Reese Campus

Course Syllabus

COURSE:	VNSG 2662 Clinical Level 3
SEMESTER:	Summer 2021
CLINICAL TIMES:	Monday through Friday; 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
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"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.

Prerequisite courses: VNSG 1260, 2661

CO-requisite courses (concurrent): VNSG 2410, 1334, 1219, 1133

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])
1. Become a Member of the Profession
2. Provider of Patient-Centered Care
3. Be a Patient Safety Advocate
4. Become a Member of the Health Care Team

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

At the completion of this course the student will:
• Apply the theory, concepts and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economical, environmental, social and legal systems associated with Vocational Nursing
• Demonstrate legal and ethical behavior
• Demonstrate the ability to care for multiple patients in multiple patient-care situations

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

COURSE COMPETENCIES: To exit this course and graduate from the Vocational Nursing Program (VNP), the student must

- Have a 75 average grade AND
- Complete and turn in all required clinical paperwork by the scheduled due date. Students who fail to turn in work fail the clinical course regardless of other grades.
- Maintain CPR and immunizations AND
- Complete all required lab practices and check offs and complete the Lab self-evaluation forms AND
- Complete 90% of the skills checklist 4 weeks prior to graduation AND
- Complete BOTH sterile procedures (foley catheter and sterile dressing change) AND
- Have no more than two (2) absences this semester AND
- Pass the Summative Evaluation AND
- Practice within the score of practice for SVNs, demonstrating movement to the graduate level of practice and clinical judgment

EVALUATION METHODS

Weekly clinical performance evaluations, Clinical Judgment Process, 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 entitles the student to receive a Certificate of Proficiency and to apply to write the examination for licensure (NCLEX-PN) to practice as a Licensed Vocational Nurse in the State of Texas.

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 3 CLINICAL OBJECTIVES: (Based on the TBON DECs)

During the clinical course, the competent vocational nursing student progresses to proficient graduate vocational 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.
4.. 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 3 CLINICAL UNIT OBJECTIVES:

MEDICAL-SURGICAL ROTATIONS

University Medical Center: Medical-Surgical Floor Objectives

Clinical Rotations are on 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
4 East	4th floor East of patio	775-8959	Medical Surgical, Pre operative and post operative Cancer patients. Wound care, IV therapy, pain management, chest tubes, blood administration, chemo and radiation patients. There are six bone marrow transplant rooms.
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 3

Criteria	Level 3
Number of patients	3-5
Medication administration with instructor supervision	Yes
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 (initially with instructor) TPCN	Yes
Sterile Dressing change (initially 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.**

Students MAY NOT bring course work to "study" during clinical rotations, complete clinical assignment paperwork (like care plans, case studies), research clinical information or other activities that distract from the clinical experience while on the units. Students should refrain from asking class questions of instructors during clinical time; instead, the student who has questions about class work should make an appointment with the appropriate class instructor for that discussion.

Maternal 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 three days and possibly NICU [NICU may be part of the pedi rotation instead] One day will consist of working in the Family Birth Center (Labor and Delivery) located on the 1st floor; two days in the Family Care Unit (Postpartum) located on the 2nd floor.

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

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.

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

PEDIATRIC OBJECTIVES:

1. Demonstrates an awareness of safety factors applicable to the hospitalized child and initiates action to provide a safe environment for the client.
2. Demonstrates the ability to assess the needs of and implements a care plan to meet the needs of the hospitalized child, using measures to make the experience less threatening for the child.
3. Maintains the holistic nature of the ill or hospitalized child by recognizing the importance of play and diversion activity in his/her overall care plan.

4. Demonstrates an understanding of nutrition for the recovery and continued growth and development of the child client.
5. Recognizes the normal range of vital signs in the child as contrasted to those in the adult client.
6. Recognizes the normal growth and development for age, thereby identifying abnormal aspects relative to the total assessment of the child client.
7. Analyzes the parent-child relationship and implements nursing measures geared to strengthen and support the child, as well as the family.
8. Demonstrates knowledge of immunization schedule and aspects of preventative pediatrics which contribute to the "weakness" of the child.
9. Demonstrate accountability for own nursing practice

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GUIDELINES FOR PEDIATRIC ROTATION

STAY OUT OF THE BREAKROOM. Report to the Charge Nurse when arriving on the floor.

#1 Rule: DOUBLE check with TPC nurse/Charge Nurse prior to performing a procedure, treatment or giving meds. An error with a child can quickly result in a poor client outcome.

#2 Rule: Children are usually allowed to sleep in the morning instead of being awakened early for vital signs unless otherwise ordered or if condition requires. Ask your TPC nurse when to take VS and do assessment.

Children's Hospital @ UMC

Pediatrics Location: 2nd Floor East
Phone: 775-8838

Pediatric ICU
Phone: 775-8828

1. Meds must be double checked by the TPC nurse. Follow Medication Administration Guidelines. The student may give oral or topical meds only. Topical meds may be applied with TPCN supervision; all other Med administration is under the supervision of the instructor.
2. Take three pediatric clients if available (less should only be taken if low census)
3. The student should spend time with the client/family--find appropriate toys, diversion activities, etc. Identify if the child is meeting milestones for age.
4. If the unit is not busy, the student may work on the child/family study or may study pediatrics ONLY. The student MAY NOT work on any other material or read magazines, newspapers, etc.

Criteria	**Level 3**
Number of patients	3-5 (take 2 if census is low)
Medication administration with instructor supervision	PO only Yes
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

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.

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.]

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	Post Partum
Rehabilitation	Med-Surg Floors
Telemetry Floors **except Renal patients**	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.

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

THE SIMULATION EXPERIENCE

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

When assigned, students will participate in simulated nursing care scenarios at the Center for Clinical Excellence located in Building 1 at the Reese Center. 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:

- This syllabus (has objectives)
- Davis Drug Guide

ADDITIONAL CLINICAL ITEMS

Students should come to clinicals with all required research, chart pack or clinic notes. 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, Clinical Judgment Experiences and vSims. 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.

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

Facility	Clinical Time	Lunch	Absent at:	Call In Time	May leave floor at
University Medical Center	0630-1530	30 minutes	0645	0600	1515
Simulation	0755-1600	Approx. 60 minutes	0800	0700	1600
EVENING SHIFTs if indicated at UMC	1400-2200	30 minutes	1340	1300	2200

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

PLEASE NOTE: The Time Clock located at UMC (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.

Outpatient Clinics Clinical Times: (must be signed in exactly at the START time in the outpatient clinics which means you must arrive at least 5 minutes early). **TIME SHEET REQUIRED FOR EACH CLINIC** turned in each Wednesday with your Clinic Packs to your clinical instructor.

Clinic	Hours	Contact/Phone No	Absent at	Lunch	Parking	Required Research PRIOR to rotation
Covenant Health Plus, 7601 Quaker	0800-1600	Sherry Marston 725-9408	0800	Approx. 1 hr (based on pt load); may eat out	Outside parameter on N or S sides; come in through front door	Antibiotic Med List Hormone Med List Immunization Med List
Lubbock Health Dept 806 18th (corner of 18th and Cricket Ave)	0830-1630 MONDAY Only*	775-2933	0800	Approx 1 hr; must be PROMPT on your return if you leave	On the street	Diagnosis Sheets for: Gonorrhea, Chlamydia, Syphilis, HIV; HPV Immunization Med List Antibiotic Med List
TTUHSC Clinics @ Pavillon, 3601 4th ST (see below for specific info)	0800-1600	743-4263 ask for unit mgr; IT Help: 743-1815	0800	Approx. 1 hr (based on pt load); may eat out	Lots	See each clinic's requirement listed below
Wound Care Clinic, 2002 Oxford Ave	0800-1600	793-8869	0800	Approx. 1 hr (based on pt load); may eat out	In the lot that enters the facility (not door spaces)	Antibiotics Med List Anti-emetics Med List

Students in the clinics work with all staff including nurses and physicians in providing outpatient care. Students should anticipate that they will assist staff with calling patients back, taking vital signs, completing focused assessments, assisting with procedures, removing sutures (nurse supervision), administering medications (nurse supervision if you have received approval from faculty—a signed contract), completing fingerstick blood sugars and Coumadin checks (nurse supervision), as well as assisting with all phases of nursing care. Students must always have complete medication information while administering any medication and follow all SPC policies and guidelines.

Assignment for each clinic: Complete the Clinic Notes posted on Black Board and follow those instructions. Submit to your clinical instructor by 8 a.m. Wednesday.

Texas Tech University Health Sciences Center (TTUHSC) Clinics Specific Information

Clinic	Abbreviation	Location	Phone Number	Days
Family Medicine	Pav FM	First floor	743-1177	M, T
Internal Medicine	Pav IM	Second Floor	743-3150	M, T
OB-GYN	Pav OB	Third floor	743-2340	M, T
PEDI	Pav Pedi	Third floor	743-7335	M, T
Urology	Pav Uro	Third floor	743-1810	M, T
Orthopedics	Pav Ortho	Fourth floor	743-2373	M, T
Ear, Nose & Throat	Pav ENT	Fourth floor		M, T
Pedi Subspeciality*	HD/507	4102 24th St Suite 507		*T, (2nd day of LH rotat)
Pedi Surgery*	HD/508	4102 24th St Suite 507		*T, (2nd day of LH rotat)
Cardiology	Pav Card	Building North of Pavilon		M, T,

ALL CLINICAL ABSENCES MUST BE MADE UP in order to successfully meet clinical objectives. Two days are available for clinical make-up at the end of each semester; therefore, students may have TWO absences during the clinical experiences.

Fridays are part of the clinical experience, and absences on those days (or failure to submit required work or attend the debriefing rather than live or by Zoom) is an absence. If a student is absent on a Friday, the student must turn in the missed work AND complete an additional vSim in order to not have this absence count against the two-day limit. Only one (1) Friday may be missed for this requirement.

Exceeding the allowable clinical absences is failure in the clinical course. The student will be administratively withdrawn.

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

Absences will have an effect on the weekly clinical evaluation. A student cannot be evaluated if the student is absent. Points are deducted from the clinical grade for absences, including Friday Lab attendance or virtual Simulations. Missed points are returned upon making these days up.

Simulation is considered a clinical experience. An absence in simulation is the same as for all other clinical experiences. Students cannot be absent from the clinical unit in the morning and then come to simulation in the afternoon.

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

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

Absences in Short Rotations:

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

Religious Holy Days Absence in the Clinical Setting:

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

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

Students will be required to make up any clinical days missed if the student absence cap has been exceeded.

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

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

* Mononucleosis

Students who come to clinical contagious are sent home with an absence AND additional point deduction.

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 clinical 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

NOTE ABOUT CLINIC TIMES—some clinics may finish their work early and staff may tell the student that they can leave early. THIS DOES NOT MEAN you can leave. Please contact your instructor and request instructions for the rest of the scheduled time; many times the student may be moved to another clinical for additional experience. To "assume" it is okay to leave the clinical setting results in an absence assigned for that day. If this absence causes the student to fail, the student will fail the clinical course, regardless of other clinical grades.

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).

CLINICAL TARDIES:

There may be an occasion where a student is running late. Students may receive a "tardy" from 0630-0644; at 0645, the student is "ABSENT".

CONSEQUENCES for tardies:

1. 10 point deduction on the clinical evaluation

2. Three (3) tardies equals one full clinical absence, resulting in the loss of a clinical absence and in a required make up day.
3. If the three tardies puts the student OVER the allowable absences that can be made up at the end of the semester, the student fails the clinical course.
4. There are NO tardies for rotations (like Simulation) that start at 0800 since this shift is already later than the hospital students.

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).

NO SHOW POLICY

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

CONSEQUENCES of No Show:

1. Failure to "call in" (either by actual call or email) on time or correctly to report an absence by 0644 to report an absence results in <u>being classified as NO SHOW.</u>
2. The absence will have to be made up as with any other clinical absence; however, the grade for the missed day will remain the same (no points awarded for the NO SHOW.)
3. A second NO SHOW results in the same as in #2 and the student is placed on probation. Probation means that the student will not have any "off campus" rotations in the reminder of this Level and in Level 3
4. A third NO SHOW results in clinical failure, regardless of other grades, and the student is administratively withdrawn.

Cell Phones in the Clinical Setting

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

Cell phones are **<u>prohibited at any time during the clinical experience</u>** and may not be used in any location of the clinical setting during clinical hours. 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 or left at home.
Students who violate this policy and have their cell phone out during the clinical day *<u>for any reason</u>* will be sent home as "absent."

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

Clinical Affiliate Approval

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

1. If a student is a former employee of a facility and <u>ineligible for rehire</u>, that student may not be able to perform clinical rotations at that facility.
2. Should alternative experiences not be available, the student must withdraw from the VNP.

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

Clinical Probation

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

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

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

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

CONFIDENTIALITY/HIPAA

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

In the Vocational Nurse's Pledge, we pledge:

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

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

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

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

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

Students must always be aware of the private information that they have about patients and must protect that information. Even if a specific name is mentioned, a violation can exist if there is enough information for other individuals to "connect the dots" and find out who the information is about. Students must be very cautious in discussing PHI – elevators, cafeterias, and even open nursing stations may be inappropriate places to discuss information.

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

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

Students must also protect all student paperwork and may not leave these out where anyone can read them. Students should always secure any identifying information when leaving that information (don't leave information at the nursing station, in patient rooms, etc.) ALWAYS LOG OFF of a computer system if you have used it!

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

Failure to maintain confidentiality is grounds for dismissal.

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

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

Failure to maintain confidentiality is grounds for dismissal.

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

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

Contacting the Clinical Instructor

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

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

When Students Should Contact the Clinical Instructor:

The clinical instructor should be contacted:

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

Dress Code for Clinical Experiences

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

1. Uniform:
   a. Teal scrub top, pant or knee-length, A-line skirt. All tops must have "SPC" embroidered logo.
   b. Must have appropriate underwear with the uniform. Bras and underpants are required for females. Underpants are required for males. White socks or white hose are required. Underwear may NOT have writing on them that shows through the scrub top/bottom. Women wearing skirts must wear a slip and white hose. Bras should be skin colored and should not be visible through the neck of the clinical uniform.
   c. The uniform must be clean and pressed (ironed). Wrinkled uniforms look unprofessional and may result in the student being sent home as absent. To avoid ironing, remove uniforms immediately from the dryer and hang the uniform up. There are commercial sprays you can use to help remove wrinkles as well.
   d. The uniform must be worn to the hospital or other health care facility each clinical day, even during specialty rotations. This rule also applies to any special events such as honor lunches or breakfasts. If a student is at a rotation where street clothes are allowed, such as day care, the student MUST dress in the clinical uniform when participating in ANY school event.
   e. A closed-toe, closed-heel *mostly* white LEATHER shoe should be worn in ALL clinical settings, including day care. Athletic shoes that are mostly white may be worn. Shoe strings must be clean and shoes should be cleaned/polished regularly. Crocks and clogs or any other plastic shoes are unsafe and unacceptable.
   f. A teal jacket may be worn (optional). If worn, it must have the "SPC" embroidered logo. It must be clean and pressed <u>DAILY</u>. Cold-natured students should purchase this item. Other jackets and coats—even during lunch—may not be worn with the student uniform. (Be advised that there is limited space to hang coats/jackets during the winter months. Expensive coats should not be worn to the hospital where they could be stolen [ripped off])
   g. A teal or black t-shirt may be worn under the scrub top for warmth. Teal or black are the only acceptable colors. A t-shirt, if worn, must be cleaned daily and must have no writing that shows through the scrub top. T-shirts must be tucked in and Not hanging out under the uniform
   h. IF a uniform is too little (as purchased) or IF it becomes too small so that it rides up over the buttocks, the student is sent home "absent" and cannot return to the clinical setting until a new uniform that fits correctly is purchased.
2. Sweaters <u>must not</u> be worn with the uniform.
3. No jewelry may be worn when in uniform other than a watch with a second hand {SMART watches are prohibited} and one flat WEDDING BAND without stones for <u>married students only</u>. Stones in rings may be damaged or may injure a patient. No body areas may be jeweled, including earrings, and tongue, nose, eyebrow, or chin studs. Plastic spacers are also unacceptable, because even if clear, they appear unprofessional.
4. No pins or other decorations may be worn on the uniform, except those approved by the faculty.
5. Tattoos must be covered at all times in the clinical setting with sleeves, wrist bands or band aids. This includes tattoos that may be underneath a uniform but because of range of motion such as lifting an arm or bending over (chest, back or buttocks). Tattoos on arms must be covered even if long sleeves are worn because there may be times the sleeves are pushed up and then the tattoos would be revealed. Tattoos on the hands must be covered with band-aids if they are offensive to any other individual. Faculty determine "offensive."
6. Hair must be kept clean, washed frequently, neatly arranged, and professional in appearance.
   a. Extreme coiffures (bushy, mohawks, extreme shavings, pompadours or other hairstyles determined by faculty as extreme) are inappropriate with the uniform. Extreme hair colors (blue, pink, bright orange, purple, green, gold, silver, maroon, bright yellow or glitter, ombre, or those that call attention to self) are not allowed. **A student should be known for good nursing skill rather than hairstyle!**
   b. Long hair must be worn in a neat and confined bun (NO MESSY BUNS). Swinging ponytails are not allowed. Long hair extensions must also be worn in a bun.
   c. No loose bangs, tendrils and/or wings or braids are permitted. If hairs falls forward when bending over, it must be secured away from the face and shoulders. A thin headband the same color as student hair may be worn. Long bangs should be pinned back.
   d. Decorative items such as ribbons, flowers, combs, barrettes, headbands, bandanas, head scarves, head-dress of any kind, beads, feathers, or "fad" items etc. must not be worn in the hair while in uniform. *Plain claw hair clamps may be worn by students to hold long hair back. These claw hair clips can only be in the following colors: black, brown, teal, or the student's own natural hair color.*

e. Head scarves/coverings or Hijabs worn for religious purposes must be black or teal and may not have adornments on them.
f. Ponytail holders must be black, brown, teal, or the student's own natural hair color.
g. Sideburns, beards and mustaches must be neatly trimmed and/or according to hospital policy.
h. The above guidelines and specific clinical affiliate grooming policies will be adhered to during the time the student is in uniform, including touring off-campus facilities.

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

ASSIGNMENT POLICY—CLINICAL PREPARATION

All assignments must be completed by the assigned due date/time. Late and/or incomplete work will not be accepted and a grade of zero will be recorded.

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.

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 may have this information in any form the student chooses, i.e., diagnosis sheets, diagnosis cards, tabbed diagnosis book, etc.
    b. Students are encouraged to have this information written so that when the student becomes nervous, there is a reference for the student to use during discussion; however, a written form is not required *as long as* the student can discuss the information in a logical, organized, reasonable manner.
    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.

To prepare for the Outpatient Clinics: Clinic rotations are senior-level rotations in which the student functions in a more independent role under the supervision of the clinical instructor and clinic nursing staff. Students on probation do not participate in off-campus rotations.

General rules:

1. Students may be assigned to a clinic more than one time during the semester; some clinics may not be available to every student
2. Each clinic has specific requirements of preparation that the student MUST do PRIOR to the rotation. Please see the table below.
3. Each clinic will require the following which should be emailed to the clinical instructor by 5 p.m. Wednesdays
    a. Clinic Note
    b. Med Log (if no meds are administered, please write "No meds administered" and submit)
    c. Med Sheet from chart pack completely filled out for that clinic
    d. Diagnosis Sheets as indicated by the clinic objective
4. Each student will submit a signed time sheet for the clinic rotation as an attachment to the clinical instructor.
5. Additional clinical deductions will be taken for failure to turn the above documents in completed and on time.
6. Students who get placed on probation will forfeit all further clinic rotations so that greater instructor supervision is available to assist the probated student
7. Students at the clinics must follow all SPC guidelines.
8. The Clinic Notes and Medication Log are posted on Blackboard

Clinic Required Research

Clinic	Required Research PRIOR to rotation
Family Medicine	Med sheets for: Antibiotics, Vitamins, Depo drugs, Immunizations (child & adult), Pain, Diuretics, Antiemetics Childhood diseases Diagnosis Sheets: Chickenpox, Measles, Mumps, Rubella, RSV,
Internal Medicine	Med sheets for Pain, Antihistamine, Antihypertensives, Immunizations, Insulin, Steroids, Antianginals, Medrols, antibiotics
OB-GYN	Med sheets for Hormones, Immunizations, Antibiotics Childhood Diseases Diagnosis Sheets: Chickenpox, Measles, Mumps, Rubella, RSV,
PEDI	Med sheets for Pain, Respiratory, Antibiotics, Immunizations, Steroids Child hood disease Diagnosis Sheets: Chickenpox, Measles, Mumps, Rubella, RSV,
Urology	Med sheets for Antibiotics, Hormones, antineoplastics
Orthopedics	Med sheets for Antibiotics, Steroids, pain
Ear, Nose & Throat	
Pedi Subspeciality*	
Pedi Surgery*	
Cardiology	Meds sheets for antihypertensives, Diuretics

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

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 student must complete the Chart Pack daily.

CLINIC NOTES: Prior to the clinic rotation, the student should review the clinic and determine the type of patient the student may be seeing based on this review.

1. The student should determine at least ONE (1) learning goal for this clinic. Remember **goals must be measurable** and **goals must have a time frame**. Since this is about you, the student, you are the focus of the goal; therefore, you can start with "I will . . ." There should be at least one learning goal for each day of the rotation. The goal **MUST BE MORE SPECIFIC** than "Today I will learn about this clinic." Please date each Learning Goal.
2. Some clinics have different areas for learning. If you worked in one specific area on the first day, you may ask to work in another area the next day. You should ask by saying that one of your learning goals for this clinic is something specific in the next area of the clinic. [Please note: staff may request that you stay in the same area; discuss this with your instructor.]

PROCESS: Using the Student Clinic Notes posted on BlackBoard:

1. Print your name, the clinic, and the date at the top of the page.
2. Write your measurable learning goal
3. Identify the chosen patient for study. Write the patient's initials, age, sex and chief complaint (CC) [why they came to the clinic]
4. Write the medical diagnosis
5. Write the home medications. Be sure to include the dosage, the route and the frequency with each medication.
6. Identify the subjective symptoms.
7. Identify the objectives signs.
8. Write your nursing interventions for this patient. At home, write the rationale for each action and underline the rationale. Nursing interventions should be listed in order of priority.
9. Identify the patient teaching that is needed and/or done. If the teaching was done, please indicate it. If the teaching was not done, please give a reason and state when it should be done.
10. Include your medication log (see information on blackboard)
11. Submit this work to your clinical instructor.

The **completed Chart Packs** should be turned in for REVIEW on Wednesdays by 0800 to each clinical instructor's box outside the office as instructed by the individual clinical instructor. Failure to turn in the chart pack/clinic notes by 0800 will result in a 25-point deduction from the clinical grade, with a 20 point deduction each day thereafter. Additional points may be taken from the clinical grade if work is incomplete.

A student who is going to be absent on Wednesday MUST email the clinical instructor prior to 0800 to report that the chart pack/clinic note is not going to be turned in Wednesday by 0800 due to illness. On the first day back in class, the Chart Pack/clinic note must be turned in; failure to notify the instructor OR failure to turn in the chart pack/clinic note upon the return to school will result in a 50 point deduction.

A delay in a didactic course for the day DOES NOT PROHIBIT meeting the 0800 Wednesday deadline (in other words, if a theory class is delayed by an instructor for some reason, the expectation will still be that the Chart Pack is turned in by 0800 Wednesday). Failure to do so results in the above deductions.

If a grade of "0" is reached for the weekly clinical course grade, that "0" will stand against the clinical average.

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.

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.

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. Information about Friday Labs will be announced on BlackBoard.

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. Information about the assignments will be posted to BlackBoard.

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 impact patient care! What YOU think, feel, believe, etc. is NOT relevant to this documentation.
Your documentation should reflect the focus of nursing care—what patient problems you are doing something about!

Organization and Specific information:

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

SPECIFIC information:

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

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 USAGE AT CLINICAL AGENCIES:

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 LAB USAGE

The computer lab(s) on any campus may be used by students during scheduled open hours or as assigned by an instructor. 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 ***Please note: the computer lab in building 5 is currently closed during the Covid Crisis. Students may use the computer labs in building 8.***

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. The weekly grade also includes the Thursday**'**s clinical judgment day and Sims Friday vSim

C. **Written Work**: vSim work;Patho form and care plans, concept maps, case studies , worksheets, as assigned

D. **Completion of Skills Checklist to 90% and Performance of both sterile skills**—four weeks prior to graduation, the student must have completed 90% of the skills checklist and must have performed the two sterile procedures at least once in order to graduate. Students who fail to complete 90% of the checklist OR who fail to complete both sterile skills, fail the clinical course, regardless of other clinical grades.

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

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

GRADING SCALE:

90-100 = A
80-89 = B
75-79 = 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, Simulation and during Zoom meetings. 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.

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

An Incident Report shall be completed for the following:

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

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

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

1. An unusual occurrence includes, but is not limited to incidents such as medication error, patient injury witnessed by a student, and student injury.
2. Students who become ill or get injured should contact the instructor immediately.
3. Students who choose to use the facility's emergency services will be required to pay for Emergency Room services and then file with SPC insurance and/or their own insurance carrier.
3. Students who are injured to the extent that they cannot meet clinical objectives must withdraw from the VNP and apply for readmission once the injury has healed and the student can meet the objectives.
4. Student Exposure Incidents: Should a student of the VNP at Reese have an exposure to blood or body fluids through needle stick or other means, the student should do the following:
   a. Wash wound with warm, soapy water <u>immediately</u>. If splash is to eyes, the eyes should be rinsed with clear water or normal saline.
   b. Notify the instructor as soon as possible.
   c. Call the facility's Employee Health department and give the following information. (The instructor should assist with this phone call.)
      1) name, room number and medical record number of source of exposure
      2) physician's name
      3) state "I have had an exposure through…."
      4) phone number of student
5. Student Vocational Nurses DO NOT report to the facility's employee health (we are not employees).

Laboratory Experiences

Competency Labs: The PSCCL (Pharmacology Skills Critical Competency Lab) occurs prior to medication administration rotations in this Level. Students must pass the PSCCL with 100% competency. Students have three (3) opportunities to pass the lab. If the student is unsuccessful upon the third try, the student fails the PSCCL and will have to withdraw from the program. The third PSCCL attempt is taped on video cassette.

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

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

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

Level II competency will cover all previously mastered Level I skills in a timed setting. Students must pass this lab in order to progress to medication administration rotations.

Leaving the Clinical Unit

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

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

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

Limitations for Students in the Clinical Setting

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

Vocational Nursing Students **cannot** perform the following procedures:

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

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

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

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

Safe Clinical Practice

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

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

Students who engage in unsafe nursing practice, either by omission or commission of acts, may be withdrawn from the nursing program, whether or not actual harm to a patient occurred, depending on the situation. The determination will be made by the

VESC. It is the potential harm to the patient from a student's action or inaction that is the basis for this determination. In most cases, students are given opportunities to improve; however, **a deliberate act of unsafe nursing practice (such as lying about patient care practices) is grounds for immediate dismissal.**

Smoking in Clinical Setting

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

Telephone Calls in the Clinical Setting

PROCEDURE:

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

Unprepared Students (for Nursing Care)

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

Unprepared Criteria:

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

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

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

Students who are unprepared are unsafe. **Unsafe students are sent home with an absence.**

Time Management of Clinical Day

Clinical Day 1

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

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

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

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

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

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

Clinical Day 2

Time Frame:	**Task/Skill/Activity**
0645-0715	Go with Assigned Nurse for Report b) Note: Name, age, physician, diagnoses, safety level, allergies, code status, voiding/BM status, activity, diet, oxygen, incisions/wounds/drains, IV sites-solutions, rates; Ordered tests, results from previous tests, Accudatas on diabetics (any changes from day 1?) Choose Patient(s) if your patient went home: a) Decide which patient(s) you will care for and note it on the yellow student assignment sheet in the breakroom. b) Introduce yourself and identify your role as a student vocational nurse and let them know what care you will be providing. (will change depending on semester) c) Make beginning entry in nurses' narrative

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

0715-0900 Assessment, AM Care

a) Complete Head to toe assessment
b) Inform TPCN and PCA of vital signs
c) Inform TPCN of any abnormalities noted in the assessment
d) Document Head to toe assessment
e) Start the Activity/I&O sheet
f) Complete the ISBAR with information gathered from report
- IF you did not receive certain information in report that is needed to complete the ISBAR, you need to ask the patient.
- You should be talking to your patients as you are performing the head to toe assessment.
g) Set up meal tray for patient(s) and assist with breakfast if applicable
h) Once your patient is taken care of, you may help out on the unit by answering call lights and helping other students and nurses.
*** Be aware that if you are standing around at the nurse's station, you will be required to answer the call lights. It is recommended that you document your assessment in the patient's room so that it will be complete by 0930.
j) Complete AM care- oral care, bathing, grooming, ROM, linens
k) Get on computer to look up History and Physical and progress notes in order to complete any missing information of the ISBAR that you were unable to collect from the nurse or the patient
***This is not the time to gather information for Research!
***Assessment must be completed and documented prior to getting on the computer.

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

Seek instructor to present information

a) The following must be completed by 0930:
Head to toe assessment documented
Braden Scale Completed
ISBAR completed
Activity and I&O sheet initiated
b) Be prepared to give report about your patient(s)

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

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

1000-1100 Finish up AM care
Follow the nurse
Assist with other patient care activities
Update Charts

1100-1130 Take vital signs and report them to the TPCN and PCA
If patient lunch is available, help set up or assist with lunch as needed

1130 (time may vary due to patient care responsibilities) Lunch-
30 Minutes total time. Report to TPCN before leaving to lunch

1200-1300 Check on patient(s), update charts, activity and I&O sheet
Assist with patient activity

1300-1430 Answer call lights

	Follow nurse Be sure room is clean Fresh water is given if pt. isn't NPO You should do a check on your patient(s) at least every 2 hours for pain, toileting, positioning, and safety checks Ask TPCN to sign off on any completed skills
1430-1500	Empty Foleys, make sure patient is clean and dry, room is clean, trash cans are not full, fresh water available, Update activity sheets and total I&Os, Report off to TPCN and make "Care Relinquished" ending note in nurse's narrative.
1515	Leave the unit and go clock out. **Do not leave the unit until 1515.** Students who leave the floor BEFORE 1515 are marked ABSENT for the entire day!

Witnessing Documents

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

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

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

Rules and regulations relating to the students at South Plains College are made with the view of protecting the best interests of the individual, the general welfare of the entire student body and the educational objectives of the college. As in any segment of society, a college community must be guided by standards that are stringent enough to prevent disorder, yet moderate enough to provide an atmosphere conducive to intellectual and personal development.
A high standard of conduct is expected of all students. When a student enrolls at South Plains College, it is assumed that the student accepts the obligations of performance and behavior imposed by the college relevant to its lawful missions, processes and functions. Obedience to the law, respect for properly constituted authority, personal honor, integrity and common sense guide the actions of each member of the college community both in and out of the classroom.
Students are subject to federal, state and local laws, as well as South Plains College rules and regulations. A student is not entitled to greater immunities or privileges before the law than those enjoyed by other citizens. Students are subject to such reasonable disciplinary action as the administration of the college may consider appropriate, including suspension and expulsion in appropriate cases for breach of federal, state or local laws, or college rules and regulations. This principle extends to conduct off-campus which is likely to have adverse effects on the college or on the educational process which identifies the offender as an unfit associate for fellow students.
Any student who fails to perform according to expected standards may be asked to withdraw.
Rules and regulations regarding student conduct appear in the current Student Guide and in the Vocational Nursing Student Handbook.

COURSE DISCLAIMER

ACCOMMODATIONS

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.

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 Center 806-716-2577, Reese Center (also covers ATC) Building 8: 806-716-4675, Plainview Center Main Office: 806-716-4302 or 806-296-9611, or the Health and Wellness main number at 806-716-2529.

CAMPUS CARRY

Campus Concealed Carry - 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, please refer to the SPC policy at: (http://www.southplainscollege.edu/human_resources/policy_procedure/hhc.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.

PREGNANCY ACCOMMODATIONS STATEMENT

If you are pregnant, or have given birth been within six months, under Title IX you have a right to reasonable accommodations to help continue your education. Students who wish to request accommodations must contact the Health and Wellness Center at 806-716-2529 to initiate the process.

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.

Course Schedule—refer to Black Board

Korbi Berryhill, MSN, RN, CRRN
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VNSG 2662 SYLLABUS CONTRACT

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

I have read the VSNG 2662 syllabus and understand the course requirements and all that I will need to do in order to become a successful, safe and therapeutic nurse.

- *I understand that this clinical syllabus has been updated from the student handbook and that the policies in this syllabus supersede the handbook.*
- *I understand that I am required to have this syllabus with me in clinical rotations and that I no longer have to carry the student handbook.*
- *I have had the opportunity to ask questions.*

I can comply with all requirements found in this syllabus and the Student Vocational Nurse Handbook

SIGNED: _____ DATE: _____