RTC
PN
Program

Clinical Syllabus

2009-2010
ROLLA PROGRAM OF PRACTICAL NURSING
CLINICAL SYLLABUS
(512 HOURS)

CLINICAL DESCRIPTION:
The general purpose of the clinical learning experience is to assist the practical nursing student with skills in implementation and completion of the nursing process in various clinical settings.

Each student will be rotated through a planned program of clinical instruction in the acute-care, long-term care and community health settings. Learning experiences are provided in the care of patients in maternal health and newborn nursing (Obstetrics/Nursery), child health (Pediatrics), nursing care of the older adult (Geriatrics), adult health nursing (Medical-Surgical), pharmacology for nurses (Administration of Medications), community health nursing, and leadership and management.

Clinical experience is obtained in a variety of healthcare settings involving culturally diverse populations across the life span.

CLINICAL OBJECTIVES/OUTCOME CRITERIA:
Upon successful completion of each clinical rotation, the student will be able to:
1. Function as a safe and effective practitioner in his/her role as a student practical nurse.
2. Demonstrate attitudes and behaviors (professional) that are respectful to the patient/client, significant others, and other health care team members.
3. Exhibit effective communication skills (verbal and nonverbal) with patients/clients and significant others in implementing nursing care and relaying information to other health care providers.
4. Comprehend, demonstrate and apply nursing principles in the clinical area.
5. Apply the nursing process to perform basic assessments on each patient/client in all clinical settings (physiological, psychosocial, and spiritual assessments).
6. Formulate an individualized nursing care plan for the patient/client utilizing the nursing care process.
7. Utilize the nursing process in implementation of a plan of care directed to meet the needs of each patient/client.
8. Exhibit a safe and competent skill in administering medications.
9. Demonstrate the ability to effectively evaluate the nursing plan of care.
10. Evaluate individual strengths and weaknesses as a student practical nurse.
11. Utilize the nursing process in the promotion of preventive, therapeutic, restorative and rehabilitative nursing (health) care.
12. Demonstrate the ability to assume the leadership role as a graduate practical nurse.
13. Participate in all learning experiences set forth in the program.
14. Successfully complete all objectives/outcome criteria outlined in the various clinical settings.

CLINICAL ORIENTATION:
Clinical orientation is provided at the beginning of the clinical experience and at the beginning of each new clinical rotation. All students will receive a copy of the Clinical Syllabus at the beginning of the Clinical Period.

Rev. 11/2009
Excerpts from the Practical Nursing Handbook are included in the clinical syllabus as appropriate. The student remains responsible for following policies and procedures as outlined in handbook. Failure to follow any policy as outlined clinical syllabus and program handbook may result in disciplinary action or academic ineligibility to continue in the practical nursing program per Rolla Public School’s Adult Disciplinary Policy, JG-R2.

CLINICAL HOURS:

Clinical hours may vary in both time and days of the week during the last 32 weeks. Consult instructor/nurse director and/or clinical syllabus for time schedule. A clinical schedule will be provided to each student prior to the beginning of a new clinical rotation.

Attendance/Tardies:
If you are going to be absent or tardy, please phone the clinical instructor no later than 5:30 a.m. at home or by cell phone. In addition to phoning the instructor when in the long term care or community health facility, phone the clinical site as well to notify of absence or tardy. When in the hospital setting (acute care), please do not phone the clinical site unless it is an emergency or you are unable to reach the instructor or leave a voice mail. If you must leave prior to completion of your scheduled clinical day, you must notify your clinical instructor and clinical preceptor (if applicable) before leaving. Phone numbers will be provided in orientation and have been provided as a tear-out page in program handbook. Remember, the faculty must let the staff know as soon as possible for reassignment if necessary. Remember if you are ill, you do not belong in the clinical area.

No excused or unexcused absences will be assigned.

Make-Up Policy:
No clinical make-up will be allowed.

Clinical Probation due to Absences:
Any student who misses more than 2 days in any clinical rotation will be placed on academic clinical performance probation and/or deemed academically ineligible to continue in the program.

Note: These Attendance policies are from the Practical Nursing Student Handbook on pages 27-29. Please see instructor or nurse director with questions regarding policy.

ATTITUDE AND CONDUCT:

The Program of Practical Nursing strives to provide learning opportunities in a positive atmosphere. The manner in which students, patients, visitors, staff members, etc., are treated reflects credit or discredit on the student, our program and school. Students are expected to be courteous, respectful, and professional at all times. (Practical Nursing Handbook, pg 30.)
STUDENT EMPLOYMENT AND CLINICAL EXPERIENCE:

The faculty has found students working the night shift prior to clinical learning experience may demonstrate impaired ability to function in a safe and competent manner; therefore, it is the policy that the student shall not work the night shift (11 p.m. to 7 a.m.) before a clinical learning experience. It is also discouraged before classroom hours as well. This policy was established to promote safe and competent care given to patients and families and to promote optimal learning for the student.

(Practical Nursing Handbook, pg. 30)

AFTER-HOURS IN CLINICAL:

Due to safety, students are not allowed to represent themselves as a “Student Practical Nurse” after school hours unless for a specific purpose such as assigned clinical hours or obtaining his/her patient assignment.

(Practical Nursing Handbook, pg. 30)

HEALTH CARE FACILITIES (CLINICAL ASSIGNMENT):

As a practical nursing student in the affiliating agencies, you will be working with physicians, nursing personnel, ancillary staff, patients and families. This will require that you conduct yourself in a professional manner. The health care facility is a therapeutic and learning environment where poor attitude and unprofessional behavior will be cause for disciplinary action or immediate dismissal.

While working in the health care facilities, the student will observe all policies of conduct for employees, as stated in the individual clinical facilities’ policy.

The clinical instructor and/or clinical preceptor is responsible for assigning learning opportunities, facilitating and evaluating student performance while in the clinical facility. The student is encouraged to seek guidance from the instructor/preceptor as needed. (Practical Nursing Handbook, pg. 30)

UNIFORMS:

Uniforms are to be worn at the designated clinical times only. They must be clean, neat and in good repair. Wearing the uniform in public places is discouraged when not related to school function.

The clinical uniform will consist of:

Male Students: Prescribed uniform top with school patch and white uniform pants, a navy emblem polo shirt with khaki pants/white uniform pants, or navy scrubs with emblem

Female Students: Prescribe White uniform with school emblem and navy vest, a navy emblem Polo shirt with khaki pants/white uniform pants, or navy scrubs with emblem

All students: Approved nursing shoes; white socks; white/beige undergarments (when in white uniform); name pin, and supplies (B/P cuff, stethoscope, pen, bandage scissors, penlight/otoscope, and small note pad)

(Practical Nursing Handbook, pg. 30-31)
PERSONAL APPEARANCE:

Because the public gains many of its impressions of our school from contact with our students, it is important that the students contribute to the public image of nursing through proper appearance and personal grooming. Neatness and proper taste in one’s dress and manner also contribute to the impression made on fellow classmates, peers, staff, etc. A good personal appearance assures poise, self-confidence and professionalism, thus, the following policies adopted from the Rolla Public Schools and Clinical Facilities have been established for both the clinical and classroom settings. Specific to the clinical setting are:

1. Dress; personal appearance; and grooming must be clean and comply with appropriate health, safety, and sanitation standards. Good daily personal hygiene in the clinical setting includes daily bath, use of effective deodorant, clean fingernails, and good oral hygiene.
2. Student’s dress, personal appearance and grooming must not materially disrupt or detract from the educational process or constitute a threat to the health or safety of the students or others.
3. Hair must be clean, simply styled and off the collar while in uniform. Beards and mustaches must be neatly groomed. Barrettes, bows, clips, hairnets, and ribbons are not allowed while in the clinical setting.
4. Makeup must be conservative. Colorless or pastel white/pink nail polish may be worn if in good repair. In certain clinical areas, nail polish is not allowed. (Obstetrics and Newborn Nursery).
5. Nails cannot extend beyond the tips of the fingers. In compliance with facility policies, no false nails, nail fill or nail jewelry will be allowed when providing “hands-on” patient care, administration of medications, preparation of food or preparation of products for patients.
6. When in the clinical and professional settings, body jewelry* shall be limited to a watch, wedding ring and/or engagement ring (provided deemed safe) and one pair of tiny post earrings (ears only). In certain clinical areas, no jewelry is allowed (Obstetrics and Newborn Nursery). *Body jewelry includes: eyebrow, nose, naval, tongue and toe rings*
7. Pins, promotional buttons, stethoscope decorative etc., may not be worn while in clinical.
8. All students must wear acceptable footwear in the clinical setting. Footwear should be tied, fastened, or buckled as appropriate.
9. Sunglasses shall not be worn during clinical.
10. All students are to wear required uniform or professional dress as directed by facility and follow all policies regarding personal appearance and dress code.
11. No chewing gum in the clinical setting.

Policy amended on 11/24/08 per faculty

If a student’s clothes or accessories fail to comply with these regulations, the student will be required to change or cover the clothing or accessory at issue or remove the accessory. A student may be sent home in order to do so. Similarly, a student whose personal appearance or grooming fails to comply with these regulations will be required to bring such personal appearance and grooming into compliance. A student may also be sent home in order to do so. The time the student is absent from clinical will constitute the proper tardy or absence on his/her record.

Refusal to comply with the personal appearance policy will result in disciplinary action in accordance with Rolla Public School’s Adult Disciplinary Policy, JG-R2 and/or Academic Performance Probation as it relates to the clinical setting.

(Practical Nursing Handbook, pgs. 33-34)
**EMERGENCY, INJURY, AND/OR ILLNESS:**

1. If you become ill or injured while on duty at a health care facility, please report to your clinical instructor and/or preceptor immediately. Please let nurse director know as soon as possible.
2. Emergency care/health care will be the responsibility of the individual student. Such care will be at the expense of the student.  
   
   *(Practical Nursing Handbook, pg. 46)*

**HEALTH CARE POLICY – CLINICAL:**

When in the clinical area, the clinical facilities’ health policies will override the school’s policies and will be followed as such.  

*(Practical Nursing Handbook, pg. 46)*

**SMOKING:**

While in the clinical setting, the student will be permitted to smoke in the designated smoking area only if the assigned facility allows smoking.  

*(Practical Nursing Handbook, pg. 50)*

**LUNCH/SCHEDULED BREAKS:**

**Lunch:** A 30 minute lunch will be scheduled each day. The student may not leave the health care facility for lunch while in clinical unless instructed by the facility policy or instructor. 

*(Practical Nursing Handbook, pg. 51)*

**Break:** A 15 minute break allowed in the a.m.

**CELL PHONES/BEEPERS/TELEPHONES:**

1. Calls will be forwarded to students only in the event of an emergency; otherwise, a message will be provided.
2. Cell phones are not to be utilized in the clinical setting. **NO Exceptions**! Please leave them in your vehicle. If you have an emergency situation, discuss with clinical instructor and/or preceptor.
3. Beepers are not allowed.  
   
   *(Practical Nursing Handbook, pg. 59)*

**POLICIES OF HEALTH CARE FACILITIES:**

RTC Handbook policies and clinical syllabus policies have been developed in collaboration with the health care settings in which we participate in clinical learning experiences.

**PARKING:** Parking will be allowed only in the designated parking areas for employees (not visitors). Instructor/Facility will provide information during orientation.

**LEARNING EXPERIENCES/METHODS OF INSTRUCTION:**

Clinical learning involves active participation by both the student and instructor in the clinical setting. Pre and post-conferences, guest lecturers, assigned patient care, interaction with health care members and specialized area observation, enhance learning experiences. **Any component of the clinical syllabus may be changed at the director and/or faculty's discretion.**

Clinical syllabus - word
EVALUATION METHODS:

The student will receive a (formal) written summative evaluation of his/her clinical performance from the clinical instructor at the end of each clinical rotation. The instructor will also confer with the student on clinical performance at various times throughout the clinical rotation referred to as a (informal) formative evaluation.

The purpose of the clinical evaluation conference is to facilitate student growth, professionalism and competence as a health care team member, according to the goals and criteria set for each clinical area.

Satisfactory/Unsatisfactory will be assigned in each of the clinical areas.

Satisfactory/Unsatisfactory performance will be assigned based upon the mastery performance of the student in each clinical area as determined by the instructor. Unsatisfactory performance in any of the NINE outlined criteria/competencies is grounds for Academic Probation with clinical emphasis and/or the student will be deemed ineligible to continue in the program of practical nursing.

A sample of the Summative Clinical Evaluation form and the outlined criteria will be provided in your syllabus in the Evaluation section. Any questions regarding clinical evaluation should be directed to the clinical instructor and/or the nurse director.

CLINICAL STATUS AND PROBATION:

Each student shall maintain a “Pass” in each clinical rotation and demonstrate the ability to meet clinical outcome criteria and function in a safe and competent manner in each clinical rotation. Students not meeting the stated requirements may be placed on academic performance probation (clinical) or deemed ineligible to continue in the program. Probation is a stated period of time that allows the student to demonstrate improvement.

In accordance with the practical nursing handbook, any clinical rotation in which a student fails to meet the clinical outcome criteria outlined in the summative performance evaluation and/or exceeds allotted days of absence in clinical may be placed on academic performance probation.

At the close of the stated probationary period, the student’s progress will be re-evaluated by the nurse director, faculty and vocational dean and/or director of the vocational school. At that time, the student will: 1. Be removed from probation or 2. Have probation extended or 3. Be deemed ineligible to continue in program (Practical Nursing Handbook, page 22-23)

HIPAA and Hospital Clinical Orientation:

All students will abide by the rules and regulations set forth in HIPAA and all clinical facility policies. All students will participate in mandatory HIPAA training.

During the clinical rotations, the student is permitted to obtain or view patient records for the purpose of preparing a patient plan of care form only. Obtaining or viewing a medical record for any other...
purposes is strictly prohibited and will be cause for disciplinary action and/or immediate dismissal (compliance infraction). (I.e., obtaining your own record or someone you know during school time while in school uniform).

Information concerning any patient and his/her illness is confidential. It is the student’s responsibility to keep this information strictly confidential. Do no discuss patient information with friends, relatives, classmates or fellow employees. No photocopying of medical record information will be allowed. The only information you will receive will be from the instructor and this information must be returned and the instructor will destroy per facility policy. The student may discuss a patient’s medical condition with other nurses, physicians, his/her instructors and other nursing students provided they are directly concerned with the care of the patient or it is in a supervised learning situation. This does not authorize the student to make moral judgments concerning the patient’s personal and private life. The student should utilize discretion when taking information home as not to disclose any identifiable patient information. This would be an invasion of privacy.

When preparing any type of written assignment, use only initials of the patient, physician, or others who care for the patient. Information or situations witnessed in the clinical setting (i.e., doctor’s office between physician/patient; physician/staff or staff/staff), are considered confidential and any breach in confidentiality may result in dismissal.

Violation of this confidentiality policy may result in immediate dismissal.

**(Practical Nursing Handbook, pgs. 31-32)**

**GRATUITIES:**

Students are not permitted to solicit or accept tips and gratuities from any source at any time; including patients, patient’s families, friends, or staff of clinical facility for services rendered in the course of assignments or duties. Students accepting tips or gratuities are subject to immediate disciplinary action or dismissal from the program.

**(Practical Nursing Handbook, pg. 31)**

**SHARPS/BIOHAZARDS**

Each student will be required to sign the sharps policy which will be kept in the student file. Students will be taught correct techniques to be used when dealing with bio-hazardous materials and/or sharps. If the student is injured by any of these items while at the clinical site or school, the student must report immediately to the clinical instructor and/or preceptor and nurse director the same day of event. An event report must be completed per clinical facility and RTC policy. The student must obtain care for the injury at his/her own expense. A copy of the clinical facility event report must be submitted to the nurse director for placement in student’s permanent file.  

**(Practical Nursing Handbook, pg.47)**

**IMMUNIZATIONS:**

All immunizations must be completed prior to clinical (exception Hepatitis B – if completing series or signed declination). Some clinical facilities may require actual proof of immunizations. If this is the case, nurse director will provide information to clinical site with student’s written authorization. Facility Policy supersedes RTC policy.

**(Practical Nursing Handbook, pg. 50)**

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CLINICAL COMPUTER BASED LEARNING (CBL) ORIENTATION:

Each student will complete required CBL’s for Phelps County Regional Medical Center and other facilities as required. Student will print a transcript for student file record by designated date set forth by nurse director prior to clinical experience. Failure to meet requirement will constitute Academic Clinical Probation.

CLINICAL AND CRIMINAL BEHAVIOR CONTACT:

During the course of the program, a student participating in clinical experiences may come in contact with and/or care for people that have been charged or convicted of criminal acts.

(Practical Nursing Handbook, pg. 33)

CRIMINAL BACKGROUND CHECKS and DRUG SCREENING:

It is the policy of most clinical facilities to require background checks. Each student will complete a background form at the beginning of the school in the orientation session before admission will be allowed to the clinical site. If the background check yields prior history of crime, the history will be reviewed and followed in accordance with the Rolla Public School Policy. Disciplinary action or ineligibility may occur. Clinical sites may require release of information of the background checks from the student prior to allowing the student to participate in clinical experience. The clinical site has the right to deny a student access to clinical rotations for criminal behavior.

(Practical Nursing Handbook, pg. 33)

DRUG /SUBSTANCE ABUSE POLICY:

The program is committed to providing a safe, healthy, and productive learning environment for all students. We are also committed to protecting our patients, patient’s families, staff and others from the potential hazards associated with drug and alcohol use in the clinical environment.

1. Student will have initial drug screening as part of the enrollment process.
2. Additional drug screening may be requested and given to any student who manifests a “reasonable belief” at any time during the school year.

The drug screening program is necessary to meet requirements of the health care facilities where the student is placed for clinical experiences, internships and preceptorships.

Failure to participate or failure to pass a drug test will be cause for disciplinary action in accordance with Rolla Public School’s Disciplinary Policy, JG-R2.

Clinical sites may require information regarding drug screening prior to allowing the student to attend clinical experiences at their facility.

(Practical Nursing Handbook, pg 34)
DRUG OR SUBSTANCE ABUSE BY STUDENT

The following policy has been established to address students with substance abuse problems that can adversely affect learning performance and safety in the clinical site:

1. While at the clinical site or authorized school-sponsored event, students are prohibited from use of and unauthorized possession, distribution or abuse of alcohol or controlled substances, prescription drugs, not used as prescribed, or other mind altering or intoxicating substances.
2. Drugs prohibited by this policy include, but are not limited to, controlled substances such as Cannabinoids (marijuana), cocaine, crack, phencyclidine (PCP), LSD, heroin, codeine, morphine, amphetamines, barbiturates, opiates, methaqualone or benzodiazepines, or any other substances included in the Federal Controlled Substance Act and any other substances which may impair the student’s ability to work in a safe and productive manner. Drugs prohibited also include prescription or over-the-counter drugs, which have not been specifically prescribed by a licensed physician/licensed nurse practitioner/licensed physician assistant or are not being used for the purpose of the manner prescribed.
3. Students will not be allowed to attend school or permitted to work in clinical settings while under the influence, or while suffering from the effects of prohibited drugs or alcohol, and will be subject to disciplinary action in accordance with Rolla Public School’s Disciplinary Policy, JG-R2.

(Practical Nursing Handbook, pgs 35)

REPORTING OF DRUG VIOLATIONS

This policy is in accordance with Rolla Public School’s Drug Policy, JFCH)

1. The nurse director/faculty or appropriate staff at clinical site who has probable cause to believe a student on the clinical site or authorized school sponsored event is behaving in a manner that is indicative of the influence of drugs must report the incident/violation immediately to the technical school administrator in charge.
2. Documentation of the incident shall be made by all school personnel and/or clinical site personnel involved with the incident. All such documentation shall be retained by the nurse director and designated administrator of the vocational-technical school. After investigation, if the report is found to be valid, the designated administrator will follow the procedures outlined in Rolla Public School’s policy.
3. The following circumstances require reporting:
   a. Evidence of drug or alcohol use, including unauthorized possession on clinical site setting or authorized school sponsored event;
   b. A student exhibits impaired behavior or work performance which causes a member of supervision to believe drugs or alcohol may have been used;
   c. A student sustains an injury or is involved in an accident that requires medical attention or treatment by a physician or other health care professional.

(Practical Nursing Handbook, page 36)
DISCIPLINARY ACTION FOR VIOLATION OF DRUG POLICY

Any student in violation of the provisions of this policy shall be subject to disciplinary actions in accordance with the provisions of school regulations, Adult Disciplinary Policy, JG-R2. Disciplinary actions provided by the school shall be independent and separate from actions taken by law enforcement officials (as necessary) or by the Missouri State Board of Nursing.

After investigation, if the report is found to be valid, the nurse director and/or designated administrator of the school will follow the procedures outlined below:

1. Student will be removed from the classroom, clinical site or school-sponsored event.
2. Student will be escorted to the administrator’s office with nurse director, faculty, and/or administration.
3. Appropriate law enforcement officials will be notified as soon as it is practical after school officials have probable cause to believe a student has possession of or is under the influence of an illegal controlled substance or intoxicant.
4. The Missouri State Board of Nursing will be notified.

(Practical Nursing Handbook, pgs 36)

ADULT STUDENT DISCIPLINARY POLICY

The district disciplinary policies are designed to foster student responsibility, respect for others, and to provide for the maintenance of an atmosphere where orderly learning is possible and encouraged. Policy is provided in practical nursing student handbook.

(Practical Nursing Handbook, pgs 36-42)
The Nursing Process
THE NURSING PROCESS

The nursing process is a systematic, decision-making process that involves assessment (data collection), planning, and implementation and uses evaluation and subsequent modifications feedback mechanisms that promote the ultimate resolution of the patient's nursing problems. The process as a whole is cyclic, the steps being interrelated, interdependent, and recurrent.

STEPS OF THE NURSING PROCESS

1. **Assessment** - Collecting data, validating data, organizing data. Systematic assessment of the patient's problems for the purpose of establishing a nursing diagnosis.
2. **Analysis/Diagnosis** - Analyze data; identify strengths and actual and potential problems; basis for plan of care; determines which problems require interventions.
   **The LPN assists the RN in formulating the nursing diagnosis and carrying out the plan of care.** Identify nursing diagnosis; identify collaborative problems; identify strengths.
3. **Planning** - Development of a plan of care to resolve the problems; establishment of goals; setting priorities; determine nursing interventions; documenting plan of care.
4. **Implementing** - Implementation of the plan of care or supervision of others who implement the plan; putting the plan into action; identifying patterns; communicating and recording data; continuous data collection; setting daily priorities; performing nursing interventions; documenting nursing care (charting); giving verbal reports, making a current care plan.
5. **Evaluation** - Evaluation of the effectiveness of the plan of care in resolving the assessed problems; determine if the plan has worked.

ASSESSMENT:

Assessment begins with the nurse's first encounter with the patient. It involves the systematic collection of data about the patient's nursing needs and the use of this data to formulate nursing diagnosis. It includes both **subjective data** (what the patient actually says; how they perceive what they are feeling; "I am having trouble breathing") and **objective data** (concrete observable information such as: physical assessment—vital signs; diagnostic values, changes in behavior; ex.- b/p 198/110; skin cool, clammy, diaphoretic)

A. **The Nursing History:**
   1. is carried out for the purpose of determining the pt's state of wellness or illness and is best accomplished as part of a planned interview.
   2. provides the nurse with the opportunity to collect data and also to convey interest, support, and understanding to the patient.

B. **The Physical Examination:**
   1. to determine the pt.'s physical alterations and limitations.
   2. to determine the pt.'s assets, which may serve to compliment his limitations.
C. **Other Sources of Assessment Data:**
   1. patient's family and/or significant others
   2. members of the health team
   3. nursing and medical records
   4. verbal and written consultations
   5. records of diagnostic studies

D. **Nursing Diagnosis:** (Those health problems that have the potential for resolution by means of nursing action)
   1. organizes, analyzes, synthesizes, and summarizes the collected data
   2. identify the patient's nursing problem(s); its particular characteristics and etiology(ies)
   3. identify potential problems as being "high risk"

**PLANNING:**

1. Assign priorities to the nursing diagnoses. Highest priority is given to problems that are the most urgent and critical.
2. Establish goals of nursing actions by nurse and patient together.
   a. specify short-term, intermediate, and long-term goals
   b. state goals in realistic and measurable terms.
3. Identify nursing actions appropriate for goal attainment.
4. Establish expected outcome criteria.
   a. state outcomes in terms of patient behaviors
   b. outcomes must be realistic and measurable
   c. identify critical time periods for the attainment of outcomes.
5. Formulate the nursing plan of care.
   a. include nursing diagnoses in order of priority, goals, nursing actions, outcome criteria, and critical time periods.
   b. write entries precisely, concisely, and systematically.
   c. keep the plan current and flexible to meet the patient's changing problems and needs.
   d. involve the patient, his family and/or significant others, nursing team members, other health team members, and community agencies in all aspects of planning

**IMPLEMENTATION:**

1. Put the nursing care plan into action.
2. Coordinate the activities of the patient, his family, and/or significant others, nursing team members, and other health team members.
3. Delegate specific nursing actions to other members of the nursing team, as appropriate:
   a. consider the capabilities and limitations of the members of the nursing team.
   b. supervise the performance of the nursing actions.
4. Record the patient's responses to the nursing actions.
   a. record the responses precisely, concisely, and objectively.
   b. recordings should be related to the nursing diagnoses.
   c. include any additional pertinent assessment data.
EVALUATION:

1. Collect objective data.
2. Compare the patient's behavioral outcomes to the outcome criteria. Determine the extent to which the goals were achieved.
3. Include the patient, his family and/or significant others, nursing team members, and other health team members in the evaluation.
4. Identify alterations that need to be made in the nursing care plan.

CONTINUATION OF THE NURSING PROCESS:

1. Continue all steps of the nursing process: assessing, planning, implementing, and evaluating.
2. Continuous evaluation provides the means for maintaining the viability of the entire nursing process and for demonstrating accountability for the quality of nursing care rendered.
ABBREVIATED GUIDE TO INTERVIEWING

Ideally, a health history and assessment tells the reader a great deal about your patient, and nothing about you, except that you've mastered the skills necessary to be a good interviewer. You can perfect your technique by using these rules:

1. Create a pleasant interviewing atmosphere.
2. Ensure privacy.
3. Use the person's name (not nickname).
4. Explain your purpose and identify yourself as a student nurse.
5. Use good eye contact.
6. Don't rush - allow 15 minutes or more for the interview.
7. Gather all available information about your patient before you interview him/her.
8. Try to develop a good rapport with your patient.
9. Use your senses.
10. Observe general appearance.
11. Observe body language.
12. Observe interaction patterns.
13. Form effective questions.
15. Use terminology that the person understands.
16. Use open-ended questions.
17. Use reflection.
18. Don't start with personal or delicate questions.
19. Defer questions that are not pertinent.
20. Use an organized assessment tool to prevent omissions.
21. Take notes.

Remember that data must be **specific** and precise. Avoid vague generalities. Instead, provide pertinent, concise, detailed information that will help determine the direction and sequence of the physical examination.

Family members often help you validate, clarify, and elaborate on the patient's history, especially his/her daily activities. The basic principles of interviewing patients apply when you interview your patient's relatives and friends. Never give information about your patient without your patient's permission (violation of HIPAA).

When you interview someone else to the patient who isn't part of his family, be sure to note the nature of the relationship and the length of time the individual has known the patient. For example, you might write: "Information received from Paul Smith, a friend, who has lived with the patient for five years."

GUIDELINES FOR DOCUMENTATION

There are various formats utilized by health care agencies for describing information about a patient and his/her care. The total of these forms make up the patient's record. Some agencies use the word "chart" while others use "health care record." The process of making entries on the patient's record is called recording, charting, or documenting. As a student, you may experience first hand two forms of documentation both in the written or computerized form.

The following guidelines are to be referred to and used by the student for documentation in the patient's record. Additional assistance in documentation may be obtained by using references and consulting with an instructor.

Documentation indicates the care you give and the patient's response to that care. Accurate and complete documentation is vital to good communication among the patient and health care team members.

DESCRIBE WHAT YOU SEE

You need to identify the patient's reaction to your actions, whether it is a medication given or a treatment applied. Record his response as well as the time, dosage, description, and any adverse effects. Check the chart for previous adverse reactions to this medication or treatment. Describe exactly what you observed, and document what you see. For example, when observing bleeding, indicate how much, what color, whether it is gushing, oozing, or running, and its source.

Is the patient having trouble moving? Does he stumble? Can he stand in a normal fashion? Is his language coherent? Is speech clear and appropriate?

Does his urine or stool have a foul smell? Does his breath have a foul odor?

These are the types of questions you need to ask yourself, so your chart will be meaningful.

BE SPECIFIC

Avoid ambiguous statements and generalizations. For example, "had an uncomfortable night" doesn't say anything specific, whereas "states was up 10 times with diarrhea during the night" tells why the patient had an uncomfortable night.

1. **Use direct quotes.** Directly quote the patient and differentiate his words from what you observed. Enclose the patient's statement in quotation marks so others will know that this is exactly what he said. The line, Mrs. Change stated, "I have a throbbing pain in my head," is specific and describes how the patient interprets the pain.

Do not chart hearsay, such as what someone else has told you about the patient, unless you quote the statement. For example, Mrs. Rodriguez's husband had said, "My wife does not like the food here."
2. **Be prompt.** Chart immediately after giving care. Chart all care, medications, and treatments at the bedside. The chart doesn't have memory lapses - though you may. If you are utilizing computerized charting, real charting time is considered within 20 minutes.

**Important:** Always chart after you give a medication (unless facility policy requires you to chart before or perform a treatment.) If you are utilizing the bar code scanning for administration of medications, follow the facility protocol.
GUIDELINES TO GIVING AN ORAL REPORT

1. State your name
2. State the patient's name
3. Room Number
4. Doctor's name/ Consulting Dr. (if any)
5. Diagnosis (recent). If surgery, name of surgery and date done
6. Pertinent information as to patient on your shift and next shifts
   a. Dressings (if any)
   b. I. V. Fluids
      1. Number of bottle infusing
      2. I.V. solution infusing and what to add next
      3. infusion rate
      4. amount left to infuse
   c. Drainage systems and character of drainage (e.g. levine, Foley, hemovac, etc.)
   d. Oxygen number of liters, mode of administration (catheter, cannula, etc.)
   e. Activity - type, how often, how tolerated, etc.
   f. Medications to be given next shift, give times
   g. Vital signs - how often to be taken, any abnormalities your shift
   h. Special treatments done or to be done
   i. Special tests or procedures done or to be done
   j. Abnormal lab results noted
   k. Special tests or procedures done or to be done such as Homan's sign, bowel sounds, isolation. etc.
   l. C & A - if ordered
   m. Lab or X-ray done or to be done and preparations needed
   n. Check your order and doctor's progress notes and give any pertinent information
   o. Visitor, relatives or sitter at patient's bedside
   p. Any information the oncoming shift needs to respond to immediately.
   q. Diet

Be sure to use an organized method such as the kardex care plan or a computer generated form with assigned patient information when giving report, whether taped or directly reported to staff. Develop your own system for reporting to include all information listed above. The information should be presented in a logical organized manner. Follow facility policy. **Remember, do not read the entire kardex or computer generated form - your cohort can do this.**

The report you give should be what you would expect to receive if you were the on-coming shift. A good report enables the on-coming shift to outline their plan of care for their patients
Development of Nursing Care Plan Clinical Assignment
STUDENT CLINICAL ASSIGNMENT

1. During the initial period of orientation to the hospitals and computerized documentation, the instructor will provide you with the information necessary to complete your assignment on Tuesday afternoon or Wednesday morning. Each instructor will provide details during the clinical orientation.

2. The instructor will show the student where the assignment sheet will be kept during the orientation period to the clinical setting.

3. Blank nursing care plan forms will be available to the student at all times in the nursing lab.

4. As part of the weekly assignment, the faculty requests that each student keep all completed patient assignment sheets and patient plan of care assignments in the provided folder. Drug cards will be required for assigned patient(s).

5. It is the student's responsibility to act in a professional manner when obtaining his/her clinical assignment.

6. If there is a designated student computer and cart, the student must utilize assigned computer as instructed.

7. Clinical orientation is provided at the beginning of each new clinical rotation.
INSTRUCTION FOR DEVELOPMENT OF THE PATIENT PLAN OF CARE

The following is the procedure for the development of the patient's plan of care required for each clinical rotation.

1. The clinical instructor/student will provide the following information about their patient assignment:
   (see sample form)
   a. patient name, age (utilize initials only)
   b. room #
   c. doctor/consulting doctors (utilize initials only)
   d. diagnosis
   e. admit date
   f. special interest items:
      1. diet
      2. activity
      3. treatments
      4. oxygen
      5. I.V.’s, etc.

2. From this information, the student should begin to formulate a patient care plan based on the given data.

3. The student should look at the patient's information in chart or on computer to use as an overview and guide. If the student is in a clinical rotation in which they cannot obtain their assignment the day before, this will be done the first day of clinical.

4. The student should look over the following information:
   a. the nurse's admission history/assessment and admission note
   b. the medical history and physical
   c. the most recent nurses notes (the past 24 hours)
   d. admission lab work
   e. most recent lab work (past 48 hours)
   f. most recent physician's progress notes (past 24 hours)
   g. most recent physician’s orders (past 24 hours)
   h. diagnostic procedure reports

5. After the student has made notes on all of the above, he/she is now ready to interview and assess the patient. (This may occur the evening before or the first day of clinical). The student should be aware of the times in which the interview will be most profitable to the student but at the same time not interfere with the patient’s comfort.

Utilize the guide for interviewing). Please be sure the patient knows you are a student practical nurse and the reason for your interview and assessment. The student should then assess the patient using the guides to make his/her own observations and to obtain his/her own nursing history. The assessment should be thorough, concise, and include problems not observed as well as those observed.

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6. The student is now ready to list the patient's problems, which can be solved with nursing intervention on the nursing care form. **Please write only pertinent data on assessment relating to the nursing problem.** Remember to utilize Maslow’s Hierarchy of Needs as a means of prioritizing the patient’s needs.

7. Your problem statement describes the cluster of symptoms and signs indicating a real or potential health problem you can identify and your nursing care plan can resolve. Utilize reference books to support your data.

8. Planning is the next step the student must complete on the nursing care plan. Planning is simply establishing goals, both short term and long term. Short term goals are developed on a daily basis for each nursing problem and should be evaluated daily (the last step of the nursing process). Long-term goals are developed for each nursing problem as well, remembering this is what you want the patient to accomplish at the time of discharge. Discharge planning should begin at the time the patient is admitted.

   **A goal should always be measurable.** One way to indicate this is by stating in your goal "as evidenced by" followed by the specific goal you want the patient to accomplish. For example: the patient will have an increased intake for the 8-hour shift as evidenced by: increasing p.o. intake from 300 cc to 500 cc and eat 50% of each meal. This is measurable; therefore, it can directly be evaluated and changed if necessary.

9. The student is now ready to carry out specific nursing measures for each problem listed (in the nursing implementation column on the nursing care form). The development of the nursing care plan of care should show the student's recognition of the patient as an individual. The plan should reflect what the student actually plans to do to meet the patient's needs. The student should utilize his/her text books as references and other references as necessary.

10. Rationale for why a particular nursing intervention (measure) is done is important for complete understanding of the success of that intervention. The student will complete the rationale column with reasons why a particular intervention was performed. Please utilize your reference books. This helps to increase and solidify the knowledge learned.

11. Evaluation is a part of the nursing process and must be done on a **daily basis** with the date listed. With the changing condition of the patient, it will be necessary to add to the problems list as those changes occur. The student must recognize the difference between pre and post-operative patients and the need for separate problems identifying these needs on the same patient. The same is true of the pre and post-procedural patient.

   Ineffective care, or care not producing the desired results or failure to reach realistic goals will require a new set of plans and should also be added onto the care plan and appropriately dated.

   **The student must recognize his/her own responsibility for developing an accurate and acceptable nursing care plan.** The student must be encouraged to ask for assistance as necessary.
Remember, the purpose of the nursing care plan is to provide continuity of holistic and individualized care. It is a means of communication. Be clear and concise so that another person caring for the same patient understands what is being done and receives clear instructions to continue that care.

(See example provided on next page of a patient plan of care form)
MEDICATION PROFILE

Each student will be responsible for completing or providing medication profiles on 5 X 7 lined index cards for all medications (scheduled and as needed) on assigned patient(s).

Each student will be responsible for knowing the following information regarding his/her patient’s drugs:

☐ Generic/Brand Name
☐ Classification
☐ Indications
☐ Action of Drug
☐ Adverse Reactions and Side Effects
☐ Route and Dosage
☐ Nursing Implications

NURSING CARE OF THE OLDER ADULT CLINICAL ROTATION

Please note that a separate medication profile form will be completed for this rotation only. Forms are available in the nursing lab. Refer to Nursing Care of the Older Adult Clinical section for sample form.
Clinical Pre and Post Conference
**PRE-CLINICAL CONFERENCE**

At the beginning of each clinical day, there will be a pre-conference. The following are possible activities for pre-conference.
1. Discuss patient assignments and answer questions.
2. Discuss clinical objectives for day.

**POST-CLINICAL CONFERENCE**

At the end of each week in clinical, there will be a post-conference. The following are possible activities for post-conference.

1. Discuss nursing care and care plans of patient's the students have cared for during the week.
2. Early in the year, the student's will look up and present, on the last day of the clinical, one disease condition he/she has observed that week. He/she should concentrate on how that disease affects the body, the nursing care and treatment.
3. Students report on abnormal lab values, preferably on their assigned patients. Discuss what the results indicate and if, or how, they can be corrected.
4. Students report on any diagnostic tests, procedures, or surgeries observed during the week.
5. Students give report from a pseudo-kardex. Each student takes the report and the others critique the report constructively.
6. Students tape a pseudo-report. Each student listens to the tape and critiques the reporter constructively.
7. Students listen to a tape which simulates a doctor on the telephone giving orders on a patient to be admitted or verbally to a nurse on rounds. The students must simulate the necessary measures to complete the doctor's orders.
8. Simulate a situation where the student would be the primary nurse caring for a patient with: Diabetes Mellitus, fractured hip, M.I., etc. Discuss the points that your initial observation or assessment should include.
9. Role play situations and follow through with nursing actions. For example: a code, finding a patient in hypoglycemic shock, etc.
10. Inservices may be scheduled, as they relate to theory or clinical.
11. In-services provided by the institution may be attended by the students if related to theory or clinical.
12. Students practice writing report on report sheets, utilizing various examples of work sheets, and ways that nurses write reports.
13. Review nursing procedures, for example: utilize an empty room and display setting up suction equipment, nasogastric insertion, etc.
14. Students work on pseudo-dosage calculations.
15. Discuss how the students feel about the experience they received for the week, any problems they encountered, observations made in reference to a particular area, etc.
16. Guest speakers may be scheduled periodically.
Clinical Evaluation Process and Criteria
CLINICAL PERFORMANCE CRITERIA AND EVALUATION PROCESS

The instructor will confer with the student on clinical performance (formative) throughout the clinical rotation. At the end of the clinical rotation, the student will receive a written summary (summative) of his/her clinical performance from the clinical instructor.

The purpose of the clinical evaluation conference is to help the student grow professionally; to function competently as a health care team member according to the goals and criteria set for each clinical area; and ultimately to graduate capable of competent functioning as an LPN.

It is the responsibility of the student to read his/her handbook for further information regarding the clinical evaluation conference and how he/she can best benefit from and participate in these conferences. Any questions regarding clinical evaluation should be directed to the clinical instructor, clinical preceptor, and/or nurse director.

The following criteria are given to the student as a basis for satisfactory clinical performance or behavior. The student must read and be thoroughly familiar with all criteria.

SATISFACTORY - PERFORMANCE the student's performance is acceptable, the criteria/competency has been mastered at the time of the evaluation; adequate, satisfies Minimum Standards and requirements set forth by RTC’S Program of Practical Nursing and Missouri State Board of Nursing

UNSATISFACTORY - PERFORMANCE the student's performance is unacceptable, the criteria/competency has not been mastered at the time of the evaluation; inadequate, unsafe, fails to satisfy Minimum Standards and requirements set forth by RTC’S Program of Practical Nursing and Missouri State Board of Nursing.

** An unsatisfactory performance in any of the nine outlined criteria/competencies denote academic probation (clinical) and/or may be grounds for academic ineligibility to continue in the program.

NOTE: The written summative clinical evaluation ratings represent knowledge, skills, and attitudes that each student has demonstrated at a given time under given conditions. It does not necessarily represent certification of future abilities.

The instructor will evaluate the student based on the written clinical objectives and criteria and/or competencies. Methods utilized in determining if the objectives/outcome criteria are being met include observation and recording of student performance by the instructor, input from agency staff and/or clinical preceptor, verbal reports made by patients, nursing care plan assignments, record of nurses’ notes, and nursing judgments, etc.
CLINICAL PERFORMANCE OUTCOME CRITERIA/COMPETENCIES

Each student will be evaluated in the following areas:

1. PROFESSIONALISM: Exhibits professional behavior
   a. **Appearance** - Follows dress code as set forth in student handbook
   b. **Attitude** - Demonstrates appropriate attitude, interest and enthusiasm
   c. **Attendance** - Present, prompt, and punctual for clinical assignment
   d. **Constructive Criticism** - Accepts constructive feedback and supervision
   e. **Initiative** - Seeks out learning opportunities; prepares to meet new challenges
   f. **Dependability** - Dependable, consistent, and reliable in all aspects
   g. **Clinical Assignment(s)** - Completes clinical assignments as instructed
   h. **Written Assignment(s)** - Completes all written assignments as instructed

2. COMMUNICATION: Demonstrates written and verbal communication skills
   a. **Interpersonal Relationships** - Establishes professional relationships
   b. **Nurse-patient/Family Relationships** - Establishes rapport and elicits trust with patient/family/significant other
   c. **Documentation** - Charts clinical findings accurately and concisely
   d. **Reporting** - Reports orally clinical finding of patient care and per facility policy
   e. **Medical Terminology/Spelling** - Utilizes appropriate terminology with correct spelling

3. COMPREHENSION/APPLICATION: Applies nursing care principles to clinical
   a. **Rationale** - Explains reasons for nursing actions
   b. **Correlates** theory to practice - Demonstrates knowledge in practice
   c. **Knowledge** - Enhances and shares knowledge base

4. NURSING PROCESS - ASSESSMENT: Conducts basic assessment
   a. **Performs** - physical, psychosocial, spiritual and environmental assessments accurately and concisely
   b. **Interprets Physical findings** - Relates findings to patient care
   c. **Evaluation of Medical Record** - Reviews medical record and incorporates findings into patient care and written work
   d. **Assists in the Formulation of Nursing Diagnosis** - Attempts to formulate appropriate NANDA nursing diagnosis from identified nursing care problems

5. NURSING PROCESS - PLANNING - Plans nursing Care
   a. **Nursing Plan of Care** - Completes nursing care plan as assigned and establishes appropriate & realistic goals.
   b. **Nursing Actions** - Describes appropriate nursing actions
   c. **Prioritizing Patient's Needs** - Uses Maslow's hierarchy to prioritize nursing care problems/diagnosis

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6. NURSING PROCESS - IMPLEMENTATION: Identifies and carries out appropriate nursing actions
   a. **Skills Performance** - Performs skills/procedures accurately and concisely
   b. **Organization** - Organizes care and proceeds in orderly fashion; time management
   c. **Safety Measures** - Demonstrates and applies safety measures in all activities
   d. **Dexterity** - Demonstrates dexterity when performing procedures
   e. **Comprehends Procedures** - Reads procedure, relates steps and explains rationale for procedures and/or nursing measures

7. NURSING PROCESS - EVALUATION: Evaluates nursing care plan; Self evaluates strengths and weaknesses of clinical performance as a student practical nurse
   a. **Adjustment of Performance to Meet Patient's Needs** - Recognizes and adjusts nursing care appropriate to meet patient's needs
   b. **Self Evaluation** - Recognizes own strengths, weaknesses, and responsibilities of clinical performance as a student practical nurse

8. ADMINISTRATION OF MEDICATIONS: Administers medications utilizing nursing process
   a. **Knowledge** - Demonstrates and correlates appropriate knowledge of medications to patient's disease process:
      1. Classification
      2. Generic name/Trade-Brand name
      3. Nursing Actions (to include patient teaching)
      4. Adverse Effects
      5. Why patient is receiving drug
   b. **Organization** - Organized and timely with preparation and administration of medications
   c. **Safety** - Demonstrates safe and competent manner in preparation, administration of medication and disposal of equipment:
      1. Utilizes 6 rights of medication administration
      2. Utilizes universal precautions in equipment disposal
      3. Demonstrates medical asepsis
   d. **Preparation and Administration** - Demonstrates proper technique in preparation and administration of medications as experience is available in clinical setting or laboratory:
      1. Prepares and administers inhalant medications
      2. Prepares and administers nose, eye, & ear drops
      3. Prepares and administers topical medications and patches
      4. Prepares and administers oral medications
      5. Prepares and administers sublingual and buccal medications
      6. Prepares and administers rectal medication
      7. Prepares and administers vaginal medications
      8. Prepares and instills medications in bladder
      9. Prepares and administers subcutaneous injections
     10. Prepares and administers intramuscular injections
     11. Prepares and administers intradermal injections
     12. Prepares and administers medications by NG & G tubes
     13. Selects and uses appropriate syringes and sharps
     14. Prepares, administers, and manages controlled substances according to federal law and facility policy
e. **Implementation** - Implements appropriate nursing measures
   1. Monitors and assesses effects of medication and intervenes when necessary
   2. Monitors medications given by infusion pumps
   3. Obtains appropriate vital signs as indicated by medication policy, I&O, etc
   4. Monitors IV therapy
   5. Verifies physicians orders for medications

f. **Documentation** - Documents medication administration and patient response accurately and concisely as instructed
   1. Documents on medication administration record appropriately
   2. Documents patient response as appropriate

h. **Drug Calculation** - Converts and calculates dosages accurately and concisely

i. **Medication Profiles** – Completes patient medication profiles accurately as instructed

j. **Preparation** - Demonstrates preparation by having supplies and reference material
   1. Utilizes appropriate reference material (own and floor references)
   2. Has available supplies (i.e. - B/P cuff, pen, stethoscope, scissors)
   3. Utilizes appropriate equipment as needed

9. **LEADERSHIP AND MANAGEMENT:** Demonstrates ability to assume role as leader
   a. **Assumes Leadership Role of Practical Nurse** - Demonstrates the ability to assume leadership of practical nurse as assigned
   b. **Delegates Job Tasks** - Delegates tasks to team members as instructed
   c. **Manages and Directs Team Members** - Directs and supervises team members

   *Note: This section on the clinical performance tool will not be applicable until the Leadership and Management Clinical Rotation.

*Please note: All preceptor evaluations will be attached to the Summative Evaluation Form at the end of the clinical rotation as applicable. All information from the preceptor will be considered on the evaluation form.*
Nursing Care of The Adult Clinical
NURSING CARE OF THE ADULT CLINICAL ROTATION

CLINICAL EXPERIENCE OBJECTIVES/OUTCOME

At the end of the clinical experience, in addition to the clinical course objectives/outcome criteria, the student should be able to:

1. Assist in the formulation of nursing diagnoses based on principles applied to physiological functioning, self-concept, role function, and interdependence of the holistic adult person.

2. Organize and implement nursing care according to goals and priorities for specific health disorders.

3. Evaluate the nursing care plan and make necessary revisions when appropriate for the adult patient.

4. Assess and plan immediate nursing responsibilities and interventions associated with care of an adult patient/client in both the acute care and community settings.

5. Assess, plan and initiate a teaching plan for the adult patient/client and/or significant others as it relates to the specific health disorder and medical-surgical management of the patient.

6. Implement and evaluate discharge planning when possible for the adult patient/client.

7. Demonstrate effective utilization of time and resources.

8. Demonstrate ability to document pertinent data (written and computerized) in the nurses’ notes and care plan, in accordance with institutional policy as it pertains to the patient.

9. Demonstrate ability to give an organized, accurate and pertinent verbal report to assigned nurse before leaving the unit and at other times, as indicated.

10. Complete nursing care plan forms, as directed.

11. Participate in all learning experiences including Pre- and Post-conference.

12. Successfully complete the Nursing Care of the Adult clinical experience by meeting all objectives/outcome and obtain a satisfactory performance on the summative clinical performance evaluation.
NURSING CARE OF THE ADULT CLINICAL ORIENTATION

A. Report promptly to assigned area at assigned time. Be prepared to participate in pre-conference at this time. (PCRMC - 0645 and SMDH – 0620)

B. Discuss problems or concerns encountered previously.

C. Obtain patient information from assignment board as designated by instructor in assigned area. Be sure to write down the name of your charge nurse and nursing assistants.

D. Report:
   1. Receive detailed report on assigned patient
   2. Do not interrupt during report to ask questions
   3. Refer to assignment sheet or computer for missed information when necessary (i.e. - diet, etc)
   4. If report is delayed, you may briefly visit your patients. Assessment and a.m. care must wait until after you have received report

E. Visit Assigned Patient:
   1. Visit all assigned patients, before starting morning care
   2. Check that side rails are up where indicated.
   3. Check patient and all equipment in use
      a. Is IV dripping? What is the fluid being infused? What is the condition of the IV site?
      b. Is NG tube patent and draining?
      c. Is hemovac or Jackson Pratt charged (done every 2 -4 hours)
      d. Is Foley patent and draining?
      e. Is dressing clean and dry?
      f. Is patient soiled due to incontinence?
      g. Is O2 working properly? What is the rate of administration?
      h. Check general condition - is patient breathing okay? What is his/her color? Any pain? Does your patient need a position change?
      i. What about patient’s orientation status and mental attitude?
      j. Prioritize patient care
      k. **Remember**, you are responsible for your assigned patient(s) the entire time you are in the area.
      l. Total I &O and document per facility policy
         1. I&O’s are totaled at end of shift at 1:30 p.m. and after
         2. Document per facility policy

F. Morning Care:
   1. Check your linen
   2. Use bath blankets on all patients requiring a bath
   3. Catheter care is to be done on all patients with Foley catheters
   4. Oral hygiene must be done; there is absolutely no excuse for this to be overlooked. Dentures are to be thoroughly cleaned
   5. Male patients shaved per personal preference.
   6. Don't overfill linen bags! Bags are limited to 1/2 capacity
G. Vital Signs:
1. Done on all assigned patients for a.m. assessment and as assigned.
2. Any additional vitals will be assigned to you in report or as they come up (post op; blood transfusions, etc)
3. If you suspect an abnormal vital sign, feel free to check it again; any abnormality should be reported to your instructor and/or team leader immediately. Do not wait to pass on an abnormal vital sign in report at shift’s end.
4. Document vitals on computer as required
5. It is your responsibility to be prepared with your stethoscope, blood pressure cuff, watch, and bandage scissors.

H. Documentation:
Written: (if applicable)
1. Have morning notes ready for instructor to review by 10:30 – 11:30 a.m.
2. No written charting prior to authorization by instructor.
3. Afternoon notes should be ready to be checked by 1:30 p.m.
4. Charts must be checked and approved by your instructor before you will be dismissed from the clinical area.

Computer: (If applicable)
1. Computers are used at PCRMC and SMDH for all nursing documentation. Orientation will be provided prior to the beginning of clinical and instruction will be on-going during the clinical rotation.
2. Personal codes will be assigned to each student. Individual passwords will be selected by each student for entry into the system.
3. No computerized documentation prior to authorization by instructor.
4. All documentation must be checked and approved by your instructor before you will be dismissed from the clinical area.

I. Breaks and Lunch: (You must remain on the premises of your clinical facility)
1. 15 minutes is allowed in the morning for break
2. Attempt to take your break at an appropriate time in regard to patient care. A morning break is essential to your well-being. If you are repeatedly unable to take a break, this may indicate unnecessary slowness or disorganization on your part.
3. Always inform instructor and/or team leader when you are leaving on break. If neither can be located, let the ward secretary know you will be off the floor.
4. It is also a good idea to sign out on the assignment board (if appropriate) so that others will know where you are.
5. Lunchtime varies. It will depend on your patient assignment.
6. Most meal carts arrive on the floors between 1200 and 1230. It is a good idea to take your 30-minute lunch break between 1100 and 1200, so that you will be on the floor when your patients are served lunch. Be available to assist the floor staff with tray distribution. By taking lunch between 1100 and 1200, you also avoid the noon "rush" and long lines in the cafeteria.

J. Patient Ambulation:
1. Always get assistance and use your gait belts!!!!!!!
2. Be willing to help others with patient ambulation when it is convenient for you.
3. A fall or injury as a direct result of you not securing proper assistance is flagrant negligence on your part and you may be held legally responsible.
4. Don't hesitate to ask nursing assistants for help. Be willing and available to offer assistance to others in return!

K. Reporting Off at Shift's End:
1. Must be done daily at end of shift - Wed. (2:30); Thurs. (1:30)
2. Report to team leader who gave you a.m. report unless otherwise instructed.
4. Be sure to let team leader know who you are reporting on.
5. Observations should be clear and concise. Your report should be informative, but not too wordy.
6. Be prepared for any questions your team leader may have.

L. Last minute Check Off List:
1. Have you reported off?
2. Is charting complete and concise?
3. Are side rails up, if appropriate? If so, how many?
4. Is patient comfortable and in proper body alignment?
5. Is water pitcher filled?
6. Are soiled chux out of waste basket?
7. Is any extra linen folded and put away?
8. Is the call light within easy reach? Is the bed in low position?
9. Bedside stand and unit clear of all clutter?
10. Are all tubes and equipment functioning?
11. Are the bed linens clean, dry and tidy?
12. Has instructor reviewed documentation and signed nurse’s notes?

M. Extra Procedures:
1. Additional procedures done at instructor's discretion. If you are consistently late with your assignment, you will miss out on valuable learning experiences.
2. You will rarely be expected to perform a clinical procedure until you have practiced it in the lab. There are exceptions, but an instructor will be there to guide you.
3. Learning is your responsibility. Be ready to make adjustments in your care plan as new experiences arise.

N. Post-Conference:
1. Will be held every Thursday from 1400-1500.
2. Students are expected to participate actively and come to post-conference prepared with assigned material.

O. Day's end:
1. Have all assigned work completed at least 30 minutes prior to dismissal time.
2. Report off to assigned team leader.
3. Organization is a must. Be ready to leave on time. Repeated inability to complete assignment on time will be discussed with the student by his/her instructor.
4. No one leaves the nursing unit until dismissed by instructor.
P. Tardiness and Absences:
1. Tardy - if you know you will be late:
   a. Call your instructor **by 0500.**
   b. Call hospital floor and leave message only if you cannot reach instructor.
   c. If you are unable to arrive by 0900 – you will not be given a patient assignment. You will be expected to assist your classmates with their patient care.

2. Absence -
   a. If you know in advance you will not be in clinical, discuss this with your instructor and nurse director
   b. Call your instructor by **0500.** If unable to reach instructor, call hospital and leave message or page instructor.
   c. Any tardiness or absence in the clinical areas requires revision in the clinical assignments, placing an additional burden on the facility staff
   d. If you are ill, you do not belong in the clinical area.

Q. Nursing Care Plan:
1. You must complete a nursing care plan form during your Nursing Care of the Adult clinical rotation as directed by your instructor. The care plan will be due on Monday at 0800 following clinical experience in a folder, in the clinical instructor’s mailbox in the nursing lab at school.

S. Medication Profile:
1. Medication profiles on assigned patient(s) must be completed and turned in with nursing care plan form in folder on Monday at 0800 following clinical experience. See above Nursing Care Plan instructions.
POST - HIP PINNING PROTOCOL

1. Patients undergoing a hip pinning will usually return from surgery with a compression dressing over the incisional area on lateral hip compression dressing over the incisional area on lateral hip.

2. Usually a hemovac drain will extend from under the dressing at the proximal end of dressing.

3. A foley catheter will be present.

4. Many patients will have had spinal anesthesia and will be unable to use legs well when arriving on floor after surgery.

5. Neurovascular checks should be performed every 30 minutes for 3 hours and then every 2 hours.

<table>
<thead>
<tr>
<th>Test for Vascular Function action by the nurse</th>
<th>Test for Motor Function action by the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorsiflex ankle and extend the toes</td>
<td>Plantar flex ankle and flex toes</td>
</tr>
</tbody>
</table>

**Vascular Checks**
Check for strong pedal pulses
Check for Homan's sign:
Dorsiflex each foot, if there is calf pain (positive Homan's sign) it may be a sign of thrombophlebitis

6. Hemovacs should be checked for patency and volume of drainage at same intervals as neurovascular checks.

7. Patient should be encouraged to deep breathe and cough every 2 hours during hospital stay.

8. Ice may be used on incisional site for initial 24 hours after surgery.

9. Observe proper positioning and precautions for hip pinnings.
   a. Position to prevent external or internal rotation of hip. Soft trochanter rolls/sandbags should be used to keep the leg in neutral rotation with the toes pointed straight up. Make certain the rolls do not put pressure on the peroneal nerve over the head of the fibula or on the lateral malleous
   b. Position to prevent foot drop (precautions also attached)

10. Patient should be assisted to turn every 2 hours. Patient should be turned to both sides maintaining operated leg abducted at all times with 2 pillows.

11. Skin care should be administered every 2 hours during turning. All bony prominences should be checked carefully. Prompt and special care should be taken to provide complete relief of pressure from areas as soon as redness is noted. Don't forget the heels!

12. Excessive drainage other than that from the hemovac should be reported to the physician.
13. Patient's bed should be equipped with overhead trapeze. Patient should be encouraged to move in bed.

14. Analgesics should be administered for control of pain but at a level which will allow patients to have control of self and be able to participate well in exercises.

15. Patient will be given 10 grains of aspirin BID while hospitalized as an anti-coagulant. Patient should be made to pump ankles vigorously 20 times every hour to prevent thrombus formation.

16. Activity the day of surgery should include conscientious turning and deep breathing routine every 2 hours, plantar and dorsiflexion 20 times each hour and encouraging patient to move and use trapeze.

17. There is no limit on hip flexion. Patient may flex the hip to tolerance.

18. Ask family to bring robes and firm walking shoes in preparation for activity.

19. The first post-op morning physical therapy should assist patient into chair at bedside. Patient may bear partial weight on the affected leg (unless otherwise specified in physicians' orders). As soon as possible, patient should be up in chair all day, in bed only for short rests as needed and to sleep at night. Nursing may assist patient in transfers.

20. Physical therapy and nursing should communicate patient's progress daily. As soon as patient is able to ambulate short distances, nursing should assist patient to ambulate at frequent intervals on the floor with walker, partial weight bearing operated leg. For safety in ambulating encourage staff to use "belt" of some sort. Sheets or towels folded on bias can be used for safety belts.

POST-OP TOTAL KNEE ARTHROPLASTY PROTOCOL

1. Patients undergoing total knee replacement will usually return with a bulky, compressive dressing (Robert Jones dressing)

2. Neurovascular checks should be done every 30 minutes for 3 hours and then every 2 hours:

   **Nerve Function Tests:**

<table>
<thead>
<tr>
<th>Test for sensory function</th>
<th>Test for motor function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>action by the nurse</strong></td>
<td><strong>action by the patient</strong></td>
</tr>
<tr>
<td><strong>Perineal Nerve</strong></td>
<td></td>
</tr>
<tr>
<td>Flick lateral surface of great toe and medial</td>
<td>Dorsiflex ankle and extend toes</td>
</tr>
<tr>
<td>surface of second toe</td>
<td></td>
</tr>
<tr>
<td><strong>Tibial Nerve</strong></td>
<td></td>
</tr>
<tr>
<td>Flick medial and lateral surfaces of sole of</td>
<td>Plantar flex ankle and flex toes</td>
</tr>
<tr>
<td>foot</td>
<td></td>
</tr>
</tbody>
</table>

   **Vascular Checks:**
   Check for strong pedal pulses
   Check for Homan's Sign: Dorsiflex each foot, if there is calf pain (positive Homan's Sign) it may indicate thrombophlebitis.

3. Hemovacs should be checked for patency and volume of drainage at same intervals as neurovascular checks.

4. Thigh-hi Ted Hose or anti-embolus stocking should be applied to the unaffected leg.

5. Provide continuous ice packs first 24-48 hour.

6. Maintain foot of bed elevated so that the affected extremity is higher than the heart. Avoid positioning in external or internal rotation. Keep leg positioned in a neutral position. Do not place pillows under knee or raise up knees in bed. Head of bed may be elevated to comfort.

7. Patient should be encouraged to deep breathe and cough every 2 hours.

8. There should be no drainage or bleeding on the outer dressing. Report any indication of bleeding or drainage on the outer dressing to the physician immediately.

9. Patients should be made to pump ankles vigorously 2 times every hour to prevent thrombus formation.

10. Patient's bed should be equipped with overhead trapeze, should be taught pelvic lift and encouraged to move in bed.

11. Foley catheter will usually be present. Bladder training may be started as soon as possible to prevent hospital acquired urinary tract infection.
12. Nursing personnel should encourage patient to perform exercise protocol:
   A. Quad sets 20/hour as tolerated
   B. Hamstring sets 20/hour as tolerated
   C. Gluteal sets 20/hour as tolerated
   D. Vigorous plantar and dorsiflexion 20/hour as tolerated
   E. Deep-breathe and cough every 2 hours

13. Observe proper positioning and precaution:
   A. Do not place pillows under operated extremity - might cause hamstring contracture
   B. Do not raise up knees on bed
   C. Position leg in neutral rotation
   D. Review precautions with patient. Make sure they understand!

14. On the first day post-op physical therapy will:
   A. Consult physician or chart on patient's condition
   B. Dangle patient at bedside to assess patient's condition
   C. Transfer patient to wheelchair and take to physical therapy
   D. Patient will ambulate in parallel bars with assistance and progress to walker if tolerated
   E. Patient will perform exercises as outlined in TKR program
   F. Patient can be up in chair as tolerated

15. On post-op day 2 through discharge patient will go to physical therapy via wheelchair BID
   A. Ambulate with walker or other assistive device
   B. Perform exercises as given in TKR program
   C. Stair climbing and other ADL activities

16. On the 2nd or 3rd day post-op, drains will be removed

16. On the 4th day post-op the dressing will be removed by physician and replaced by knee immobilizer - should wear immobilizer at all times except when exercising in physical therapy

18. When ready for discharge
   A. Home program will be discussed and provided
   B. Appointments may be made for patient to return for outpatient therapy

19. Nursing, physical therapy and physicians should communicate frequently
POST-OP TOTAL HIP ARTHROPLASTY PROTOCOL

1. The operated leg should be maintained abducted at all times by applying a foam abduction pillow or multiple pillows.

2. Usually 1 hemovac drain will extend from the incisional area from under the dressing.

3. The incisional area will be covered with a compression dressing.

4. A foley catheter will usually be present.

5. Neurovascular checks should be performed every 30 minutes for 3 hours and then every 2 hours.

<table>
<thead>
<tr>
<th>Test for Vascular Function</th>
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<td><strong>Personal Nerve</strong></td>
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<td>Plantar flex ankles and flex toes</td>
</tr>
</tbody>
</table>

**Check for Homan's sign:**
Dorsiflex each foot, if there is calf pain (positive Homan's sign) it may indicate thrombophlebitis.

6. Hemovacs should be checked for patency and volume of drainage at same intervals as neurovascular checks.

7. Hemovacs will usually be removed on the second or third post-op day.

8. Thigh-hi Ted hose or anti-emboli stockings should be applied immediately in recovery room to un-operated leg-elastic wraps should be applied to groin on operative leg- wrapping from toes proximal with care taken to assure support without causing circulatory compromise with improper tension. Wraps and stocking should be removed and reapplied at the beginning of each shift. After drains are removed, mate to stockings can be applied.

For proper fit each patient should be measured as follows for Ted hose:

A. Measure ankle circumference at narrowest girth.
B. Measure calf circumference at largest calf girth.
C. Measure the thigh circumference at point one inch distal to gluteal crease.

Give these measurements to Central Supply and they will supply the proper size.
9. Ice may be used to incisional site for initial 24 hours after surgery.

10. Respiratory therapy may see patient while hospitalized.

   Patient should be encouraged to deep breathe and cough every 2 hours during hospital stay. Respiratory therapy has blow bottles and incentive spirometers available as aids.

11. Observe proper positioning and precautions:
   A. Small amplitude hip flexion - not to exceed 60 degrees
   B. Operated extremity must be kept in an abducted position at all times using foam abduction splint or pillows.
   C. Position to prevent external and internal rotation of hip. Soft trochanter rolls should be used to keep the leg in neutral position with the toes pointed straight up. Make certain the rolls do not put pressure on the perineal nerve over the head of the fibula or the ankle malleoli.
   D. May be turned to either side but hip abduction splint must be in place or two pillows placed crosswise to prevent hip abduction (crossing the midline)

12. Skin care should be administered every 2 hours. All bony prominences should be checked carefully. Prompt and special attention should be taken to provide complete relief of pressure from areas as soon as redness is noted - don't forget the heels!

13. Excessive bloody drainage other than from the hemovacs should be reported to the physician

14. Patient's bed should be equipped with overhead trapeze. Patients should be taught to use the trapeze and encouraged to move in bed - be sure to caution them not to bend the operated hip more than 60 degrees nor to abduct the operated hip.

15. Analgesics should be administered for control of pain but at a level which will allow patients to have control of self and be able to participate in exercises.

16. Patients will be given 10 grains of aspirin BID while hospitalized (unless allergic or GI problems). Patients should be told to continue them at home until told to discontinue by the physician.

17. Patients should be made to pump ankles vigorously 20 times every hour to prevent thrombus formation.

18. Activity to be encouraged:
   A. Deep breathing routine every 2 hours
   B. Plantarflex and dorsiflex feet vigorously 20 times each hour
   C. Encourage patient to move and use trapeze-making sure they understand not to bend the operated hip more than 60 degrees nor adduct the operated extremity
   D. Assist to turn to both sides every 2 hours-make sure abduction splint or 2 pillows are between legs to prevent hip adduction
   E. Quad sets 20 each hour as tolerated
   F. Gluteal sets 20 each hour as tolerated
   G. Small amplitude hip flexion-not to exceed 60 degrees
19. Head of bed may be elevated—but never to allow more than 60 degrees of hip flexion at any time during the hospital stay.

20. Precautions should be reviewed with the patient until patient has thorough understanding

21. On the first or second post-op day, physical therapy will review and practice the transfer to a firm straight back chair at bedside:
   A. Patient will get out of bed with operated extremity first to maintain it in an abducted position
   B. Patient will lean back to insure operated hip does not flex more than 60 degrees
   C. Two persons will assist patient to standing - to prevent hip from bending more than 6 degrees
   D. Rolled blanket will be place in back of hard chair and patient will lean shoulders against back of chair so hip does not flex more than 60 degrees
   E. Legs must be kept abducted at all times
   F. Reverse procedures to get back in bed
   G. The operated extremity should go in bed last so it can be maintained in an abducted position
   H. Patient may be up in chair for meals that day
   I. Patient may now be assisted in chair as much as tolerated per nursing personnel

22. Nursing and physical therapy should be sure patient understands that they should never lean forward when sitting in a chair.

23. Nursing should encourage patient to be up in chair all day, in bed only for short rests and to sleep at night.

24. When the patient is allowed to bring the walker or crutches to the room, nursing should assist patient to walk frequently. Patient may now use toilet with a stool extender.

25. Nursing and physical therapy should communicate daily on patient's progress.

26. Patient's hospital stay will usually be about 10-12 days.

27. Patients may practice stair climbing before discharge if appropriate.
Nursing Care of The Older Adult

Clinical
NURSING CARE OF THE OLDER ADULT

CLINICAL OBJECTIVES/OUTCOME CRITERIA

Upon the completion of the clinical experience and the clinical course objectives/outcome, the student will be able to:

1. Assess, plan, assist in the formulation of nursing diagnoses based on principles applied to physiological functioning, self concept, spiritual needs, and role function of the aged (geriatric) patient/resident.

2. Organize and implement nursing care according to the goals and priorities established for the aged (geriatric) patient/resident.

3. Evaluate the nursing plan of care and make revisions as appropriate.

4. Assess, plan and initiate a teaching plan for patient/resident and significant others.

5. Assess, plan, and implement immediate nursing interventions associated with care of a patient/resident in long term care.

6. Observe the process of admittance to Long term Care facility and/or Skilled Nursing Facility as applicable.

7. Implement and evaluate discharge planning.

8. Demonstrate effective utilization of time and resources.

9. Exhibit therapeutic communication with the aged patient/resident and/family.

10. Demonstrate the ability to document pertinent data on the patient's/residents chart in the nurse's notes and plan of care as applicable.

11. Demonstrate ability to give an organized, accurate and pertinent verbal report to the staff/charge nurse before leaving the unit and at other times as indicated.

12. Develop nursing care plan and teaching plan on assigned patient/resident as instructed.

13. Participate in all learning experiences.

14. Successfully complete the Nursing Care of the Older Adult (Geriatrics) clinical experience by meeting all the objectives/outcome as stated and obtain a satisfactory performance on the summative clinical performance evaluation.
NURSING CARE OF THE OLDER ADULT

1. Clinical experience will take place at a designated long term care facility. Assignment will be provided.
2. Meet in the facility assigned with clinical preceptor/instructor as instructed.
3. Report will be received via taped/oral report or walking rounds at designated time.
4. Clinical days are: Wednesdays and Thursdays. Hours are assigned per facility.
5. Clinical Instructor will make rounds during rotation.

6. Daily assignments include:
   A. Getting report/reporting off
   B. Total patient/resident care.
   C. Charting per instructor/preceptor instructions.
   D. Procedures prn (Be prepared - Review basic skills).
   E. Observing with P.T. (Physical Therapy) if available
   F. Reading the computerized documentation or patient charts if time permits.
   G. Assisting others (your classmates, nurses, nursing assistants) prn.

7. Charting
   A. Documentation per assignment
   B. All actual documentation must be co-signed by instructor or preceptor prior to leaving the unit.
   C. Refer to the Nursing Care of the Adult guidelines in the Clinical Syllabus
   D. Cornell notes will be provided for notes to be turned into instructor as assigned.

8. Bathing Schedule: (only considering our clinical days)
   A. As instructed/assigned per facility
   B. It is not absolutely necessary that your patient/resident have complete bedbaths, everyday as assessment of skin integrity is very important for the elderly. If in question, contact your preceptor or instructor for assistance.
   C. Check with nursing assistants. If you are PCRMC TCF – Be sure to look at assignment board for OT (Occupational Therapy) – They do baths and ADL’s.

9. Feeding/Recording of Diet
   A. Please take note of type of diet and if your patient/resident needs assistance with feeding. You will be expected to see that your patient’s/resident’s nutritional needs are met as well as others.
   B. Each type of food is recorded in % in the appropriate charting. It is imperative that you pay special attention and record appropriately.
   C. Snacks must be offered and charted even if patient/resident refuses.
   D. Residents are encouraged to eat in the Dining Room. It is against regulation to perform any nursing procedure on resident while in the dining room.

10. Breaks/Lunch
    A 15-minute break in the a.m. with a 30 break allowed for lunch. Please make sure your patient’s care is met. Report to your preceptor and/or instructor prior to break or lunch. Inform preceptor or instructor of location before leaving (if allowed) in accordance with facility policy.
11. Assignment Board

**Nursing Homes**
Assignments will be made in accordance with facility policy

**PCRMC TCF**
An assignment board is located on the wall directly across from nurse’s station (right side). Please pay special attention to O.T. (Occupational Therapy – ADL’s) If your patient has ADL’s - you will not be providing morning care unless otherwise instructed. ADL’s are usually posted by 0800.

12. Review Nursing Care of the Adult section in clinical syllabus. There is helpful information for your assistance in the LTC rotation (such as: I and O, hip protocols, etc.)

13. Make this the best learning experience possible. All questions are important - never hesitate to ask. Your instructor and clinical preceptor are looking forward to a fantastic rotation with you!!!!!

You make your clinical experience what you want it to be. Remember, make a good impression, this might be your next employer.
NURSING CARE OF THE OLDER ADULT CLINICAL ROTATION
CLINICAL WEEKLY ASSIGNMENT

This is a general schedule of weekly goals in your clinical rotation. Remember, if something comes up but is not listed in the week’s assignment, do not miss out on the opportunity. If you have any questions, contact the assigned instructor/preceptor to clarify. Each weekly assignment builds upon the previous week. Remember, while not every week has the specific assignment of assisting the certified nursing assistants, it builds great team work to assist as needed as well as great learning opportunities. Please note: you will always be working with an assigned clinical preceptor, clinical instructor or both.

**Week 1: (Assist with CNA, No specific patient/resident assignment)**
- Orient to facility, shadow preceptor
- Basic Nursing Care – Hygiene, transfers, positioning, vital signs, feeding + Any nursing procedures (Tube feedings, Catheterizations, glucometers, etc.)
- Time Management and organizational skills

**Week 2: (Assigned 1 specific resident/patient)**
- Work with preceptor and CNA’s
- Assessment of 1 assigned resident/patient
- Documentation (paper or computerized)
- Any nursing procedures (Tube feedings, Catheterizations, glucometers, etc.)
- Observe Certified Medication Technician (CMT) or nurse administer medications
- Time Management and organizational skills

**Week 3: (Assigned 2 specific residents/patients)**
- Work with preceptor
- Assessment of 2 assigned residents/patients with complex care
- Documentation (paper or computerized)
- Wound Care/Treatment (Work with Treatment nurse)
- Medication Administration per Facility policy. Students can only administer medications with nurse preceptor, LPN/RN or instructor. Student can NOT administer medications with a CMT (Certified Medication Technician)
- Identify Teaching project
- Time Management and Organizational Skills

**Week 4: (Assigned 3 specific residents/patients)**
- Work with preceptor
- Assessment of 3 assigned residents/patients
- Documentation (paper or computerized)
- Special Care residents (Dementia) + and/or Wound Care/Treatment Nurse
- Medication Administration per Facility policy. Students can only administer medications with nurse preceptor, LPN/RN or instructor. Student can NOT administer medications with a CMT (Certified Medication Technician)
- Discuss Teaching project with clinical preceptor and clinical instructor
- Time Management and Organizational Skills

**Week 5: (Assigned 3 specific residents/patients)**
- Work with preceptor
- Assessment of 3 assigned residents/patients
- Documentation (paper or computerized)
- Special Care residents (dementia) and/or Wound Care/Treatment Nurse
- Medication Administration per Facility policy. Students can only administer medications with nurse preceptor, LPN/RN or instructor. Student can NOT administer medications with a CMT (Certified Medication Technician)
- Implement and evaluate teaching project (nursing care plan)
- Preceptor Evaluation of Student Performance

Clinical syllabus - word
**Clinical Homework:**

This is to be turned in on Monday upon returning to class to assigned clinical instructor’s mail box at 0800. Please place all work in clinical folder provided.

**Week 1:** Weekly written journal assignment. This form will be available in nursing lab. **It will be due every week.**

**Week 2:** Weekly written assignment + complete Head to Toe Assessment of 1 resident on Care Plan form + 1 nursing care plan on resident of choice. Be thinking of a teaching project for week 5 to address teaching needs of assigned residents or facility as discussed with preceptor and instructor.

**Week 3:** Note on journal form indicating what you will be teaching week 5 on the top of the page. Complete Concept map form of 1 assigned residents needs. Identify the top 3 priority nursing problems by numbering them 1-3 and explain why. Concept Map form will be available in the nursing lab - Complete NCOA Medication Forms (see page 61) for 1 resident and/or **Complete medication profile form on all residents medications administered to.**

**Week 4:** Tentative Teaching Plan of Care for assigned resident or facility as discussed with preceptor and instructor. You must support your teaching plan with data on the front side of the care plan form and the teaching plan is on the back of the nursing care plan form. **If administering medications, complete NCOA medication profile forms on all residents medications administered to.**

**Week 5:** Turn in complete Teaching Plan of Care. Obtain Clinical Evaluation form for preceptor to complete. Discuss with the preceptor. Place in folder to be attached with Summative evaluation by instructor. **If passing medications, complete NCOA medication profile forms on all residents medications administered to.**
Clinical Skills

Rolla Practical Nursing students are prepared to perform the following skills under the supervision of either a Licensed Practical Nurse or a Registered Nurse.

If you are ask to do a skill that you are unfamiliar with or you are not sure if you are allowed to perform the skill, call your instructor for approval prior to completing the skill.

Opening Sterile Packs and Preparing a Sterile Field
Sterile Gloving and Un-gloving
Passive ROM
Patient Transfers
Bed Bath
Oral Care
Vital Signs
Head to Toe Assessment
Neurological Check
Venipuncture for obtaining Blood Samples
Capillary Blood Tests
Culture Specimen Collection: throat and wound
Stool Specimen collection
I and O
Feeding
Insertion or Removal of Nasogastric Tube
Tube Feeding
Pulse Oximetry
Nasopharyngeal Suctioning
Endotracheal and Tracheostomy Suctioning
Tracheostomy Care
Catheterization of male or female patient
Insertion and removal of Foley catheter
Bladder Irrigation
Enema
Ostomy care
Administration of Medications to include: Intradermal, subcutaneous and intramuscular injections
TED hose
Dressing Change
Wound Irrigation and wound care
Cast Care
Traction Care
Medications (oral, inhalation, parenteral (NO IV’s), etc)
**RTC PN Program**  
**NCOA Clinical Rotation**

*Instructions:* Complete this form for all medications administered with the exception of assigned resident(s). Medication profiles must be completed for assigned resident(s)

<table>
<thead>
<tr>
<th>Drug (Generic/Brand)</th>
<th>Classification</th>
<th>VS (Temp, B/P, AP, Resp) Approp?</th>
<th>Nursing Action</th>
<th>Lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex: Coumadin warfarin</td>
<td>Anticoagulant</td>
<td>No VS</td>
<td>Monitor for bleeding Vitamin K – antidote</td>
<td>PT/INR</td>
</tr>
<tr>
<td>Keflex Cephlexin</td>
<td>Anti-infective</td>
<td>Temp</td>
<td>Monitor for symptoms approp for infection</td>
<td>Culture as approp</td>
</tr>
</tbody>
</table>

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Child Health Nursing Clinical
ROLLA PROGRAM OF PRACTICAL NURSING
CHILD HEALTH NURSING

CLINICAL EXPERIENCE OBJECTIVES

Upon completion of the child health nursing clinical rotation, the student should be able to:

1. Demonstrate knowledge of normal anatomical, physiological, and psychosocial development of the child from infancy through adolescence by:
   A. Performing interventions to assure the safety of the child.
   B. Displaying skill in observation and communication that will enable the nurse to meet the basic needs of the child as a holistic person.

2. Demonstrate an understanding of common maladaptions of the various body systems by:
   A. Assessing the child's needs by applying the nursing process.
   B. Developing nursing care plans.
   C. Displaying skill in performing procedures and techniques in caring for the pediatric client.

3. Demonstrate knowledge of communication techniques by:
   A. Using therapeutic interaction with the child and family.
   B. Documenting appropriately in the client's record.
   C. Communicating appropriately with members of the health care team.

4. Demonstrate professionalism in the clinical setting as evidenced by the following behaviors:
   A. Teaching the client and family methods to facilitate positive adaptation.
   B. Functioning as a member of the professional health care team in a child health nursing discipline.
   C. Being punctual and prepared for assignments.
   D. Neat and well groomed.
   E. Accountability for personal behavior at the practical nurse level.

5. Successfully complete child health nursing by meeting all objectives as stated and obtaining a satisfactory performance on the summative clinical performance.
CHILD HEALTH CLINICAL ROTATION ORIENTATION

I. General
   A. Please report to Cafeteria @ 0625 for pre-conference.
   B. Specific instructions will be given if other facilities or areas are utilized.

II. Specific
   A. Routine care
      1. Intake and output on all patients.
      2. Daily weight on all children 3 and under, nude; please roll scale to patient's room.
      3. Vital signs on all patients each AM and noon.
      4. Routine B.P. on all patients 4 and older at least once in AM.
      5. Wear hospital gown over uniform when caring for young patients.
      6. Record assessments on work sheet immediately (vital signs, emesis, B.M.'s etc.)
      7. Report pertinent observations immediately, don't wait until the end of the day.
      8. Students are to feed their assigned patients (plan lunch break around patient care).
      9. Accompany assigned patients to various departments (x-ray, lab, etc).
      10. PCH totals before 9:00 AM on board at desk.

   B. Bath
      1. Shower or tub available in each room
      2. May take child to another room for bath if necessary
      3. Baby bath tubs are readily available.
      4. Wash hair when needed, be sure to dry well.
      5. Don't forget oral hygiene.
      6. May need to give routine bed bath.

   C. Safety
      1. Crib rails are to be up at all times.
      2. No infant feeders.
      3. Child must be supervised in playrooms.
      4. Do not allow child to be in walker without supervision.
      5. Check croup tents for proper functioning. Tent should be cool.
      6. Do not put temp. probe covers in the trash in the patient's room.
      7. Do not prop bottles in patient's mouth.
      8. No homemade pacifiers.
      9. Set good examples.
     10. Use crib nets when necessary.
     11. Inform parents and visitors about safety.
D. General
1. Young infants need visual stimulation as well as tactile stimulation. Make mobiles of bright colored objects.
2. Assess your patient's growth and development (is your patient's psychomotor, gross motor, fine motor skills developed for his/her age group?) (Is her/his weight within normal limits for age?)
3. Pad beds (cribs) well with mattress pads, etc., especially when child is in a croup tent. Change when damp.
4. Plastic bottles for children who hold their own bottle. Get clean bottle for each feeding or wash. Always use new nipple.
5. No dirty (B.M.) diapers to be discarded in patient's room. Always discard in utility room. Use a diaper pail for others.
6. Encourage mothers/fathers to rest when you are caring for your patient.
7. Be a teacher every chance possible.
8. Assess your patient from head to toe. Remember your young patients cannot always tell you their discomforts.
9. When a child is discharged family member/guardian is to go to business office. The patient is to remain on the floor.
10. Always assist when your patient is discharged. Walk down with them.

E. Charting
1. Computerized documentation will be utilized per your instructor.
2. Voids are usually charted by number of times a child voids unless specifically ordered accurate I & O. If so, may have to weigh the diapers as directed.
3. Update care plans when needed.
Maternal Health and Newborn Nursing Clinical
ROLLA PROGRAM OF PRACTICAL NURSING
MATERNAL HEALTH/NEWBORN NURSING

CLINICAL EXPERIENCE OBJECTIVES

Upon completion of the maternal health clinical experience, in addition to the program clinical objectives, the student should be able to:

6. Demonstrate an understanding of the anatomical, physiological, and psychosocial adaptations of the labor process by:

   A. Correctly admitting a client to the labor room.

   B. Assess clients needs and planning interventions of physical, emotional, psychosocial care, and support during labor.

   C. Informing client and family the process in which they are involved.

   D. Accurately applying the external fetal monitor and interpreting recording, and reporting data.

   E. Accurately administering the admission perineal shave and enema as ordered by the physician.

   F. Accurately assessing uterine contractions for frequency, duration, and intensity.

   G. Accurately assessing and recording the client's vital signs and fetal heart tones.

   H. Administering special methods to keep the labor client as comfortable as possible.

   I. Utilize proper aseptic technique in all areas.

   J. Preparing the birthing/delivery room as directed during the orientation phase.

   K. Observe the delivery procedure.

   L. Observing the immediate care of the newborn and possibly care for the newborn as directed by a assigned nurse or instructor.

2. Demonstrate knowledge of the principles relating to the postpartum anatomical, physiological, and psychosocial maternal change by:

   A. Assessing postpartum clients using the 8 point assessment tool.

   B. Utilize the nursing process to plan interventions to meet client's individual and family needs as demonstrated in written care plan.

   C. Implementing interventions to meet the individual client's and family's needs.

   PAGE 67
D. Accurately record and report data as directed by hospital policy.

E. Teaching clients and families newborn and postpartum care, utilizing hospital teaching plans.

F. Correctly implement dismissal procedure of client and newborn according to hospital policy.

3. Demonstrate basic knowledge of common obstetrical complications by:
   A. Reporting the recording early signs of complications.
   B. Planning, implementing and evaluating appropriate interventions.

4. Demonstrate knowledge of the principles relating to the anatomical, physiological, and psychosocial adaptation of the neonate by:
   A. Caring for the neonate immediately after delivery and during his/her hospitalization.
   B. Performing neonatal assessment: physical, neurological, anatomical, and gestational age.
   C. Planning, implementing, and evaluating appropriate interventions to meet the needs of the well and ill neonate.

5. Demonstrate professionalism in the OB department, evidenced by the following behaviors:
   A. Teaching the client and family methods to facilitate positive adaptations to labor, birth, and post-partum.
   B. Being punctual and prepared for assignments.
   C. Neat and well groomed.
   D. Functioning as a member of the professional health care team in the OB department.
   E. Communicating with staff, instructors, peers, clients and their families, and hospital visitors in a professional manner.
   F. Respecting and maintaining and the confidentiality of each client.
   G. Accountability for personal behavior at the practical nurse level.

6. Successfully complete maternal newborn clinical nursing meeting all objectives as stated and obtain a satisfactory performance on the summative clinical performance evaluation.
MATERNAL HEALTH/NEWBORN NURSERY CLINICAL ORIENTATION

I. General

A. Be dressed in scrubs and ready for report by 0700 in the OB area on Wednesdays and Thursdays.
B. Scrubs will be furnished by the obstetrical department.
C. Report to assigned area for report.
D. Wash hands well for obstetrics.

Note: Be sure to bring clinical shoes, stockings/socks, note pad, pencils, scissors, nametags, etc.

II. Breaks and Lunch

A. Fifteen minutes break in morning
B. 30 minutes - Lunch break 11:00-12:00
   1. arrange with charge nurse
   2. arrange around patient care

III. Charting and Reporting

A. Report any pertinent facts to charge nurse immediately.
B. Report at end of day to team leader. (Tues. - 1500, Wed. - 1400)
C. Computerized documentation is required. Chart at least every two hours.

IV. Obstetric Patient Admission

A. Routine admission procedure
   1. Vital signs, FHR, E.D.C., gravida, para. doctor, membranes, show, (dilation, effacement, station per O.B. nurse)
   2. Time contractions if in labor
   3. Urine specimen (mini cath. or clean catch)
   4. Nursing assessment (Head to toe assessment)
   5. Apply external monitor - type in information (patient's name, doctor, V.S., uterine dilatation, EDC, para, gravida)

B. Put patient's clothes in plastic bag & label with name.
C. Administer enema and perineal prep, if ordered, with instructor's or O.B.'s nurses supervision.
D. Complete all admission information sheets as directed in orientation.

V. Labor Room/Birthing Room

A. Routine
   1. N.P.O. except ice chips or as ordered
   2. Bedrest if membranes have ruptured (Temp. every 1-2 hours)
   3. Vital Sign and fetal heart tone assessment as ordered
   4. Chart on labor room record (flow sheet)
   5. Keep patient comfortable and dry
   6. Always check with your team leader for specific orders.
B. Procedures
1. S S enema - disposable kit in admission pack (contains 6 Chux, Shave kit, enema bag)
2. Mini prep - perineal shaving
   a. urinary meatus to rectal area
   b. disposable prep set kit in admission kit
   c. most doctors use this procedure
3. Amniotape (check for ruptured membranes)
   a. sterile gloves
   b. no antiseptic spray
   c. place tape (Nitrazine paper) inside vagina
   d. read and chart results
   e. results:
      - amniotic fluid (alkaline) ph - 7.0-7.5
      - urine (acid) ph 5-6
      - phisohex (acid) ph 4.5
      - vaginal infections may be acid
   f. procedure should be supervised with instructor or R.N. team leader
4. Obtain fetal heart tones
   a. methods
      1. monitor (external and internal)
      2. Doppler
      3. fetoscope
   b. Chart rate, rhythm, location, quality and method
   c. Average rate (120-160 beats per minute)
   d. Report immediately any changes below 110 - above 160
   e. Assess for variability, early, late, variable decelerations
5. Time contractions
   a. frequency       c. patient's reaction
   b. quality         d. methods
      1. monitor (external and internal)
      2. palpation
      3. chart frequency, quality and patient's tolerance
      4. frequency (beginning of one contraction to beginning of next contraction)
      5. duration (beginning of contraction to end of contraction)
6. Catheterization with instructor or R.N. team leader's supervision
   a. Foley (for C-Sections)
   b. Female catheter for specimen
   c. Straight catheter for urinary retention
7. Supportive nursing measures

C. Observational Procedures
1. epidural catheter insertion
   a. test dose (3cc)
      epidural tray four inch width tape
      medication
      adverse reaction (hypotension, one side numbness, etc.)
b. insertion of medication (doctor or nurse)
   1. Usually after 4 cm dilatation
   2. Follow physician's order for vitals and other orders
   3. Observe for adverse reactions (hypotension, paresthesia, convulsions, etc.)
   4. Treatment for adverse reactions:
      - notify charge nurse
      - turn on side (left, preferable)
      - administer $O_2$ (per charge nurse)
      - increase IV infusion (per charge nurse) (student does not perform)

2. Amniotomy (artificial per physician)
   a. Supplies
      1. Amniohook
      2. Chux under patient
      3. FHT Monitor
      4. Bed rest unless otherwise ordered
      5. Temp. every 1-2 hours.
   b. Fetal heart rate immediately after rupture
   c. Complete bed rest (unless directed otherwise)
   d. Semi fowler's position
   e. chart time, physician, amount, consistency, color, fetal heart rate

3. Oxytocin stimulation of labor (Pitocin drip)
   a. Nurse must always be present
   b. Apply monitor
   c. Observe for signs of complications (fetal bradycardia, tachycardia, heart irregularity, excessive uterine contractions)
   d. Obtain vital signs, FHR, and contractions as directed

4. Insertion of prostaglandin vaginal suppository or prepudil gel.
   a. must lie flat x 30 insertion
   b. see procedure manual

5. Ultrasound (Medical Imaging Dept)
   a. Accompany patient
   b. May need to force fluids prior to test
   c. Some ultrasounds may be performed on the floor

6. Oxytocin challenge test
   a. nurse must be present at all times
   b. external fetal heart and uterine monitor
   c. assist as directed
   d. IV per nurse (student does not perform)

7. Non stress test (assess fetal heart rate with movement need at least 3 movements in 10 minute period)
   a. external fetal heart rate monitor
   b. Adaptor connected for mother to mark fetal movement
   c. Test for 20 to 30 minutes as directed (see above)
   d. Urine specimen may be obtained if mother is diabetic
   e. Assess mother's vitals - type information on monitor strip patient's name, Doctor, V.S., etc.)
   f. Reactive if FHR increases with movement
   g. May have to give Mom orange juice to stimulate movement

Clinical syllabus - word
h. Place Mom in 30° in bed. Never lay her flat in bed.
i. Complete outpatient record.
j. Explain procedure to Mother
k. Patient may keep on clothes - will lie on paper sheets
l. Don't forget the call light

VI. Post Partum Care
A. Immediately
1. Vital signs, head-to-toe assessment, fundus and lochia every 15 minutes for 1 hour, then at 30 minutes; then every hour times four and chart (see postpartum vital sheet)
2. Give initial bath (1 hour postpartum)
   a. partial bath (wash breast first if nursing mom)
   b. pericare (tucks and peri-bottle). Instruct patient.
   c. change pads (front to back)
   d. apply panties
   e. change gown
   f. apply patient's bra
3. Measure and record first two voids
4. Obtain diet tray from kitchen if permitted
5. Obtain OB admission pack and label (contains chux, panties or belt, peri-bottle and pads, sacks and hand wipes)
6. Obtain Tucks
7. Educate your patient about care
B. Routine Vaginal Postpartum care
1. May ambulate once the numbness in legs has subsided
2. Vital signs
3. Shower or bed bath
4. Sitz bath for 20 minutes (twice on day shift) if ordered
5. Ambulate patient twice
6. Check patient's elimination (defecation & voiding)
7. Assess episiotomy and perianal area (pain, hemorrhoids, bruising, swelling)
8. Assess breast (encourage patient to wear supportive bra) redness, heat, pain, engorgement, cracked nipples, etc)
9. Observe fundus location and consistency
   a. should involute 1cm each day postpartum; Charting example - Fundus firm - 1 central
   b. may be boggy due to distended bladder, excessive bleeding or clots
   c. may be displaced to right due to distended bladder
10. Observe lochia
   a. type
      rubra (bright red immediately after delivery) reddish brown for 1-3 days
      serosa - pinkish brown for 4-6 days
      alba - whitish yellow for 10 days
   b. odor
   c. amount - charting example: Moderate amount of lochia rubra
11. Daily head-to-toe assessment
12. BUBBLE-HEP 9-point assessment
13. Administer medication and treatments
C. C-section postpartum
1. same as routine delivery and postoperative care
2. vital signs same as any other
3. surgical incision (clean, dry, intact, edges well approximated, without bruising or redness
5. ambulate as ordered
6. diet as ordered
7. pericare and *tucks *(optional)

VII. Reflex assessment on patients with P.I.H.
1. reflexes are graded on a 0 to 4+ scale
   4+ - very brisk, often indicative of disease, associated with clonus
       (rhythmic oscillations between flexion and extension)
   3+ - brisker than average and possible but not necessarily indicative of disease
   2+ - average normal
   1+ - somewhat low normal
   0 - no response
2. hyperactive reflexes suggest upper motor neuron disease
3. differences between sides are usually easier to assess than symmetrical changes
4. lower than normal may be indicative of magnesium toxicity
5. assess vital signs hourly

VIII. Dismissal
1. Same procedure as med-surg
2. Make sure there is doctor's order - instructions on home care
3. Per wheelchair
4. Patient is to hold infant in arms
5. Chart procedure
6. Tear down chart as directed
7. Clean unit - strip bed, etc.
8. Complete discharge summary sheet (most important)

NURSERY - NEWBORN CARE
I. General information
A. Three minute scrub hands to elbows (Betadine, Phisohex or Septisol)
B. **No** rings, watches or caps to be worn
C. Pin watch to name tag (on the side that you would not hold an infant)
D. End of shift report

II. Routine Care
A. Vital signs-rectal temp, apical pulse and respirations at least every 4 hours
B. Weigh - (may be done on nights)
C. Bathe - phisoderm and cord care (alcohol, triple dye or N/S) after initial bath
D. Feed or take to Mom, compare ID bracelets, per crib always
E. Record elimination, weight and pertinent information in record book
F. Chart only with charge nurse and/or instructor supervision
G. Remove cord clamp in 24 hours if dry (please check with team leader)
III. Phototherapy (for treatment of physiological jaundice)
   A. Care for infant as directed
   B. Change position frequently
   C. No clothes
   D. Light should be 12-18 inches from infant
   E. Apply mask to eyes (be sure eyes are closed)
   F. Offer additional fluids
   G. Remove eye patch for feeds
   H. Neosporin ointment every 6 hours OU

IV. Admission of neonate
   A. Vital signs, weight (pounds and grams) length and head circumference (inches and centimeters)
   B. In isolette until stable temp (C section neonate 24 hours)
   C. Initial bath (betadine) when temp. is at least 98.6° - 99° rectal. Be sure to check with charge nurse. Wear gloves until after initial bath.
   D. Safety alarm band on infant after initial bath
   E. Triple dye cord
      1. charge nurse and/or instructor approval
      2. all lab work is returned and is within normal limits
      3. do not wash or apply alcohol to cord for 24 hours
      4. protect abdomen with 4 X 4
   F. All new delivered will have vital signs every hour x 4, then every 4 hours - unless otherwise ordered.

V. Nourishment
   A. Breast feeding
      1. obtain supplies for Mom
         a. sterile cotton balls
         b. sterile 4 X 4's
         c. sterile bottle of water
         d. Masse cream *(Optional)
      2. * Routine procedure
         a. encourage Mom to wear supportive bra
         b. wash hands and breasts prior to feeding
         c. allow baby to nurse only 3 minutes first 24 hours and increase one minute each day to 7-10 minutes on each breast (this is only a suggestion)
         d. position Mom in comfortable position
         e. assist Mom
            1. make sure areola and nipple is in baby's mouth
            2. baby's tongue is not in roof of mouth
            3. chest to chest
            4. if baby's ears are moving, they are nursing properly
         f. Mom is to wash breasts with sterile water cotton ball and allow to air dry, prior to and after feeding
         g. apply Masse' cream after cleansing & air drying if ordered
3. Observation of Mom's breast
   a. inflammation
   b. soreness
   c. cracked
   d. vesicles
   e. excessive engorgement
4. May be as often as every 2 hours

B. Bottle feeding - every 3 - 4 hours
1. right formula
2. record amount
3. right time
4. Formula is only good for 1 hour after opening - Discard after that time; New bottle and nipple for each feeding.

C. Gavage feeding
1. assist only
2. direct supervision of instructor or R.N. in charge

D. Nutritional assessment
1. observe behavior (content, irritable, short sleeper)
2. watch for signs of dehydration
   a. dark concentrated urine, dry hard stools
   b. dry skin with little turgor "bounce"
   c. low grade fever
   d. elevated urine specific gravity (above 1.020)
   e. in severe cases, sunken fontanel
3. Measure intake breast fed infants weigh before and after feeding (1g = 1 ml)
4. measure weight gain
5. Record on worksheet and chart

VI. Circumcision
A. Set up supplies
B. Make sure permit is signed
C. Properly identify infant
D. Check black book for physician's orders, supplies and preparation
E. Obtain clean diaper and bulb syringe
F. Properly restrain infant
G. Prep infant according to physician's order (Betadine spray, etc.) pg.8
H. Love infant afterward, may take out to Mom
I. Observation after procedure
   1. swelling
   2. bleeding
   3. voiding (there is a danger of urinary retention)
   4. may need to keep Vaseline or triple antibiotic gauze on penis

VII. Rooming In - Normal newborns may "room in" with Mom if desired. However, babies must not be left unattended in Mom's room. If Mom leaves for any reason to take a sitz bath or go smoke or if she wants to sleep, the baby must go back to nursery.

VIII. General guidelines
A. Students are under direct supervision of the charge nurse and instructor.
B. Transport infants to mother's room in crib; be sure to properly identify the infant by comparison
to the I.D. bracelets.
C. Students do not insert NG tubes or give injections without the direct supervision of a nurse or
instructor.
D. Students are given infant care educational classes.
E. Students are to ask permission to observe deliveries if this is not the students assigned patient.
F. Students assigned to the nursery may accompany nursery personnel to deliveries (this includes
C-sections).
G. Completion of assignments and reports are to be given to team leaders prior to leaving the OB-
Nursery unit; failure to do so may be reason for failure to satisfactorily pass this clinical rotation.
H. Students are responsible for information presented in the day of clinical orientation.
I. Wash hands between babies.
J. C-Section infants in isolette for 24 hours.
K. Infant must be discharged by the infant's doctor.
L. Wet and dirty diapers are disposed in red bag trash containers.
M. Infants with RH negative blood, O type blood or infants with physical problems may have N/S
gauge to umbilical cord and not "triple-dyed." Check with nursery nurse.
N. Change linen in crib daily.
O. Security bands on all infants at all times. If infant leaves floor for a specific reason be sure to
inform the desk nurse.
P. Initial bath on counter, or in isolette/warmer. Daily baths in individual crib.
Q. Care plans are due as directed in clinical syllabus.
R. Always remember confidentiality and safety at all times.
Community Health & Mental Health Clinical
ROLLA TECHNICAL CENTER
PROGRAM OF PRACTICAL NURSING

COMMUNITY HEALTH NURSING CLINICAL ROTATION

PHILOSOPHY:
We believe an important part of the student Practical Nurse’s clinical experience is to gain as much knowledge as possible about the role of the practical nurse in the community setting.

We believe this knowledge may best be gained through observation only, participatory, direct care through preceptorship in a multitude of health care settings in the community.

We believe the student practical nurse will be better able to function once graduated as a Licensed Practical Nurse because of his/her understanding of the functions/roles each community health care facility fulfills in the holistic care of the culturally diverse population throughout the lifespan.

CLINICAL OBJECTIVES:

Upon completion of this community health rotation, the student practical nurse will be able to:

1. Give a general overview of the type of patients/clients the agency/facility serves. (to include cultural backgrounds, lifespan diversity, growth & development patterns, etc.)
2. Describe the various types of programs, services, care provided in the agency.
3. Discuss the qualifications of the nurse in the agency/facility.
4. Describe the role of the nurse; the student nurse, the licensed practical nurse and the registered nurse (to include how the role has changed and the expectations).
5. Discuss the benefits of the programs, services, care provided to the community.
6. Describe the community health experience on a journal entry form. (To be turned in at the assigned time following the completion of the rotation to Mrs. Spurgeon, Community Health Instructor).
7. Demonstrate the ability to perform skills as assigned.
8. Satisfactory performance as evidenced by “pass” on performance evaluation at end of each area in community health rotation as evaluated by both clinical instructor and preceptor (as applicable.)
When in Community Health/Mental Health rotations and Specialty/Observation areas, ie: Surgery, Endoscopy, Radiation Oncology, Cardiac Rehab:

The students are to follow instructions provided regarding: observation only, participatory observation or preceptorship.

Observation Only means the student is not to participate in any skills that require “hands on” experience without the presence of an instructor, preceptor or as instructed by the nurse director.

Participatory Observation means the student is to participate in designated non-invasive skills with the supervision of a Registered nurse or designated preceptor as instructed by the nurse director.

Direct Care through Preceptorship means the student is assigned an approved preceptor at a designated clinical site that will serve in the instructor role as designated by the instructor or nurse director.

If there are any questions in the student or staff’s mind regarding this policy or the written guidelines, please notify the practical nursing instructor(s) or nurse director immediately.

- A clinical overview/orientation will be given in class prior to the beginning of the scheduled clinical rotation
- This policy applies to all areas in Community Health and Pediatric experiences outside the hospital
ROLLA TECHNICAL CENTER
PROGRAM OF PRACTICAL NURSING

PHYSICIAN’S OFFICE/COMMUNITY CLINIC

We believe an important part of the student practical nurse’s clinical experience is to gain as much knowledge as possible about the role of the practical nurse in the community setting.

We believe this knowledge may best be gained through direct care through preceptorship and/or observation (only or participatory) in a multitude of health care settings in the community.

We believe the student practical nurse will be better able to function once graduated as a Licensed Practical Nurse because of his/her understanding of the functions/roles each community health care facility fulfills in the holistic care of the culturally diverse population throughout the lifespan.

CLINICAL OBJECTIVES:

Upon completion of this community health rotation, the student practical nurse will be able to:

1. Describe the various types of services provided by the physician’s office/community clinic.
2. Describe the populations (culture, age, etc) served by the physician’s office/community clinic.
3. Discuss the primary focus (specialty) of the physician’s office/community clinic.
4. Describe the role of the office nurse.
5. Discuss the qualifications of the office nurse. (both LPN & RN if applicable.)
6. Describe in writing a summary of your experience in the physician’s office/community clinic.
7. Discuss in writing the objectives of the rotation. (To be turned at assigned time following the completion of your rotation to Mrs. Spurgeon, Community Health Instructor)
8. Demonstrate the ability to perform skills as assigned.
9. Satisfactory performance as evidenced by “pass” on performance evaluation at end of clinical rotation as evaluated by both clinical instructor and preceptor (if applicable).
We believe an important part of the student practical nurse’s clinical experience is to gain as much knowledge as possible about the role of the practical nurse in the community setting.

We believe this knowledge may best be gained through direct care through direct hands-on care through preceptorship and/or observation (only or participatory) in a multitude of health care settings in the community.

We believe the student practical nurse will be better able to function once graduated as a Licensed Practical Nurse because of his/her understanding of the functions/roles each community health care facility fulfills in the holistic care of the culturally diverse population throughout the lifespan.

**CLINICAL OBJECTIVES:**

Upon completion of this community health rotation, the student practical nurse will be able to:

1. Describe the various types of programs, services, care provided by the school nurse.
2. Describe the multitude of culturally diverse populations, ages, and growth and development patterns observed within the school setting.
3. Describe the role of the school nurse within the community setting.
4. Discuss the changing roles and expectations of the school nurse within the community setting.
5. Discuss the qualifications to become a school nurse.
6. Describe in writing a summary of your experience in the school setting.
7. Discuss in writing the objectives of the rotation. (To be turned in at an assigned time following the completion of your rotation to Mrs. Spurgeon, Community Health Instructor).
8. Demonstrate the ability to perform skills as assigned.
9. Satisfactory performance as evidenced by “pass” on performance evaluation at end of clinical rotation as evaluated by both clinical instructor and preceptor (if applicable.)
ROLLA TECHNICAL CENTER
PROGRAM OF PRACTICAL NURSING

PUBLIC HEALTH
HOME HEALTH
HOSPICE

We believe an important part of the student practical nurse’s clinical experience is to gain as much knowledge as possible about the role of the practical nurse in the community setting.

We believe this knowledge may best be gained through direct care through direct hands-on care through preceptorship and/or observation (only or participatory) in a multitude of health care settings in the community.

We believe the student practical nurse will be better able to function once graduated as a Licensed Practical Nurse because of his/her understanding of the functions/roles each community health care facility fulfills in the holistic care of the culturally diverse population throughout the lifespan.

CLINICAL OBJECTIVES:

Upon completion of this community health rotation, the student practical nurse will be able to:

1. Describe the various types of programs, services, care provided by the public health/home health/hospice nurse.
2. Describe the multitude of culturally diverse populations, ages, and growth and development patterns observed within the public or home setting.
3. Describe the role of the public health/home health/hospice nurse within the community setting.
4. Discuss the changing roles and expectations of the public health/home health/hospice nurse within the community setting.
5. Discuss the qualifications to become a public health/home health/hospice nurse.
6. Describe in writing a summary of your experience in the public health/home health/hospice setting.
7. Discuss in writing the objectives of the rotation. (To be turned in at an assigned time following the completion of your rotation to Mrs. Spurgeon, Community Health Instructor).
8. Demonstrate the ability to perform skills as assigned.
9. Satisfactory performance as evidenced by “pass” on performance evaluation at end of clinical rotation as evaluated by both clinical instructor and preceptor (if applicable.)
Leadership
&
Management
Clinical
ROLLA TECHNICAL CENTER
PROGRAM OF PRACTICAL NURSING

LEADERSHIP AND MANAGEMENT FOR THE PRACTICAL NURSE

CLINICAL OBJECTIVES/OUTCOME CRITERIA

Upon completion of this clinical rotation, the practical nursing student will be able to:

1. Demonstrate leadership roles and responsibilities of the graduate practical nurse.

2. Delegate job tasks to appropriate health care team members within the scope of the practical nurse’s responsibilities.

3. Demonstrate effective time management skills.

4. Exhibit ability to organize and prioritize care for the selected group of patients and/or clients.

5. Direct and assist appropriate health care team members to meet the holistic needs of the patient/and or family.

6. Demonstrate a satisfactory performance in all areas of the summative clinical performance evaluation with the addition of leadership and management component.
LEADERSHIP AND MANAGEMENT INFORMATION

1. Each student will be assigned to a specific facility for the leadership and management rotation.

2. There are several different clinical facilities utilized for this rotation.

3. Each student will orient to his/her assigned area. A packet of specific information for the assigned facility will be given to the student during orientation.

4. This clinical rotation is designed to correlate with the leadership and management theory.

5. Refer to Clinical Preceptor Program information provided by clinical instructor.

6. Refer to Defined Activities list provided by clinical instructor.
Intravenous Fluid Therapy & Administration Clinical
Rolla Technical Center
Program of Practical Nursing

Intravenous Fluid Therapy
Clinical Experience Objectives

The purpose of the Intravenous Fluid Therapy clinical rotation is to provide the student practical nurse with the knowledge and skills to perform Intravenous Therapy Fluid Administration in accordance with the Missouri Nurse Practice Act upon licensure as a Licensed Practical Nurse in a multitude of settings to a culturally diverse population across the life span.

Upon completion of the 8 hours of required clinical, the student should be able to:

1. Identify the course prerequisites.
2. Identify the objectives of the LPN Intravenous Fluid Therapy Course.
3. Identify the purpose of the LPN Intravenous Fluid Therapy course and clinical.
4. Identify the duties and functions of the LPN in performing intravenous fluid therapy as defined by Missouri Rule 4 CSR 200.6010, Intravenous Fluid Treatment Administration.
5. Complete and master all skills in the laboratory setting.
6. Demonstrate the ability to document pertinent data in accordance with institutional policy.
7. Demonstrate the selection of the appropriate device and insertion of the intravenous line.
10. Accurately calculate and establish an infusion flow rate.
11. Monitor and maintain existing Intravenous Therapy delivery system while minimizing potential for complications.
12. Demonstrate ability to discontinue peripheral intravenous line.
13. Exhibit knowledge of intravenous fluids and medications to include specific considerations associated with safe and efficient delivery.
14. Successfully complete lab return demonstrations, 8 hours of clinical experience, and obtain an 80% on the final exam and 100% Pass in clinical.
Rolla Technical Center
Program of Practical Nursing

Intravenous Fluid Therapy

**Clinical Assignment:**

Each student will be assigned an 8-hour clinical experience after completion of the skills in the laboratory setting at the end of the 3rd trimester.

More information will be available at the time of assignment.

Assignment will be completed at the Physician Surgery Center in Rolla MO.
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Clinical Syllabus

Part 2
March - July