritual, social and cultural well being
3. communicates accurately and completely responses of patients to treatment to other health care professionals clearly and in a timely manner
4. Fosters coping mechanisms of patients and their families during alterations in health status and end of life.
5. Seeks clarification as needed

6. Informs patient of Bill of Rights
7. Communicates ethical and legal concerns through established channels of communication
8. Uses basic therapeutic communication skills when interacting with patients, their families, and other professionals.
9. Facilitates maintenance of patient confidentiality
10. a. Demonstrates accountability by providing nursing interventions safely and effectively using a directed scope of practice.
    b. Provides nursing interventions safely and effectively using established evidence-based practice guidelines
11. Provides direct patient care in disease prevention and health promotion and/or restoration

**F. Identifies and reports alterations in patient responses to therapeutic interventions in comparison to expected outcomes**.

1. Reports changes in assessment data
2. Uses standard references to compare expected and achieved outcomes of nursing care
3. Reports patient's responses to nursing interventions

**G. Implements teaching plans for patients and their families with common health problems in well-defined health learning needs.**

1. Identifies health-related learning needs of patients and their families.

**H. Assists in the coordination of human, information, and material resources in providing care for assigned patients and their families**.

1. Communicates effectively with patient, family, staff, Health Care Team, faculty [verbal, nonverbal, teaching]
2.Reports unsafe patient care environment and equipment
3. implements established cost containment measures in direct patient care
4. assists with maintenance of standards of care

**III. PATIENT SAFETY ADVOCATE:** ***The SVN 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. Demonstrates knowledge of the Texas Nursing Practice Act (NPA) and Texas Board of Nursing (BON) rules that emphasize safety, as well as all federal, state, and local government and accreditation organization safety requirements and standards.**

1. Practices according to the Texas NPA and Texas BON rules, and SPC policies
2. Seeks assistance if practice requires behaviors or judgments outside of individual knowledge and expertise.
3. Uses standards of nursing practice to provide and evaluate patient care
4. Recognizes and reports unsafe practices and contributes to quality improvement processes.

**B. Implements measures to promote quality and a safe environment for patients, self, and others.**

1. Promotes a safe, effective care environment conducive to the optimal health and dignity of the patients and their families.
2. Accurately identifies patients [2 patient identifiers]
3. Safely performs preventative and therapeutic procedures and nursing measures including safe patient handling. Safely performs therapeutic skills, treatments & procedures at this level of student practice.
    a. completes all required remediation
4. Safely administers medications, following all SPC policies and PSCCL guidelines
    a. able to discuss medications in relation to diagnoses
    b. completed all required remediation
5. Clarifies any order or treatment regimen believed to be inaccurate, non-efficacious, contraindicated, or otherwise harmful to the patient.
6. Reports reactions and untoward effects to medications, treatments, and procedures, and clearly and accurately communicates the same to other health care professionals.
7. Reports environmental and systems incidents and issues that affect safety. Provides safe environment [SR, brakes, bed position, ambulation/transfers safely, follows Safety Codes, administers CPR/Heimlich]
8. Implements measures to prevent risk of patient harm resulting from errors and preventable occurrences.

**C. Assists in the formulation of goals and outcomes to reduce patient risks.**

1. Implements measures to prevent exposure to infectious pathogens and communicable conditions.
    a. anticipates risk for the patient
    b. washes hands appropriately
    c. wears gloves appropriately
    d. follows Isolation Precautions
    e. maintains clean environment [room clean, no linens on floor, trash maintained, meal trays out, etc]
2. Implements established policies related to disease prevention and control

**D. Obtains instruction, supervision, or training as needed when implementing nursing procedures or practices.**

1. Evaluates individual scope of practice and competency related to assigned task [knows when to ask for help]
2. Seeks orientation/training for competency when encountering unfamiliar patient care situations

**E. Complies with mandatory reporting requirements of the Texas NPA.**

1. Reports unsafe practices of healthcare providers using appropriate channels of communication
2. Reports safety incidents and issues through the appropriate channels

**F. Accepts and takes assignments that take into consideration patient safety and organizational policy.**

1. Accepts only those assignments that fall within individual scope of practice based on experience and educational preparation.

**IV. MEMBER OF THE HEALTH CARE TEAM (HCT):** ***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 patient and their families***.

**A. Communicates and collaborates 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. Involves patients and their families with other interdisciplinary health care team members in patient care across the lifespan
2. cooperates and communicates to assist in planning and delivering interdisciplinary health care.

**B. Participates as an advocate in activities that focus on improving the health care of patients and their families.**

1. Respects the privacy and dignity of the patient
2. Identifies unmet health needs of patients.
3. Acts as an advocate for patient's basic needs, including following established procedures for reporting and solving institutional care problems and chain of command

**C. Participates in the identification of patient needs for referral to resources that facilitate continuity of care, and ensure confidentiality.**

1. Identifies support systems of patients and their families
2. a. Communicates patient needs to the family and members of the HCT.
   b. Maintains confidentiality according to HIPAA guidelines

**D. Communicates and collaborates in a timely manner with members of the interdisciplinary health care team to promotes and maintain optimal health status of patients and their families.**

1. Communicates changes in patient status and/or negative outcomes in patient responses to care with members of the interdisciplinary HCT.
2. Follows legal guidelines in communicating changes in patient status, including chain of command and Texas NPA.
3. Contributes to positive professional working relationships
4. Recognizes and manages conflict through the chain of command
5. Identifies and reports need for nursing or interdisciplinary team meetings

**E. Communicates patient data using technology to support decision making to improve patient care.**

1. Identifies, collects, processes, and manages data in the delivery of patient care and in support of nursing practice and education
2. Uses recognized, credible sources of information, including internet sites
3. Accesses, reviews, and uses electronic data to support decision making
4. Applies knowledge of facility regulations when accessing patient records.

## SPECIFIC LEVEL 2 CLINICAL UNIT OBJECTIVES:

## MEDICAL-SURGICAL ROTATIONS

**University Medical Center: Medical-Surgical Floor Objectives**

**Clinical Rotations are Monday, Tuesday**

| Unit | Location | Phone | Speciality |
|---|---|---|---|
| 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 | Gertiatric 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 |
| 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 | 2-3 |
| Medication administration with instructor supervision | After successful PSCCL |
| EMR documentation on student pages | Yes |
| Chart Pack | Yes |
| VS and brief assessment by 0730 | Yes |
| Full assessment documented by 0930 | Yes |
| Staple removal with instructor supervision | Yes |
| Foley Catheter insertion (preferred with instructor) TPCN | Yes |
| Sterile Dressing change (preferred with instructor) TPCN | Yes |
| Follow Do and Don't List in handbook | Yes |

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

## Maternal Child 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 2 days of labor and delivery and 2 days of postpartum care to complete this rotation.**

### Family Birth Center (FBC) and Family Care Unit (FCU) at UMC
### ( L&D/PP GUIDELINES):
### L&D 2nd Floor / Post Partum/Nursery

The FBC/FCU rotation at UMC Hospital is two days and possibly NICU [NICU may be part of the pedi rotation instead]

The rotation will consist of working in the Family Birth Center (Labor and Delivery) located on the 1st floor; and in the Family Care Unit (Postpartum) located on the 2nd floor. If clinical space is available, the student will spend at least one week in each area.

**FBC:** You will be assigned with a TPC nurse and her laboring patients each A.M. Complete your ISBAR. 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.

Under direct supervision and permission of the delivery nurse, the student who has passed PSCCL may administer Erythromycin eye drops to the newborn.

You must have your drug card with you to administer it. You may not administer any other medications to the newborn.

**FCU:** You will be assigned 2 patients 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. Select a patient on Tuesday for your OB Care PLan You may select a vaginal or C-section patient. Bring your care plan information and your OB book with you to the floor.

During the FCU rotation, you will also do your Nursery Rotation. The babies 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!)**

Under supervision and with permission of the TPCN, you may administer oral medications to the mother. You must have a drug card for each medication.

**Bring your Nursing Skills Checklist with you during these rotations.**
Postpartum, Labor and Newborn a – m
Antepartum, Labor and Newborn a – c (antepartum is located on the 3rd floor at UMC with FCU.)
You may take one antepartum patient during your postpartum rotation.

**Items Required for this rotation:** Postpartum and L&D ISBARs, infant ISBAR, chart pack (with lab and med sheets completed); DX and Med cards required by OB instructor

## 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
2. Successful passage of PSCCL exam
3. Successful passage of PSCCL lab

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 Applied Nursing Skills (VNSG 1402) during Level 1 and will demonstrate knowledge of drug classifications in Level 2.
2. This instruction will include IM injection lab in which students inject each other with sterile saline and 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.**

**RESPONSIBILITIES:**

1. All nursing students are responsible for learning the medication skill and for practicing in the nursing lab.
2. During the PSCCL, instructors will NOT make any comments, but upon coming to an error, will say "stop" and the student will have an opportunity to make any adjustment. Should the student self-correct, the lab will continue. Should the student be unable to self-correct, the student will fail the lab and have to be rescheduled. Instructors will NOT make any other comments. **If the student has to be stopped more than three (3) times, the student fails the PSCCL.**
3. Students will "talk" through the entire lab procedures as if they were actually in the hospital setting; i.e., when reviewing the chart, the student will say "I am reviewing the chart for meds – here is the order for Digoxin 0.125 mg and here is the notation on the MAR."
4. Once the PSCCL has been passed, students will proceed to the clinical setting and may administer medications with instructor supervision.
5. The student should practice enough prior to the PSCCL so that there is success during the lab. A failed PSCCL lab will be re-scheduled at a later date; however, due to timing and scheduling, a student may fail medication rotation because there was not enough time to complete the lab and get the required 4 days of medication administration

**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 cards 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, and IVPB medications.

***Please Note: Information obtained from the Pixus 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.

**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. This policy will carry over from medication rotation all the way through to graduation.**

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 *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!**

7. Follow hospital policies which state that SVNs may give medications by all routes **EXCEPT IV** with supervision by the instructor.
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 will fail the clinical course, regardless of other grades.

## MEDICATION ADMINISTRATION AFTER MED ROTATION

**Medication Administration by Student Vocational Nurses after successful medication rotation**

**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 and escorts student to the patient room, at all times. 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 (except on pediatrics where only oral and topical medications can be administered) 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 complete medication information **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
   Rehabilitation
   Telemetry Floors **except Renal patients**
   Post Partum
   Med-Surg Floors
   Long Term Care facilities
   Students may give meds to two or more patients.
6. Students will administer 0900 to 1500 medications on the day shift and 1700 to 2100 meds on the evening shift. Students either give ALL medications that they are allowed to give (PO, IM, SQ) for the assigned patient(s) or NO medications. In other words, a student would not give 5 pills and then ask the TPCN to give 5 pills – this would be too confusing!
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 PIXUS.
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***.
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.

## 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. Refer to the Student Handbook for specific guidelines for this facility.
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, SBAR, 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 calling 716-4719 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 in the computer lab.

**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. You must be on time after lunch or you will be counted as absent**. If you return late from lunch, you are sent home absent 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:

- Student Vocational Nurse Handbook
- This syllabus with the Level 2 Clinical Objectives and specific unit objectives
- 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 Student Handbook for the full dress code

## 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 and Friday Lab. The student may be administratively withdrawn from the course when absences become excessive as defined in the course syllabus.

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 (see Student Handbook) or Friday absences. ALL ABSENCES MUST BE MADE UP AT 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) is failure in the clinical course***. The student will be administratively withdrawn. FOR MORE INFORMATION, please refer to the student handbook.

**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; Grace Medical Center | 0630-1530 | 30 minutes | 0640 | 0600 | 1515 |
| Crown Point Medical Suites | 0530-1430 | 30 minutes | 0540 | 0500 | 1415 |
| Carillon House | 0530-1430 | 30 minutes | 0540 | 0500 | 1415 |
| Simulation | 0755-1600 | Approx. 60 minutes | 0800 | 0700 | 1600 |
| EVENING SHIFTs if indicated at UMC | 1400-2200 | 30 minutes | 1340 | 1300 | 2200 |

| | | | | | |
|---|---|---|---|---|---|
| Friday LAB | 0755-1600 | Approx. 60 minutes | 0800 | 0700 | 1600 |

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 (or Covenant) 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.

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)

Student **MAY NOT** attend clinicals when running a fever, experiencing vomiting or diarrhea, having pink eye or any other infectious process. The student should anticipate that such illnesses or other emergencies may occur and should judiciously take an absence. *Please refer to the Student Vocational Nurse Handbook for more information on attendance, infectious processes for which the student should stay home*, NO SHOW policy and call in procedures.

LUNCH—the lunch break in the hospital setting is 30 minutes; this begins when the student reports off care of the patient until the time the student returns and resumes care. If the student spends 10 minutes waiting on the elevator, the student has 20 minutes remaining on the lunch break.

In some outpatient settings, the student may be given an hour for lunch IF there are no meetings during the noon hour which would give the student an additional learning experience (see each clinic objective). A student who takes excessive lunches or who leaves the site when there was a meeting during the noon hour will receive full disciplinary action and possible dismissal for unprofessional conduct.

BREAKS—please refer to the Student Handbook for information about breaks

TARDIES—tardiness is considered unprofessional. ***There are NO tardies in the Vocational Nursing Program.***

CLOCKING IN/OUT: Clocking in/out for other student 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).

Please refer to the Student Handbook for more information about the clinical experience and policies and the **NO SHOW policy.**

## 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 the, 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.

**Requirements:**

1. 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. The student must have this information on the Pathophysiology Sheet.
    b. Written information assists the student in learning; when the student becomes nervous, there is a reference for the student to use during discussion.
    c. Students who are unable to discuss this information will receive a clinical deduction and may be instructed to have written information on subsequent clinical experiences.
2. 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 each patient. There is a deduction for any incomplete Med List
    b. Students who are unable to discuss the medications will receive a clinical deduction and may be instructed to have write additional information on medications.
    c. For students with really poor discussion of medications or for incomplete med list, med administration may be forfeited, with additional point deductions.
3. The student will demonstrate 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 Analysis Sheet is to be thoroughly completed for each 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.

**PROCESS:**

1. First day of clinicals: In the afternoon, ***after all patient care is completed***, 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
2. 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!**
3. 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.
4. 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.
5. IF PATIENTS are dismissed, the student is expected to pick a new patient and begin the research process again.
6. IF PATIENTS are dismissed on the last clinical day, the student is expected to select new patients to provide care for during the day; however, clinical preparedness will not be required that evening.

**CHART PACK:**

In all medical-surgical rotations, the student must complete individual research and the chart pack. 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 should be turned in for a check on Wednesdays by 0800 to each clinical instructor's box outside the office as instructed by the individual clinical instructor. After each is checked, the Chart Pack is returned to the student for safe-keeping. Some chart packs may become a part of the Clinical Case Study and/or Care Plan and will not be returned to the student in these assignments.

## 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, line out 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 of "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 it should be avoided 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 impacts patient care! What YOU think, feel, believe, etc. is NOT relevant to this documentation.**

## 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.

**FRIDAY CLINICALS:**

The Friday Clinical Experiences are used to supplement current clinical practice in a variety of ways and to provide opportunity for students to enhance clinical skills, develop greater clinical judgment, and to have time to make appointments to see instructors. Various activities will be done on Fridays including vSims, labs, Case Studies, Care Plans and Clinical Tests. The time for Friday activities is from 8-4, with all assignments being submitted by 4 p.m. Attendance is monitored. Clinical Uniform is required for all activities at the school (uniform is not required for vSims completed independently). Events are scheduled on a weekly basis. Below are different assignments for Friday labs.

**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 in Friday lab. Students will be required to write Care Plans and Case Studies as part of the clinical experience.

**CARE PLAN Instructions**

The purpose of writing this care plan is to assist the student in the critical thinking aspect of patient care.

- As assigned, choose different patients that challenge your thinking and require nursing judgment and intervention. [Please note: you cannot use the same patients for the care plans for care plans and case studies]
- Complete your ISBAR and chart pack. These items must be turned in with your Care Plan. **Your documentation must support the choices you make in this care plan—for example, you cannot use "pain" as a nursing diagnosis if there is NO evidence of pain within your documentation.**
- Type a cover page
- Write an introduction to this patient—include the rationale for choosing to study this patient (you may use personal pronouns in your rationale).
- Nursing Diagnosis List (centered heading).: Make a list of all possible nursing diagnoses that apply to this patient—from the patient diagnoses, problems, etc. . Your problem list must be <u>formally</u> written:

  The Nursing Diagnostic Label, related to the etiology as evidenced by signs/symptoms {tests, diagnoses are NOT signs/symptoms} Remember that RISK problems do not have evidence (if evidence is present, then it is a REAL problem, not a risk).

*Example of writing a REAL Diagnostic Statement*: Pain related to below the knee amputation as evidenced by patient grimacing, holding stump, rating pain "11" on 1-10 scale

*Example of writing a RISK Diagnostic Statement*: Fall Risk related to new below the knee amputation, unstable in balance and having to learn to use crutches

- From your list choose the TOP FOUR Patient PROBLEMS and complete the care plan.
    a. At LEAST two of the problems MUST BE REAL problems, not risk. (After all, if the patient doesn't have any real problems, why was the patient in the hospital?) **THERE MUST BE EVIDENCE IN YOUR DOCUMENTATION OF THE PROBLEMS YOU SELECT.** (If you choose knowledge deficit, there must be evidence of teaching in your documentation.)
    b. Please number the care plans according to PRIORITY (the most important patient problem is #1). [Please note: ALL hospitalized patients have been identified as potentially having these four (4) problems: Pain, Risk for injury, risk for infection, risk for skin integrity impairment. These four problems should NOT be used unless they are truly a priority problem and there is evidence of these problems in your chart pack!]
    c. Write the care plan out. A suggested format follows:

NURSING DIAGNOSIS:
PATIENT-CENTERED GOAL:
MINIMUM OF 5 NURSING ACTIONS, EACH WITH A RATIONALE **Please note: to be thorough and to do the best for the patient, some problems require many more interventions than just 5 as seen in the example below. Please include ALL appropriate interventions for this patient.**

**If the rationale is taken directly from a textbook, it must be referenced—you must attribute the thinking to the source.**

EVALUATION—the evaluation must use the words "Goal met" or "Goal Not Met" or "Goal Partially Met" with the words "as evidenced by" [may be abbreviated AEB] and then actual evidence presented. If the goal is not met or partially met, there must be an evaluative statement and any changes needed to the care plan should be included.

***EXAMPLE: (Using our pain statement above)***

Care Plan #1 (Top Priority Problem)

NURSING DIAGNOSIS: Pain related to below the knee amputation as evidenced by patient grimacing, holding stump, rating pain "11" on 1-10 scale

PATIENT-CENTERED GOAL: [The patient] will have reduced pain within 30 minutes of nursing intervention as evidenced by no grimacing, no holding the stump, ability to sleep or rating pain < 3 on 1-10 scale. (recurring goal for pain)

Nursing Actions and Rationales:

1. Assess pain using a reliable scale, note location, intensity, frequency, duration of pain.
   Rationale*: Adequate assessment allows for early intervention and allows patient to fully participate in care if pain is controlled [Carpenito (2013), pg 201]*
2. Monitor patient's vital signs for signs of pain including increased heart rate, blood pressure, respiratory rate
   Rationale*: Acute pain activates the sympathetic branch of the ANS causing such responses as increasing heart rate, blood pressure and respiratory rate and can indicate intervention is needed. [Carpenito (2013), pg 203]*
3. Observe patient for nonverbal indicators of pain such as facial grimacing, guarding or holding an area, moaning, crying
   Rationale: *Behavioral and physiological responses may indicate pain and the need for intervention. [Doenges, (2015), pg 110]*
4. Teach patient the use of relaxation, guided imagery to assist in pain relief
   Rationale: *These effectively manage pain by increasing sense of control, reducing feelings of helplessness and provide a calming diversion, disrupting the pain-anxiety-tension cycle [Burton & Ludwig (2012), pg 568]*
5. Use non-invasive pain-relief methods (hot, cold applications, massage) and/or provide diversions (TV, music, conversation). Alter the environment to encourage relaxation (close blinds, open, etc)

Rationale: *Studies have shown that the brain secretes endorphins which have an opiate-like effect on pain. This effect is responsible for the positive effects of non-invasive pain relief measures [Carpenito (2013), pg 203]*

6. Administer prescribed analgesics
   a. Assess VS (BP, R) before administration
   b. Oral route preferred
   c. Avoid IM if possible due to erratic absorption and increased pain

   Rationale: *Pain management should be aggressive and individualized to eliminate unnecessary pain [Doenges, (2012) pg 482]*

7. After administration, return in 30 minutes to assess effectiveness
   Rationale: *If pain relief not achieved, additional nursing interventions are required; physician may need to be contacted [Doenges, (2012), pg 482]*
8. Consult with physician if dosage or interval change is needed; dose may be increased by 50% until effective; may need multimodal analgesia

   Rationale: *Multimodal analgesia (2 or 3 classes of analgesics) can be more effective than one class only. The combined lower doses of each class are more effective than higher doses of 1 class and there are less Side Effects (SEs). {Carpenito,, (2013), pg 203]*
9. Manage SEs of opioids (fatigue, drowsiness, dry mouth). Report Respiratory depression immediately (below 10, decreased O2 sat) *{Carpenito,, (2013), pg 203]*

   Rationale: *Management of SEs can increase comfort and use of medications. Resp depression calls for aggressive intervention {Carpenito,, (2013), pg 203]*
10. Explain diagnostic tests and procedures in detail relating discomforts/sensations and give approximate duration

    Rationale: *Preparation for painful procedures reduces stress and therefore pain of the experiences {Carpenito,, (2013), pg 203]*
11. Anticipate pain and pre-medicate patient prior to procedures or therapies

    Rationale: *Management of pain prior to a painful procedure or therapy can decrease the amount of analgesia needed and the effects anxiety will have on the pain experience. {Carpenito,, (2013), pg 203]*
12. Determine types of pain:
    a. Somatic (aching, gnawing, throbbing)
    b. Visceral or soft tissue (dull, aching, cramping, not localized)
    c. Neuropathic (burning, stabbing, stinging, electric, pins & needles, shooting or numbness)
    d. Muscle spasm (cramping, spasm, tightening)

Rationale*: Nocieptive pain can be somatic and visceral. Somatic pain results from the activation of peripheral nociceptors as in muscles, joins, bone or connective tissue. Visceral pain results from activation of nociceptors in the abdomen or chest. Visceral and somatic pain are responsive to opioids and NSAIDS. Neuropathic pain results when there is abnormal processing of input by the PNS or CNS; opioids alone usually do not manage this type of pain. Neuropathic pain responds to anticonvulsants, serotonin reuptake inhibitors, antidepressants. Muscle spasms respond to muscle relaxants. {Carpenito,, (2013), pg 203]*

13. Share goal with patient and family

    Rationale: *Helping patient and family understand the pain experience can enhance positive coping. {Carpenito,, (2013), pg 203]*

14. Provide information about medication effectiveness and discuss drug tolerance
    Rationale: *Fear of pain can be relieved if understanding of effectiveness occurs; addiction is believed to be rare and there is no evidence that adequate opioid administration causes addiction (as opposed to drug-seeking behaviors) {Carpenito,, (2013), pg 203]*

EVALUATION: Goal met as evidenced by no grimacing, resting with eyes closed, respirations even and regular, stump on support pillow and relaxed position. Wife states "I think he's not hurting, he's been asleep about 20 minutes." Continue with plan throughout hospitalization.
DATE and TIME of evaluation, signature

OR if patient was still in pain: Goal not met as evidenced by continued complaint of pain after all nursing interventions, still grimacing and holding stump; Plan revised: call to physician obtained PCA pump with Demerol 10 mg IVP q 15 minutes. Patient instructed on use. Continue with plan with new additional action.
DATE and TIME of evaluation, signature

- Conclusion/Summary: Write a conclusion/summary of the care of this patient (an overall evaluation). Include a paragraph about what you have learned from this patient and completing the care plan (you may use personal pronouns in this paragraph)
- Include a formal reference page.

Place all work, organized, into a pocket folder and turn in by the due date.

**CASE STUDY INSTRUCTIONS:**

The purpose of Case Study Assignment is to assist the student in developing clinical judgment and critical thinking Patients for study should be selected early in the semester so that the student has an opportunity to reflect and think about that patient care as soon as the assignment is made. The ISBAR and complete chart pack must be turned in with each study. You must be able to answer all of the questions for credit.

- Provide a cover page
- Provide a reference page in correct format; must have a minimum of three professional references
- If you use information directly out of text, it must be referenced within your writing
- Please refer to how to write a paper in the VNP for all general instructions
- Type the work using Times New Roman 12 point font, double spaced
- Work must be written in complete sentences with correct spelling, punctuation and grammar. Follow the guidelines regarding the use of abbreviations.
- Answers should be THOROUGH—meaning there should be depth to each answer. One sentence will not usually satisfy!
- Place all work in a pocket folder

Answer the following questions but written in paragraphs with headings (refer to manual) about this patient.

**ASSESSMENT AND PLANNING CARE:**

1. What is the primary problem and what is its underlying cause or pathophysiology?
2. What clinical data from the chart is RELEVANT and needs to be trended because it is clinically significant?
3. List all relevant nursing priorities. What nursing priority captures the "essence" of your patient's status and will guide your plan of care?
4. What nursing interventions will you initiate (or did you initiate if this was a past patient) based on this priority and what are the desired outcomes?
5. What body system(s), key assessments and psychosocial needs will you focus on based on your patient's problem or nursing care priority?
6. What is the worst possible/most likely complication(s) to anticipate based on the primary problem?
7. What nursing assessments will identify this complication EARLY if it develops?
8. What nursing interventions will you initiate if this complication develops?

**NURSING INTERVENTIONS**

9. What clinical assessment data did you just collect that is RELEVANT and needs to be TRENDED because it is clinically significant to detect a change in status?
10. Does your nursing priority or plan of care need to be modified in any way after assessing your patient?
11. After reviewing the primary care provider's note, what is the rationale for any new orders or changes made?
12. What educational priorities have you identified and how will you address them?

**CARING AND THE "ART" OF NURSING**.

13. What is the patient likely experiencing/feeling right now in this situation?
14. What can I do to engage myself with this patient's experience, and show the patient that he/she matters to me as a person?

**Clinical Exams**: When scheduled, the clinical exams are designed to test clinical competencies—facts that the student must know in order to be a safe practioner. Examples are "what is a normal blood pressure reading?" What is the normal H&H? etc. These are things that the student has had in both theory and clinical practice and should be able to remember throughout clinical performance. These are usually fill-in-the-blank exams and do count toward the paperwork grade.

**Dosage Calculations Exams**: In order to administer medications, all students must pass the Dosage Calculations Exams by the third attempt early in the semester in order to progress to med rotation. If a student cannot pass by the third

attempt, the student fails the clinical course. Additionally, other calculation exams may be given throughout the semester to assure that students maintain competencies. These may be given without notice.

## CLINICAL CARE MAPS

Clinical Care Maps are designed to enhance critical thinking and to allow the student to connect disease processes, labs, diagnostics, medications, diet and to see the relationships that these have for the patient. This thinking leads to SAFE PATIENT CARE. CCMs use color and short wording to emphasize relationships of nursing care and should help the student develop critical thinking skills. CCMs can be done in any patient situation.

**You may choose to do your Map by hand (see supplies listed below) or you may use your computer in a WORD document. The colors must be the same for either way.**

**Required supplies**: colored pencils or markers, ruler, protractors, 8 ½ x 11 manila folders (you can open the manila folder and have a larger working area)

You will also need your patient information, your diagnoses, medications and labs.

**Instructions for completing your CCM**: When care maps are assigned, choose one patient from this week to complete your care map. It must be emailed to your clinical instructor by the specified time on the assigned day. If you do a map by hand, please scan on your smart phone and send it as an attachment. If you do it on computer, please attach it in an email as an attachment (do not just send it as part of the email).

**How to THINK and write your map:**

1. Put your general information in the center of your folder. Think about any of those factors that will affect the patient's outcome and care (is the patient old? Does that patient have specific cultural or religious beliefs?) WHAT brought the patient to the hospital—**the chief complaint**: "a subjective statement made by a patient describing the most significant or serious symptoms or signs of illness or dysfunction that caused him or her to seek health care."
   Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier
2. Now you need to think about the patient's diagnosis(es). You must know what these are [SAFE NURSING PRACTICE]—you cannot understand what the patient is going through and how to care for that patient if you don't know about the disease and it's pathophysiology—to do so is UNSAFE NURSING PRACTICE. What is the medical diagnosis? A **medical diagnosis** "identifies a disease condition based on an evaluation of physical signs, symptoms, history, and diagnostic tests and procedures. http://quizlet.com/6336548/nursing-process-diagnosis-flash-cards/
   A **pathophysiology** is an abnormal process that occurs in the body that leads to the development of the disease.
3. Add those to the map spaced evenly around the map so that you have space to write. Does your patient have risk factors for these diseases or for complications of the diseases?
4. What signs/symptoms does the patient have (compared to the literature?)
5. Review the patient's medications? What is their purpose (why are they prescribed?) What are we expecting to happen? What conditions do they treat? Medications aren't just prescribed for the fun of it—there has to be a reason—you need to discover the reason, then write the meds by the appropriate diagnosis—this is SAFE NURSING PRACTICE.
6. Look at your labs and diagnostics. What do they indicate (why are they ordered—what is the physician looking for?) You have to discover this (SAFE NURSING PRACTICE). Are some ordered because of medications? Do some of the medications affect the labs? (In your drug book, drugs that affect labs or are affected by labs are written as *Lab Considerations.*) Think about these and add these to your map.

7. What nursing care is required for this patient—what do you need to do to help this patient get better? Don't just look at the obvious physical actions—what about communication (spending time talking to the patient)? What about spiritual needs (is patient depressed, hopeless?) Consider what basic nursing care tasks (like a bed bath) are important to the patient [what all does a bed bath do? –it is more than just washing the patient!] Nurses must provide thoughtful, therapeutic nursing care for SAFE NURSING PRACTICE.
8. After you carefully think about, add the other elements.
9. If maps are very deficient or if they are grossly incorrect, the student will be expected to make corrections and submit by 7 p.m. that day.
10. MAP CLINICAL CONFERENCES: If assigned, the Clinical Instructor for your group will host a Zoom meeting for presentation of your Maps. During the meeting, each student will present their map. During the presentations, the student, the clinical group and the instructor will discuss the map, ask questions and make suggestions. The purpose of this discussion is to expand everyone's critical thinking and to critically think and make clinical judgments about patient care
11. If the student fails to submit the map by the deadline, the student will be counted as absent for the clinical day.

## Clinical Care Map Colors

**YELLOW Circle: (This is information about your patient).Please use black ink, then color the circle yellow—don't write in yellow. Pt's initials, age, sex, code status, allergies, diet, culture, religion, "chief complaint", date of admission, height, weight. Initial VS should be in yellow box, but VS for each day should be dated and in pink.**

**Black Box: Primary Diagnosis(es), Secondary Diagnosis, surgeries and other pre-existing medical problems should be listed in separate boxes around the folder. Each disease should be defined UNLESS you have a diagnosis card, map card or are completely versed in that disease process. If you have a diagnosis card or map card, you must have that with your map. If you are versed, place a # by that diagnosis. If a patient has many disease processes, be sure and ask your instructor for clarification for which ones need to be on your map on Monday before you leave! Underline the patient's signs/symptoms of the disease.**

**Gray Circle: For any RISK factors that your patient may have that has led to a particular condition, indicate it with a gray circle.**

**Red Circle: Medications. List each medication that the patient is receiving by the diagnosis the medication is treating. If a medication is DC'd during your care, place an "X" over the circle and write the date. If a new medication is added during dates of care, please add new circle with date. If a medication requires a specific nursing action or specific lab, indicate it by the medication in the appropriate color (see below). For meds that have no specific diagnosis, indicate that separately and write the reason for the med in LIME green.**

**Green triangle: "lab data": CBC, electrolytes, CMP, BMP, CHF-BNP, Cardiac Panel, Amylase, Lipase, UA, C&C, ABG's,etc. . . . .Use your lab list from your chart pack to assist in this section. Place the lab with the appropriate diagnosis and/or medication. For repeated labs, place dates with the results.**

**Brown circle: Consults (examples: PT, OT, RT, ST, and other physician's)**

**Dark Blue box: Diagnostics: xrays, MRI, CT, EGD, EEG, colonoscopy, cardiac cath's, appendectomy, hysterectomy, pacemakers, CABG, EKG, bronchoscopy, mastectomy, ultrasounds, barium swallow, mammograms, biopsies, PICC line**

**placements, Central line placements, Doppler studies, shunt placements, etc. Place them by the appropriate diagnosis. Write the dates by the ordered diagnostics.**

**Purple Box: Write appropriate nursing interventions by each disease process, meds & labs. This needs to be very specific to your patient. Place a check mark by any action that you completed.**

**Orange Protractor: At the bottom of the page, write specific patient teaching and discharge instructions for this patient. Remember that Discharge Planning begins on admission.**

Light Blue Box: Address any complications from the disease process. Add nursing interventions where appropriate.

IV Fluids: Draw an IV bag of the fluid and add it to your map.

Red Star: any unusual events, hazards, adverse reactions that have occurred.

Show relationships by a solid line connecting the different elements; if an element directly affects or leads to a particular element, add an arrow to the line. If the element *possibly* is related to another element, indicate this by a broken line/arrow.

***ANY noted resemblance to another student's work will be considered plagiarism! You must do your own work!***

**VIRTUAL SIMULATIONS (VSIM): When assigned, each student will complete a vSim located on the vSim website. The vSim will be posted on BlackBoard when assigned and will open at 0630 (regular clinical hours).**

1. You are expected to start the work no later than 8 a.m.
2. The student will complete the following on the vSim
    a. Pre-test
    b. Simulation
    c. Post-test
    d. Pathophysiology form
    e. Med form
    f. Lab form
    g. Self-reflection
3. The student may do the simulation and post-test more than one time; however, **only the first attempt of each will be counted in the grading.**
4. The Patho form, Med Form, Lab Form and self-reflection all must be completed and uploaded to BlackBoard by 4 p.m. on Fridays.
5. Students who do not complete the vSim work on Friday will be counted as absent.

***ANY noted resemblance to another student's work will be considered plagiarism! You must do your own work!***

**FRIDAY LABs:** As assigned, students will be required to practice/perform various nursing lab skills throughout the semester to assure competency. Students should continually be practicing their skills so that they become proficient. Should a student fail or miss a required lab, that student may not perform that particular skill until after remediation (on the student's own time), and then repeated check-off of the skill. Should the student not obtain proficiency of the skill by the end of the semester, the student fails the clinical course.

**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.

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.**

**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, Accudatas, 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 xrays, 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. Currently only the computer labs in building 8 are open to students; the computer lab in building 5 is closed. 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.*

**CLINICAL DRESS CODE** Please refer to the student handbook for the complete clinical dress code.

**GRADING POLICY**

Students must earn an overall grade of 75 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 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. Students will not pass medications until this exam is passed.

**B. Weekly clinical evaluation**—students will receive a weekly clinical evaluation based on the student's individual clinical performance and preparedness to practice nursing. The weekly ratings are averaged together for the length of the course. The student must have a 75 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 75 average on all required written work. ALL work must be turned in complete by the deadline according to the schedule. 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.

D. **Skills Checklist and Performance of at least one sterile skill:** Students must continue to complete the skills checklist and must score 75% 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
80-89.99 = B
75-79.99 = C
. <75 = F (There is no "D" in clinicals)

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

**GRADE BREAKDOWN**

Weekly Evaluations: 60%
Written Work: 40%

**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.

**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.

**Cell Phones:** cell phones are PROHIBITED at any clinical setting, including Friday lab and Simulation. Students should not have cell phones on their person, in their back packs, pockets or other personal areas during clinicals. Cell phones should be left in the student vehicle so that there is no temptation to use. Students who violate this policy and have their cell phone out during the clinical day for any reason will be sent home as absent—no matter when the infraction is discovered. If this absent causes the student to exceed the allowable absences, the student fails the clinical course, regardless of other clinical grades. This is considered a professional violation. Please refer to the Student Handbook for more information.

## 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.

## COURSE DISCLAIMER

**ACCOMMODATIONS**

**4.1.1.1. Diversity Statement** In this class, the teacher will establish and support an environment that values and nurtures individual and group differences and encourages engagement and interaction. Understanding and respecting multiple experiences and perspectives will serve to challenge and stimulate all of us to learn about others, about the larger world and about ourselves. By promoting diversity and intellectual exchange, we will not only mirror society as it is, but also model society as it should and can be.

**4.1.1.2. Disabilities Statement** Students with disabilities, including but not limited to physical, psychiatric, or learning disabilities, who wish to request accommodations in this class should notify the Disability Services Office early in the semester so that the appropriate arrangements may be made. In accordance with federal law, a student requesting accommodations must provide acceptable documentation of his/her disability to the Disability Services Office. For more information, call or visit the Disability Services Office at Levelland (Student Health & Wellness Office) 806-716-2577, Reese Center (Building 8) 806-716-4675, or Plainview Center (Main Office) 806-716-4302 or 806-296-9611.

**4.1.1.3 Non-Discrimination Statement** South Plains College does not discriminate on the basis of race, color, national origin, sex, disability or age in its programs and activities. The following person has been designated to handle inquiries regarding the non-discrimination policies: Vice President for Student Affairs, South Plains College, 1401 College Avenue, Box 5, Levelland, TX 79336. Phone number 806-716-2360.

**4.1.1.4 Title IX Pregnancy Accommodations Statement** If you are pregnant, or have given birth within six months, Under Title IX you have a right to reasonable accommodations to help continue your education. To activate accommodations you must submit a Title IX pregnancy accommodations request, along with specific medical documentation, to the Director of Health and Wellness. Once approved, notification will be sent to the student and instructors. It is the student's responsibility to work with the instructor to arrange accommodations. Contact the Director of Health and Wellness at 806-716-2362 or email cgilster@southplainscollege.edu for assistance.

**4.1.1.5 OPTIONAL STATEMENT - Campus Concealed Carry Statement** Texas Senate Bill - 11 (Government Code 411.2031, et al.) authorizes the carrying of a concealed handgun in South Plains College buildings only by persons who have been issued and are in possession of a Texas License to Carry a Handgun. Qualified law enforcement officers or those who are otherwise authorized to carry a concealed handgun in the State of Texas are also permitted to do so. Pursuant to Penal Code (PC) 46.035 and South Plains College policy, license holders may not carry a concealed handgun in restricted locations. For a list of locations and Frequently Asked Questions, please refer to the Campus Carry page at: http://www.southplainscollege.edu/campuscarry.php

Pursuant to PC 46.035, the open carrying of handguns is prohibited on all South Plains College campuses. Report violations to the College Police Department at 806-716-2396 or 9-1-1.

**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**
**Korbi Berryhill, MSN, RN, CRRN**
**Vocational Nursing Program Director**
**South Plains College Reese Center**

## VNSG 2661 SYLLABUS CONTRACT

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

PRINT NAME: _____

*I have read the VSNG 2661 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 have had the opportunity to ask questions. I can comply with all requirements found in this syllabus and the Student Vocational Nurse Handbook. At this time I do understand the Covid Policies as explained in the SVN Handbook and can comply with those restrictions.*

*Signed:* _____ *Date:* _____