Plainview Center

Course Syllabus

COURSE: VNSG 1160 Clinical Level 1
SEMESTER: Fall 2025

CLINICAL TIMES: Thursday & Friday Times vary depending on clinical assignment see semester schedule on Blackboard
INSTRUCTOR: Stacey Koelder, LVN
OFFICE: PC 104 E
OFFICE HOURS: Monday: 10-4, Wednesday 8-12 and Friday via appt. confirmed by email
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"South Plains College improves each student's life."

GENERAL COURSE INFORMATION

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

CO-requisite courses (concurrent): VNSG 1400, VNSG 1201, VNSG 1420, VNSG 1204, VNSG 1323

COURSE DESCRIPTION

A method of instruction providing detailed education, training and work-based experience and direct patient/client care, generally at a clinical site. On-site clinical instruction, supervision, evaluation and placement is the responsibility of college faculty. Clinical experiences are unpaid external learning experiences.

STUDENT LEARNING OUTCOMES

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

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

At the completion of this course the student will:
1. Apply the theory, concepts and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with Vocational Nursing
2. Demonstrate legal and ethical behavior
3. Demonstrate the ability to care for a patient in an acute patient-care situation or long-term care
4. Demonstrate safety practices within the health care setting
5. Demonstrate interpersonal teamwork skills
6. Communicate in the applicable language of health care
7. Be prepared to practice within the legal, ethical, and professional standards of vocational nursing as a health care team member in a variety of roles

8. Exhibit an awareness of the changing roles of the nurse

9. Utilize the nursing process as a basis for clinical judgment and action
10. Accept responsibility for personal and professional growth
11. Be present and punctual for all clinical assignments and labs with no more than 1 absence.
LEVEL 1 CLINICAL OBJECTIVES (BASED ON TBON DECs) During the clinical course, the beginning vocational nursing student progresses to novice nurse through the following: **Texas Board of Nursing Differentiated Essential Competencies (DECS) Vocational Nursing**
I. Member of the Profession. ***A. Function within the nurse's legal scope of practice and in accordance with the policies and procedures of the employing health care institution or practice setting.*** **Clinical Judgments and Behaviors:**
1. Function within a directed scope of practice of the vocational nurse with appropriate supervision.
2. Assist in determination of predictable health care needs of patients to provide individualized, goal-directed nursing care.
3. a. Practice according to facility policies and procedures.
b. Question orders, policies, and procedures that may not be in the patient's best interest.
B. Assume responsibility and accountability for the quality of nursing care provided to patients and their families.
1. Practice according to the Texas laws and regulations
2. a. Provide nursing care within the parameters of vocational nursing knowledge, scope of practice, education, experience, and ethical/ legal standards of care.
3. a. Practice nursing in a caring, nonjudgmental, nondiscriminatory manner.
b. Provide culturally sensitive health care to patients and their families.
c. Provide holistic care that addresses the needs of diverse individuals across the lifespan.
4.a. Use performance and self-evaluation processes to improve individual nursing practice and professional growth.
4b. Evaluate the learning needs of self, peers, and others and intervene to assure quality of care.
5. a. Assume accountability for individual nursing practice.
b. Follow established evidence-based clinical practice guidelines.
6. a. Follow established policies and procedures.
b. Question orders, policies, and procedures that may not be in the patient's best interest.
c. Use nursing judgment to anticipate and prevent patient harm.
7. Demonstrate professional characteristics that display a commitment to nursing care and to recognizing and meeting patient needs.
8. Use communication techniques to maintain professional boundaries in the nurse/ patient relationship.
9. Uphold professional behavior in nursing comportment and in following organizational standards and policies.
10. Implement principles of quality improvement in collaboration with the health care team.
C. Contribute to activities that promote the development and practice of vocational nursing.
1. Identify historical evolution of nursing practice and issues affecting the development and practice of vocational nursing.
2. Work collegially with members of the interdisciplinary health care team.
3. Participate in activities individually or in groups through organizations that promote a positive image of the vocational nursing role.
4. Recognize roles of vocational nursing organizations, regulatory agencies, and organizational committees.
5. Practice within the vocational nursing role and Scope of Practice.
6. Serve as a positive role model for students, peers, and members of the interdisciplinary health care team.

D. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning
1. Participate in educational activities to maintain/improve competency, knowledge, and skills.
3. Use self-evaluation, reflection, peer evaluation, and feedback to modify and improve practice.
4. Demonstrate accountability to reassess and establish new competency when changing practice areas.
5. Demonstrate commitment to the value of lifelong learning.
6. Engage in self-care practices that promote work-life balance.

II. Provider of Patient-Centered Care

A. Use clinical reasoning and knowledge based on the vocational nursing program of study and established evidence-based practice as the basis for decision making in nursing practice.
1. Use problem-solving approach to make decisions regarding care of assigned patients.
2. a. Organize care for assigned patients based upon problem-solving and identified priorities.
b. Proactively manage priorities in patient care and follow-up on clinical problems that warrant investigation with consideration of anticipated risks.
c. recognize potential care needs of vulnerable patients
3. Identify and communicate patient physical and mental health care problems encountered in practice.
4. Apply relevant, current nursing practice journal articles to practice and clinical decisions.
B. Assist in determining the physical and mental health status, needs, and preferences influenced by culture, spirituality, ethnicity, identity, and social diversity of patients and their families, and in interpreting health-related data based on knowledge from the vocational nursing program of study.
1. Use structured assessment tool to obtain patient history.
2. Perform focused assessment to assist in identifying health status and monitoring change in patients.
3. Report and document focused patient assessment data.
4. Identify predictable and multiple health needs of patients and recognize signs of decompensation.
5. Share observations that assist members of the health care team in meeting patient needs.
6. Assist with health screening.
7. Differentiate abnormal from normal health data of patients.
8. Recognize healthcare outcomes and report patient status.
9. a. Recognize that economic and family processes affect the health of patients.
b. Identify health risks related to social determinants of health
C. Report data to assist in the identification of problems and formulation of goals/ outcomes and patient-centered plans of care in collaboration with patients, their families, and the interdisciplinary health care team.
1. Integrate concepts from basic sciences and humanities to deliver safe and compassionate care in delivery of patient care.
2. Identify short-term goals and outcomes, select interventions considering cultural aspects, and establish priorities for care in collaboration with patients, their families, and the interdisciplinary team.
3. Participate in the development and modification of the nursing plan of care across the lifespan, Including end-of-life care.
4. Contribute to the plan of care by collaborating with interdisciplinary team members.
5. Assist in the discharge planning of selected patients.
6. Demonstrate fiscal accountability in providing patient care.
7. Demonstrate basic knowledge of disease prevention and health promotion in delivery of care to patients and their families.
D. Provide safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.

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

1. Identify health-related learning needs of patients and their families.
2. Contribute to the development of an individualized teaching plan.
3. Implement aspects of an established teaching plan for patients and their families.
4. Assist in evaluation of learning outcomes using structured evaluation tools
5. Teach health promotion and maintenance and self-care to individuals from a designated teaching plan.
6. Provide the patient with the information needed to make choices regarding health
7. Provide patients and families with basic sources of health information.
H. Assist in the coordination of human, information, and physical resources in providing care for assigned patients and their families.
1. Participate in implementing changes that lead to improvement in the work setting.
2.a. Report unsafe patient care environment and equipment.
2 b. Report threatening or violent behavior in the workplace
3. Implement established cost containment measures in direct patient care.
4. Assign patient care activities taking patient safety into consideration according to Texas Board of Nursing rules (217.11).
5. Use management skills to assign to licensed and unlicensed personnel.
6. Assist with maintenance of standards of care.

III. Patient Safety Advocate

B. Implement measures to promote quality and a safe environment for patients, self, and others.
1. Promote a safe, effective caring environment conducive to the optimal health, safety, and dignity of the patients and their families, the health care team and others consistent with the principles of just culture.
2. Accurately identify patients
3. Safely perform preventive and therapeutic procedures and nursing measures including safe patient handling.
4. Clarify any order or treatment regimen believed to be inaccurate, non-efficacious, contraindicated, or otherwise harmful to the patient.
5. Document and report reactions and untoward effects to medications, treatments, and procedures and clearly and accurately communicate the same to other health care professionals.
6. Report environmental and systems incidents and issues that affect quality and safety, and promote a culture of safety.
8. Implement measures to prevent risk of patient harm resulting from errors and preventable occurrences.
9. Inform patients regarding their plans of care and encourage participation to ensure consistency and accuracy in their care.
C. Assist in the formulation of goals and outcomes to reduce patient risks.
1. Assist in the formulation of goals and outcomes to reduce patient risk of health care-associated infections
2. a. Implement measures to prevent exposure to infectious pathogens and communicable conditions.
b. Anticipate risk for the patient.
3. Implement established policies related to disease prevention and control.
D. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices.
1. Evaluate individual scope of practice and competency related to assigned task.
2. Seek orientation/ training for competency when encountering unfamiliar patient care situations.
3. Seek orientation/ training for competency when encountering new equipment and technology.
E. Comply with mandatory reporting requirements of the Texas Nursing Practice Act
1. Report unsafe practices of healthcare providers using appropriate channels of communication.

2. Understand nursing peer review rules and implement when appropriate.
3. Report safety incidents and issues through the appropriate channels.
4. Implement established safety and risk management measures
**** F. Accept and make assignments that take into consideration patient safety and organizational policy.***
1. Accept only those assignments that fall within individual scope of practice based on experience and educational preparation.

IV. Member of the Health Care Team:

A. Communicate and collaborate with patients, their families, and the interdisciplinary health care team to assist in the planning, delivery, and coordination of patient-centered care to assigned patients.
1. Involve patients and their families with other interdisciplinary health care team members in decisions about patient care across the lifespan.
2. Cooperate and communicate to assist in planning and delivering interdisciplinary health care.
3. Participate in evidence-based practice in development of patient care policy with the interdisciplinary team to promote care of patients and their families.
B. Participate as an advocate in activities that focus on improving the health care of patients and their families
1. Respect the privacy and dignity of the patient.
2. Identify unmet health needs of patients.
3. Act as an advocate for patient's basic needs, including following established procedures for reporting and solving institutional care problems and chain of command.
4. Participate in quality improvement activities.
5. Refer patients and their families to community resources.
C. Participate in the identification of patient needs for referral to resources that facilitate continuity of care, and ensure confidentiality.
1. a. Identify support systems of patients and their families.
b. Identify major community resources that can assist in meeting needs.
2. a. Communicate patient needs to the family and members of the health care team.
b. Maintain confidentiality
c. Promote system-wide verbal, written, and electronic confidentiality.
3. a. Advocate with other members of the interdisciplinary health care team on behalf of patients and families to procure resources for care.
b. Assist patient to communicate needs to their support systems and to other health care professionals.
4. Identify treatment modalities and cost of health care services for patients and their families.
D. E. F. Communicate patient data using technology to support decision making to improve patient care.
1. a. Identify, collect, process, and manage data in the delivery of patient care and in support of nursing practice and education.
b. Use recognized, credible sources of information, including internet sites.
c. Access, review, and use electronic data to support decision-making
2. a. Apply knowledge of facility regulations when accessing client records.
b. Protect confidentiality when using technology.
c. Intervene to protect patient confidentiality when violations occur.
3. a. Use current technology and informatics to enhance communication, support decision making, and promote improvement of patient care.
b. Advocate for availability of current technology.
4. Document electronic information accurately, completely, and in a timely manner.

G. Assist health care teams during local or global health emergencies or pandemics to promote health and safety, and prevent disease.
1. Recognize the impact and prepare to respond to an emergent global or local health issue in an assistant role
2. Guide patients, staff, and others in understanding the extent of the emergency and their response
3. Participate with the health care team to promote safety and maintain health during an emergency or pandemic
4. Include public health strategies in the care of individuals and communities that address resolution of a global or local crisis and promotion of health among the population.

COURSE COMPETENCY

The student will successfully complete 1160 with a "C" (76) or better and follow safe nursing practices. See Level 1 EXPECTATIONS and OBJECTIVES on Blackboard. All assignments must be turned in whether or not they meet the grading deadline. Students who fail to turn in assigned paperwork fail the clinical course, REGARDLESS OF OTHER CLINICAL GRADES!

EVALUATION METHODS

Weekly clinical performance evaluations, weekly documentation/paperwork and other assignments with a final Summative Evaluation at the end of the semester.

ACADEMIC INTEGRITY

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

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

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

VARIFICATION OF WORKPLACE COMPETENCIES

Successful completion of this course and all required concurrent theory courses entitles the student to receive a Certificate of Proficiency and to apply to write the examination for licensure (NCLEX-PN) to practice as a Licensed Vocational Nurse in the State of Texas.

BLACKBOARD

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

FACEBOOK

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

SCANS and FOUNDATION SKILLS

Refer also to Course Objectives. Scans and Foundation Skills attached

SPECIFIC COURSE INFORMATION

SPECIFIC UNIT OBJECTIVES

MEDICAL-SURGICAL ROTATIONS

Covenant Hospital: Medical-Surgical Floor Objectives

Unit	Location	Phone	Specialty
Covenant Hospital	2nd-3rd floor	296-5531	Medical and Surgical patients such as pneumonia, GI bleeds, skin issues, pain. Telemetry patients; includes pre/post op procedures and medical problems.

PRAIRIE HOUSE

Unit	Location	Phone	Specialty
Prairie House	1301 Mesa Dr	293-4855	A 121 bed premiere skilled nursing and rehabilitation care center providing comprehensive inpatient care. The Facility provides the full range of PT, OT and Speech therapies.

PLAINVIEW HEALTH CARE CENTER

Unit	Location	Phone	Specialty
Plainview Healthcare Center	2510 W. 24th St.	296-5584	A long term care and rehabilitation facility that occupies 51 occupants.

General Guidelines for ALL Medical Surgical Rotations in Level 1

Criteria	Level 1
Number of patients	1-2
Medication administration with instructor supervision	No
Documentation on student pages only	Yes
Chart Pack (follow instructions on Level 1 EXPECTATIONS and OBJECTIVES	Yes
VS and brief assessment by 0730	Yes
Full assessment documented by 0930	Yes
Follow Do and Don't List in handbook (only after being successfully checked off in the lab by an instructor)	Yes

THE SIMULATION EXPERIENCE

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

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

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

During Simulation, students fulfill all roles of the nurse and are not restricted to student limitations. Students must treat the simulation experience as a REAL patient situation; if appropriate action is not taken by the student, the patient will experience a negative outcome, including death. On a rotating basis, students will be assigned roles for each scenario. All roles are important and all students have learning opportunities in any role.

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

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

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

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

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

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

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

TEXT AND MATERIALS – Required

Tabers Medical Dictionary

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

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

- This syllabus with Level 1 Clinical Objectives and specific unit objectives
- VNSG Clinical Handbook
- Level 1 EXPECTATIONS and OBJECTIVES
- Skills Checklist

Students MAY NOT

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

ADDITIONAL CLINICAL ITEMS

Students should come to clinicals *prepared* to care for patients. The ISBAR and Narrative/Chart Pack are required for each patient. The student must be in full clinical uniform which includes the student badge, stethoscope, blood pressure cuff, penlight, bandage scissors, black ink pen and analog watch. Refer to the Student Handbook for the full-dress code.

ATTENDANCE POLICY (*READ CAREFULLY)

Clinical Attendance

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

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

Recognizing that sometimes students are ill or have ill children or have some other real reason to be absent, students may have ONE absence this semester—this includes any day the student is sent home for clinicals for a rules violation. ABSENCES MUST BE MADE UP BY THE END OF THE SEMESTER. ***Exceeding allowable clinical absences (1) may result in failure in the clinical course*.*** The student may be administratively withdrawn.

*If the student has a documented emergency that leads to exceeding 1 clinical absence, the student will be responsible for notifying the instructor. The student must present evidence to the INSTRUCTOR AND PROGRAM COORDINATOR regarding the reasons for all absences. The INSTRUCTOR AND PROGRAM COORDINATOR will review and determine if a true emergency existed for each of the absences. Failure to plan (childcare, transportation, traffic, tardiness) is not an eligible emergency. There are absences available in each course in case one of these needs arises. However, exceeding absences is grounds for dismissal. Should you use an absence, please be aware that if you encounter a true emergency later in the semester and you have already used your absence for a non-emergency, the attendance policy will be upheld, and you may be dismissed from the VNP. The decision of the INSTRUCTOR AND PROGRAM COORDINATOR is final.

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

Students must meet with the clinical instructor prior to the start of their clinical day. Students will be checked by the instructor to ensure students are prepared for the clinical day. If the student is found to be unprepared, but is able to correct, deductions may be taken from the grade per the weekly clinical evaluation. If unable to correct, student will be sent home absent and must make up clinical day.

Facility	Clinical Time	Lunch	Absent at:	Call In Time	May leave floor at
Covenant Hospital	0630-1530	30 minutes	0630	0530	1515
Prairie House	0630-1530	30 minutes	0630	0530	1515
Plainview Health Care	0630-1530	30 minutes	0630	0530	1515
Simulation	0755-1600	Approx. 60 minutes	0800	0700	1600
Skills Lab	0755-1600	Approx. 60 minutes	0800	0700	1600

Clinical time is "on the job" learning. Students are expected to be up and working throughout the entire shift. Students MAY NOT leave the assigned unit at the hospitals until 3:15pm. This means that the student gives report, checks on the patients and participates in patient care until 3:15pm and then gathers belongings, leaves the floor and signs out. Students who leave the floor before 3:15pm or students who sign out right at 3:15pm (which means they left unit early in order to sign out) are given an absence for the entire day.

PLEASE NOTE: The Sign in sheets will be located at the help desk at Covenant in the lobby.

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

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

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

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

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

BREAKS and LUNCH during clinical rotations:

Break Process:

1. Students may take one 15-minute break in the morning *AFTER* completing a.m. patient care (student must complete assessments, vital signs, open charts). The student should not be in the break room or student room except for the one morning break. A student who takes a break without accomplishing any nursing activity is sent

home as “absent.”

2. Students may take one 15-minute break in the afternoon *BEFORE* 1400. The student should not be in the break room or student room except for the one afternoon break.
3. Between 1400-1515, the student should be completing documentation, doing last rounds on patients, completing I&Os and giving report to the TPCN. This is not the time for breaks.
5. Students may not divide the 15-minute break into three 5-minute breaks. The student only gets one morning and one afternoon break.
6. Students should remain on the assigned units for breaks.
7. Students taking prolonged breaks or leaving the floor during break times without notifying TPCN will be sent home with an absence, no matter what time of day the infraction is discovered.
8. Breaks are not guaranteed.

Lunch Process:

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

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

SIGNING IN/OUT: Signing in/out for other student(s) is PROHIBITED and is considered unprofessional conduct as dishonest behavior. All students involved will be dismissed from the Vocational Nursing Program (please refer to the Student Handbook).

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

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

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

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

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

* Fever > 100.4^{o} F
* Conjunctivitis (Pink Eye)
* Diarrhea lasting more than 12 hours
* Group A Strep—culture confirmed or physician diagnoses
* Jaundice—yellowing of the skin which might suggest viral hepatitis

* Cold Sores (herpes) that are weeping, open (not crusted over)
* Active measles, mumps, pertussis, rubella, chicken pox or shingles
* Upper respiratory infection (cold) with productive cough (green or yellow sputum)
* Tuberculosis and/or positive TB skin test
* Head lice
* Scabies (mites that burrow under the skin causing a rash)
*any draining wound such as an abscess or boil
* Impetigo
* Mononucleosis

NO SHOW POLICY

Professional behavior requires the student to call in any time he/she will be absent. When absent on a clinical day, the student must Call Instructor and email Instructor by the specified deadline- See Clinical Handbook. STUDENTS MUST EMAIL PRIOR TO THE SHIFT FOR THE ABSENCE TO NOT COUNT AS A 'NO SHOW"—ONCE THE SHIFT STARTS, IT IS A "NO SHOW" (so at 0630, the student is No Show if there has not been a call-in). Just not showing up is unprofessional and is detrimental to patient safety. No Shows apply to the entire clinical year as they would in employment; if a student has a No Show in the previous semester, it still is a part of the record.

CONSEQUENCES of No Show:

1.Student is marked as a no call, no show and is marked absent.
2. Student must make-up clinical absence.
3. 2nd No call, no show will result in a meeting with the Coordinator for further disciplinary action.
4. 3rd No call, no show will may result in a INSTRUCTOR AND PROGRAM COORDINATOR committee meeting or dismissal from the program.

Faculty Appointments: Faculty will be available to offer extra assistance to students on **by appointment**. In order to allow students the best opportunity for assistance, students MUST make appointments with the faculty by emailing the instructor for an available appointment time.
Appointments are scheduled throughout the day and students must take the first available appointment. It is not professional behavior to just "drop in" during these times.

ASSIGNMENT POLICY—CLINICAL PREPARATION

All assignments must be completed by the assigned due date. Late work is not acceptable and a zero will be given, however all work must be submitted. Incomplete work must be submitted, but deductions will be taken per the clinical evaluation/rubric.

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

Clinical Preparation

Preparing for clinical practice is a DUTY of the student vocational nurse and leads to SAFE NURSING PRACTICE. The student is required to prepare for clinical in such a way as to understand the medical diagnoses and medications, the implications of labs and diagnostics, the potential complications and how to prevent them, and the required nursing

care. Adequate preparation is a must. The student should plan on a minimum of two hours of prep time per day for each clinical experience.

To prepare for hospital experiences; Please also refer to the Clinical Expectations placed on Blackboard

Documentation/Chart Pack: In all medical-surgical rotations, the student must complete individual research and the chart pack. The Chart Pack is the student's practice documentation and is considered a legal document (it may be subpoenaed for evidence); therefore, the Chart Pack/Documentation should be treated with respect and completed up to the point the student relinquishes care of the patient. The completed Chart Packs/documentation should be stamped by Mrs. Hall on Friday before 0900 and turned in to the appropriate Instructor clinical box. After each is checked, the Chart Pack is returned to the student for safe-keeping. For more information on the Chart Pack and clinical research, please go to that area on Black Board.

Students will not be able allowed to care for prisoners or patients requiring airborne isolation.

Clinical Probation

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

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

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

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

Contacting the Clinical Instructor

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

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

When Students Should Contact the Clinical Instructor:

The clinical instructor should be contacted:

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

Dress Code for Clinical Experiences

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

1. Uniform:
   a. Royal blue scrub top, pant or knee-length, A-line skirt. All tops must have "SPC" embroidered logo.
   b. Must have appropriate underwear with the uniform. Bras and underpants are required for females. Underpants are required for males. White socks or hose are required. Underwear may NOT have writing on them that shows through the scrub top/bottom. Women wearing skirts must wear a slip and white hose. Bras should be skin colored and should not be visible through the neck of the clinical uniform.
   c. The uniform must be clean and pressed (ironed). Wrinkled uniforms look unprofessional and may result in the student being sent home as absent. To avoid ironing, remove uniforms immediately from the dryer and hang the uniform up. There are commercial sprays you can use to help remove wrinkles as well.
   d. The uniform must be worn to the hospital or other health care facility each clinical day, even during specialty rotations. This rule also applies to any special events such as honor lunches or breakfasts. If a student is at a rotation where street clothes are allowed, such as day care, the student MUST dress in the clinical uniform when participating in ANY school event.
   e. A closed-toe, closed-heel *mostly* white LEATHER shoe should be worn in ALL clinical settings, including day care. Athletic shoes that are mostly white may be worn. Shoe strings must be clean and shoes should be cleaned/polished regularly. Crocks and clogs or any other plastic shoes are unsafe and unacceptable.
   f. A royal blue jacket may be worn (optional). If worn, it must have the "SPC" embroidered logo. It must be clean and pressed DAILY. Cold-natured students should purchase this item. Other jackets and coats—even during lunch—may not be worn with the student uniform. (Be advised that there is limited space to hang coats/jackets during the winter months. Expensive coats should not be worn to the hospital where they could be stolen [ripped off])
   g. A royal blue t-shirt may be worn under the scrub top for warmth. Royal blue is the only acceptable color. A t-shirt, if worn, must be cleaned daily and must have no writing that shows through the scrub top. T-shirts must be tucked in and Not hanging out under the uniform
   h. IF a uniform is too little (as purchased) or IF it becomes too small so that it rides up over the buttocks, the student is sent home "absent" and cannot return to the clinical setting until a new uniform that fits correctly is purchased.
2. Sweaters must not be worn with the uniform.
3. No jewelry may be worn when in uniform other than a watch with a second hand {SMART watches are prohibited} and one flat WEDDING BAND without stones for married students only. Stones in rings may be damaged or may injure a patient. No body areas may be jeweled, including earrings, and tongue, nose, eyebrow, or chin studs. Plastic spacers may be used as long as they are clear and flush with the skin.
4. No pins or other decorations may be worn on the uniform, except those approved by the faculty.
5. Tattoos :
   a. Facial tattoos must not be visible. If a student has a facial tattoo, it must be covered with dermablend or another brand of tattoo concealer.
   b. Tattoos on the upper extremities down to the wrist must be covered with clothing (Scrub undershirt in royal blue) or bandages.
   c. Tattoos in other areas may be left uncovered (hands, wrist, neck, chest, behind the ears) unless the words or images convey profanity, violence, discrimination, sexually explicit content or anything deemed offensive by fellow students, instructors, faculty, patients, patient family or hospital staff.
6. Hair must be kept clean, washed frequently, neatly arranged, and professional in appearance.
   a. Extreme coiffures (bushy, mohawks, extreme shavings, pompadours or other hairstyles determined by faculty as extreme) are inappropriate with the uniform. Extreme hair colors (blue, pink, bright orange, purple, green, gold, silver, maroon, bright yellow or glitter, or those that call attention to self) are not allowed. **A student should be known for good nursing skill rather than hairstyle!**

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

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

COMPUTER USAGE

Clinical Computer Usage: Computer systems at the clinical sites are for the purposes of clinical work. Students may only use the agency computer systems for accessing important patient data the student needs for safe and effective patient care. Students MAY NOT use the agency computer for personal usages such as checking emails (even SPC or instructor-

sent emails are prohibited on agency computers), Blackboard, websites (including drug or diagnoses websites) or other personal usage. No "research" is to be done during the clinical period. Students who engage in inappropriate computer usage will be placed on probation for the first offense and will be dismissed from the VNP for a subsequent offense. Refer to the Student Vocational Nurse Handbook.

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

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

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

Computer Checklist

History and Physical

Go to Notes Tab located at top of screen -> Select Note Type or Service Type -> Look for (H&H) History and Physical

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

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

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

Progress Notes

Go to Notes tab located at top of screen -> Select Note Type or Service type -> Look for Physician Progress Notes

- There is typically a progress note for every day of their stay during this admission. You should read at least the first and last progress note. I f , when reading the progress note, you do not know how all of the sudden several diagnoses have changed or been added, you can skip back and read more of the progress notes.
- Again, you must read all the way to the bottom. At the bottom, you will find the Impression and Plan. Use this information to fill in your ISBAR with current and past medical diagnoses. Also, fill in what is happening now. You can also see if they are planning discharge.

MAR

1. Get your White Medication Sheet from the chart pack.
2. Fill in the medication name, route, dose, frequency and times.
   This is not the time to fill in classification, indication, side effects, V/S needed etc.- that is for research.
3. For Scheduled medications you will need to right click on the MAR tab located at the top of screen -> Select Scheduled medications -> right click on medication-> look at Order detail. This should show you the times that the medication is scheduled. Be aware that if the med is BID- you are looking for 2 times, TID- 3 times, etc…
4. To look at continuous medication repeat steps located above and instead of selecting scheduled you will select continuous. Repeat for PRN medications.
5. You only need to fill in frequency for PRN medications, not times because they are not scheduled at set times.

Example of Scheduled vs. PRN:

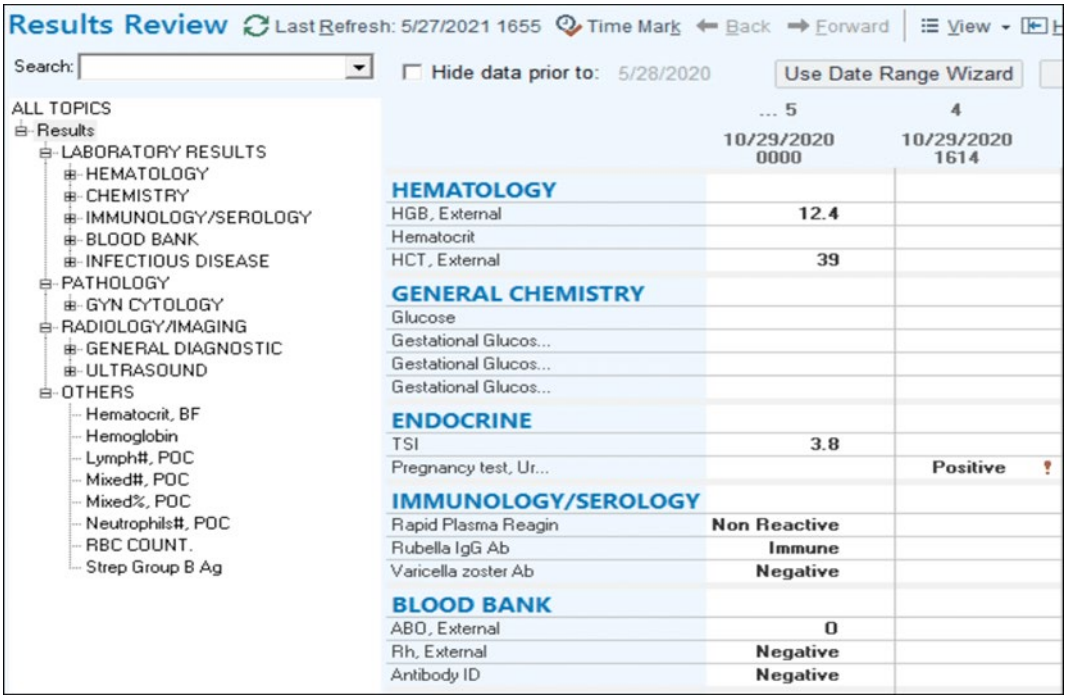
Medication	Classification	Indication	Dose/route	Frequency/time	Side effects	v/s
Furosemide (Lasix)			20 mg PO	Daily 0900		
Acetaminophen (Tylenol)			500mg PO	Q4h PRN		

Orders

- Click on orders tab located at top of the screen.
- Be sure to note any wound care, Ted Hose, SCDs, Oxygen, IV fluids, Accu-checks, Diet, Fluid Restriction, Weight bearing restrictions, etc…

Flowsheets (Labs, Radiology, ect.)

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



- You will need to look at your patient's admission date and get your lab sheet from your chart pack. Fill in the labs from the date of admission.
- Then look at the most current labs and fill those labs in on the next column. You need to write this information in black ink.
- DO NOT write in the normal values or draw your high or low arrows in blue or red at this time. This is for you to do at home as research.
- Be sure to look at the left hand column (Hematology, Chemistry, etc.) You can toggle through the labs using this column.
- Make sure to note any Microbiology. This is where you will find cultures such as blood cultures, urine cultures, wound cultures.
- If your patient has Accu-checks, you will find them in the MAR.
- Next Click the Radiology/Imaging Tab.
    - Get your Diagnostics paper from your chart pack and fill in any x-rays, MRI, US, results from the current admission

COMPUTER LAB USAGE

The computer lab is available and may be used by students during scheduled open hours or as assigned by an instructor. Printer paper will not be provided for students to print materials but students may seek assistance from faculty or staff to request lab paper from the college if needed. Lack of computer lab paper is not an excuse for not completing assignments

CLINICAL PAPERWORK

Students will be required to turn in written paperwork as assigned on the Expectations and Objectives page. All assignments are due at 0900 on the scheduled date. Late work may be given a zero; HOWEVER, all assignments must be

turned in and turned in complete in order to exit the course. Students who do not turn in all work will fail the course, regardless of other grades.

Guidelines for Writing a Narrative Note in the Vocational Nursing Program

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

General Writing Rules:

1. Write on one side of the Narrative Note only. If you need more than one sheet of paper, continue writing on a second sheet, not on the back.
2. Handwriting must be legible—if it cannot be read, it has no value.
3. Treat this work as a LEGAL document—this means that it could be used in a court of law. Your Chart Pack could be subpoenaed.
4. This writing is about the patient—the focus is the patient and how the patient is, what the patient needs, does, wants, etc. The nurse signature indicates that the nurse is the one providing the care unless the nurse indicates in the writing that someone else provided care, so the writing must be clear.
    a. If a sentence starts with a verb, then the subject *understood* is the patient.

Example:

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

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

Example:

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

c. Personal pronouns, *I, we, me, you, us*, should not be used in the narrative assessment.

d. What the student thinks, feels, does, is not important in this writing except to write what happens to the patient as a result of the care given.

5. The date and time must initiate the writing, flush left of the page.
    a. Each new entry should have the time
    b. Military time should be used; therefore, no colon should be used in between the hour and minutes.

Example:

Incorrect: **07:10 Report received, care assumed. . ..**
Correct: **0710 Report received, care assumed. . ..**

    c. If a new page is started, re-write the date and time continued with that entry.

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

Example:

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

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

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

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

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

Specific Writing Criteria:

1. The documentation needs to be "opened" or started with the initial opening statement that tells (a) how the nurse took over care, (b) identifies who the patient is and why the patient is there, and (c) tells how the nurse first found the patient.

Example:

0700 Report received and care assumed of a 74-year-old male with diabetes, (L) BKA, weakness for Dr. Rabbit, supine in bed with eyes closed, respirations even and regular.---------- *N. Nurse, SVN.*
In this example, "report" and "care" are the subjects that start this sentence. The age is given to identify the patient as well as the diagnoses and physician. The patient was apparently sleeping, as indicated by stating that the eyes were closed and the respirations were even and regular (as opposed to dead with no respirations). The statement would have been incorrect to say "sleeping" because the only way to be sure the patient was asleep would be to wake the patient up.

2. The patient position should be clear. People "lie" and chickens "lay"—patients are in positions: supine, left or right lateral, Fowler's, prone, etc.
3. Complete Vital Signs should be written because they are "vital" to the patient.
4. Orientation should be specific—to say "x 3" is incorrect because there are many questions that could be asked to determine orientation.
    a. The correct word is "oriented." Orient as a verb means to "find direction" or "give direction." The noun form of this kind of orienting is orientation.
    b. Sometimes people in their speech will form an imagined verb from orientation and say orientate or make it a verb as orientated. At best, orientate is a back-formation used humorously to make the speaker sound pompous.
    c. The correct word is the verb orient.
    d. Orientate is more widely accepted in the U.K. than in the U.S.A., but <u>it should be avoided</u> in any formal or standard writing.
5. Describe what you see. Don't say "natural" or "normal" for skin color—unless you have seen the patient prior to the hospitalization, how do you know what is natural or normal?
6. Avoid using the word "normal"—who determines "normal"? Instead use the descriptive terms
    a. Lung sounds are clear, adventitious, wheezes, rhonchi, rales, congested
    b. Bowel sounds are present, normoactive, hypoactive, hyperactive, absent
    c. Skin is pink, brown, tan, pale, ruddy.
7. If the patient says something that is important to document, use quotation marks to show that that information came directly from the patient.
8. Don't assume—if you find the patient on the floor, describe it but don't assume the patient fell (they have been known to deliberately get on the floor). Don't assume there is a bruise because of an injection.
9. Intravenous (IV) access can be through a peripheral vein such as those found in the arms or legs, a subclavian vein or a jugular vein. In most instances on a med-surg floor, the access is peripherally, usually in the lower arms. IVs can be continuous, meaning that they usually have 500-1000 mL bag of solution running continuously throughout care, OR IV access can be *intermittent, meaning* that the vein has an IV port, but solutions do not run all the time—usually for about 30 minutes several times a day for medications, only. Documentation of the IV access must be clear. For a CONTINUOUS IV, termed as "IV," there should be **documentation of the solution, the** amount, the rate, the pump being used (or if it is by gravity), and the site of the IV access with the access site described as to location, condition and dressing. An intermittent access is termed "INT". For the INT, the site should be described as to location, condition and dressing. When either is DC'd, the description of the removal

and of the site should be included, as well as the dressing applied and instructions given to the patient about the DC.

10. If there is an *abnormal* condition or assessment, describe it and include what nursing actions were taken, including who was notified about the abnormality. If the patient reports pain, don't just document the pain. You must also document who you reported the pain to and what was done about it. The documentation should also indicate that you verified pain relief. If there is abnormal skin turgor, you must also include who was informed about it. If the IV infiltrates or develops phlebitis, you should document that it was DC'd (and by whom if it was not you), if it was restarted, and what was done about the injured vessel.
11. Describe wounds and/or dressings. Don't just say there is a wound present.
12. Decubitus prone areas—the back, the buttocks, the heels—should be specifically addressed.
13. If a Foley catheter is present, the size and type of catheter, amount and color or urine should be clearly indicated. If the Foley is connected to a Continuous Drainage Unit (CDU), that must be stated. The location of the CDU should be stated as well to show that the safety of the catheter was maintained.
14. Safety is a major issue in the hospital. All safety care should be noted in the documentation: ID bands, safety bands, allergy bands, restraint devices, side rails, call light, bed position, brakes, and any alarms. Sitters should be noted if they are part of the safety device. If family have been instructed to not leave the patient alone, family must be noted as part of the safety information.

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

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

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

Instructions for Completing the Chart Pack

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

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

1. Each patient should have the ISBAR completed because this is your communication tool. You use one (1) ISBAR for the patient for all dates of care. There is room in the "assessment" area to write in your report information or you may use the back of the page. [If you must get a new patient, you need a new ISBAR]. THE ISBAR MUST BE VALIDATED BY THE INSTRUCTOR.
    a. Write your name in the Introduction area.
    b. In the R area, you should identify immediate nursing concerns for this patient and you identify/start discharge planning. Both of these should have further documentation in your nursing narrative.
2. From Blackboard, print the "chart pack"; you will need a new chart pack each day for each patient.
3. Assessment Page 1: write your name, patient initials, room number and date of the assessment across the top. At the bottom of the page is a place to document the time of the assessment. This format is basically a CHECKLIST of important assessment areas. It is to help you remember what to assess and then to document the assessment. You should complete it at the bedside. KEEP IT NEAT!
    a. Go through each assessment area, placing a check mark (√) in all areas that apply to this patient and completing all blanks as necessary as you complete your patient assessment—**BE WARY OF THE TEMPTATION TO COPY FROM DAY-TO-DAY! This is unprofessional, illegal and unethical.**
    b. If your patient has diabetic checks (accudatas), be sure to get that information for breakfast) on your assessment page. If that check is covered by insulin, be sure and document that. YOU SHOULD ALWAYS KNOW YOUR PATIENT'S LATEST BLOOD SUGAR (diabetic patients). Also, be sure to inspect the diabetic patient's feet
    c. Be sure that you document your initial safety check on the checklist. You will also document this in your FLOW SHEET, but this is your FIRST check.
    d. Under skin, describe the color—using descriptive terms but not "NORMAL FOR RACE" or a similar statement. Actually, describe the color.
        i. The Braden scale should be done on each patient, using your scale to make that determination. (You will no longer complete a Braden scale worksheet on each patient). Write in the Braden Score.
    e. Be sure under "musculoskeletal" that you appropriately mark the pulses on the stick figure.
    f. If something does not apply to your patient, leave it blank
    g. Some areas indicate that they must be described in the narrative.
    h. ANY unusual finding should be marked with an asterisk* and then detailed in the narrative. This is a patient problem.
4. Assessment Page 2: Write your name, patient initials, room number and date across the top. There is a Narrative charting checklist provided for you at the top of the page to remind you of what you should include. This is the NARRATIVE NOTE. "Narrative" means story—this is the story of the patient that you will write for the day. You must write in BLACK ink and your writing MUST BE LEGIBLE! Please note the following basic rules:
    a. This is considered "legal"—your records could be subpoenaed, so remember that when you document! ONLY factual information should be put in the patient's record.
    b. Writing must be clear. Correct spelling and punctuation are essential! Misspelled words could be used to indicate poor nursing care!

c. This story is about THE PATIENT. Therefore, the *subject understood* of each sentence is "the patient" unless you change the subject. You do not need to write "the patient" every time—it is acceptable to start the sentence with the verb, realizing that "the patient" could be placed in front of the verb.
    i. You must be cautious with this—if you fail to change the subject of the sentence, it could be read and interpreted as if the patient was doing his/her own care. For example, if you write "gave bed bath", it legally reads "the patient gave bed bath"—as if the patient gave his own bed bath. To write this, you would change the subject to "bed bath" and then you would write "bed bath given." Now, it clearly reads that you were the one giving the bed bath.
    ii. Because this story is about the patient, you NEVER use personal pronouns in your narrative "I" "me" "we" . . . it is NOT about you. It is about the patient, the care given to the patient, and the patient's response to that care!
    iii. If you document care given by others, use their name and credential as much as possible so that it is clear who the care giver was. "TPCN" may be easy for you to write, but is unclear in the documentation.
d. NEVER cross out, white out, erase or use any other method to remove an error. If there is an error made in the charting, use ONE line to cross through the error, and place your initials above that line [follow this same rule for all papers written in the VNP]. Any attempt to obliterate documentation indicates that something is being hidden. Do not write the word "error" anywhere on the chart—this could be used against you in a court of law, indicating nursing errors.
e. If you forget to document something that you did at an earlier time, write in the current time that you remembered, and then in the narrative write "Late entry for _____ (the time you took action), then complete the documentation. *Eventually as a licensed nurse, you will document on a computer which automatically times each entry—therefore, it is important that you correctly learn to write a late entry.*
f. Your student paperwork is CONFIDENTIAL. Always be aware of where you leave your papers. For all of your student paperwork, please only identify your patient by initials. Do not leave your papers out where anyone can read them.
g. Be FACTUAL—only document what you observe or do or what the patient tells you, using direct quotes if necessary. Do not make a judgmental statement, but instead describe the behavior. For example, do not write "patient is angry." Instead describe the behavior "yelling, cursing, and throwing urinal at staff" is more specific and allows the reader to determine the patient's state of mind. You could even quote the patient's yells or curses to give a more accurate picture of the patient.
h. Use only APPROVED abbreviations. The national trend is to use fewer and fewer abbreviations so that there is clarity in the documentation.
i. The left column is the Time column. Please write—in military time—each time you are noting the care given. In the right column, is where you write your notes.
j. NEVER leave blank spaces in the narrative chart. Always draw a single line through any empty space to prevent subsequent entries from being made in your documentation by another person.
k. To begin your documentation, "open" your chart.
    i. The OPENING statement should include the following:
        1. report was received
        2. care was assumed
        3. of the patient by sex and age
        4. the diagnosis and the physician—this shows that you are taking care of the patient and that you know who the patient is and why they are there.
    ii. The next statement should be how you found the patient when you first went into the patient room. Is the patient (in bed? What position was the patient in? Was the patient breathing? Is the patient safe?)
        1. *Position:* chickens "lay" and people "lie" [lying]—patients in bed are in a position: supine, prone, left lateral, right lateral, High-fowler's etc. Do not say "the patient was laying in bed" or "lying in bed"!
        2. *Breathing:* the patient should be breathing! You need to note that you saw that their respirations were present, regular, etc.

a. *You cannot say the patient is "sleeping"—how do you know they are sleeping? The only way to know for sure is if you wake the patient up.*
b. *Their eyes may be closed. This is what you observe. This is why you document their breathing.*

3. Describe what safety features are present.

iii. Other items that must be described:

1. Pain—rating on a scale, location, intensity, duration
   a. What is done about the pain
   b. Follow-up—did whatever was done about the pain, change the pain?
2. Wounds—must be described, including location, dressings, care, etc.
3. IV/INT: the IV/INT site, dressing, condition should be described. If it is an IV, the solution, rate, amount should also be described—this is for primary solutions, not IVPBs. You must know the difference.

iv. Asterisk items from assessment page must also be described in narrative and what was done about those items.

v. Any unusual assessments or specific nursing actions should be addressed in the narrative. The narrative should show that care was given to the patient and that the patient needs were addressed. If the patient doesn't need nursing care, why are they still here?

vi. IF A PATIENT ***REFUSES*** any care, it must be documented

1. The REFUSAL must also be reported to the TPCN and the instructor WHO WILL VERIFY THE REFUSAL. Document your reporting the refusal in the chart: *"Refused bath; refusal reported to TPCN Cindy and Instructor Backus."*

vii. If the patient leaves the unit for any reason, the reason should be documented, how they left and with whom they left with. Their time of returning to the unit should also be documented, along with a quick assessment to make sure the patient is okay. *"To x-ray via w/c accompanied by transportation assistant. Returned to room, assist to bed; respirations even and regular, denies needs at this time."*

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

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

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

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

5. Page 3: FLOW SHEET—**This is your every 2-hour documentation!**
   a. ALL **bold face** items must be documented every 2 hours throughout the shift:
      i. Pt position: what position is the patient in: B (back), R (right side) L (left side) P (prone), is the patient independent in turning = I. If the patient gets up to the chair = U; if the patient dangles on the bedside, "D." Write in the appropriate letter every 2 hours. If there is something that happens and is not here, write this in the narrative.
      ii. Check armband and allergy band every 2 hours and initial. If there is a change or a loss, write this in the narrative.
      iii. What position is the bed in? Use the arrows to indicate this. If something unusual happens with the bed, write this in the narrative.
      iv. Where is the call light? Initial that you have checked its availability every two hours. If something happens unusual, write it in the narrative.
      v. Are the bed brakes locked? Initial every two hours that you know the brakes are locked. If something unusual happens, write it in the narrative.
      vi. Are the siderails up at the head of the bed? Initial that you have checked every two hours. If

there is something unusual happening or if the lower rails are also raised, write this in the narrative, explaining why the lower rails are raised. You would also need to narrate more information about assisting the patient out of bed or other safety measures if the lower rails are up.

vii. The IV/INT site should be inspected at least every 2 hours and you should note if it is Clean (C), Dry (D) and intact (I). You should write CDI at each time it is checked. If the IV infiltrates or other problems develop, those should be noted in the narrative. If the IV is DC'd or restarted, it should be documented in the narrative.

viii. Oxygen therapy should be noted via the device (write in the blank) and the Liters completed. Initial each time it is checked. If the Oxygen is DC'd or changed, it should be noted in the narrative. You should also note how the change in order has affected the patient's respiratory function.

ix. Initial every time the Incentive Spirometer (IS) is used by the patient. If the patient is not using IS, leave this area blank. If the patient is having respiratory issues, you should evaluate the need for IS.

x. Initial every time you have the patient TCDB. If the patient's care does not require TCDB, leave this blank. If the patient is having respiratory issues or has had any anesthesia, or if the patient is having respiratory issues, nurses should automatically introduce TCDB to the patient.

xi. Is there family present? Indicate the number of family members present by writing in the number. Specific family questions, requests, or problems should be documented in the narrative.

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

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

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

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

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

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

the patient in the way of nutrition.

g. For diabetic patients, record the AC lunch accudatas and amount of insulin given is appropriate. You should always be aware of your patient's blood sugar. If there is an unusual occurrence, document this in the narrative.
h. INCISIONS, WOUNDS, Pressure ULCERS: for each wound, please write in the location (i.e. midline abd), the type of wound (i.e. surgical, pressure) a brief description and the dressing type—can use OTA if the wound is open to air. If there are more than 4 wounds or if there is great drainage or dehiscence, etc., then describe this in the narrative as well as the care given.

GRADING POLICY

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

Final semester grades will be based on the following:

A. Departmental Math Exam—this grade was determined at the beginning of the semester.
B. Weekly clinical evaluation—students will receive a weekly clinical evaluation based on the student's individual clinical performance and preparedness to practice nursing. The weekly ratings are averaged together for the length of the course. The student must have a 76-performance average in order to complete the course, and if not, fails the clinical course, regardless of other clinical grades. The weekly grade also includes the Friday Lab Evaluation and Self-Reflection (refer to Black Board for more information on Friday lab).
C. Written Work: Assessments, quizzes, reflections, interviews, Case Studies and Care Plans, other –students should strive for a 76 average on the written work.
D. Completion of Skills Checklist—students should perform skills and document those skills on the Student Skills Checklist. Students that do not have at least 80% of the skills completed by the deadline are placed on probation for the next clinical course and given a short time to bring their skills up to completion. If, after the probationary period, the student is unsuccessful, the student may be withdrawn from the program.
E. CPR and Immunizations—CPR and immunizations must be kept current. If CPR expires or if an immunization booster/update is required, the student may not attend clinicals, accruing absences. Should this put the student over the allowable absences, the student will fail the clinical course, regardless of other grades. If the student misses one day due to an expired CPR or immunization, that student will have to make up that day in the clinical setting. IT IS THE RESPONSIBILITY OF THE STUDENT TO MAINTAIN CPR AND IMMUNZATIONS.
F. Summative Evaluation—at the end of the semester, the student will have a summative evaluation that states if the student met all expectations of the clinical experience. The student must have completed all assignments, remediation, clinical experiences and make up days in order to have a successful summary.

GRADING SCALE:

90-100 = A
80-89.99 = B
76-79.99 = C
<76 = F (There is no "D" in clinicals)

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

GRADE BREAKDOWN

Weekly Evaluations: 70%
Clinical paperwork: 30%

COMMUNICATION POLICY

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

Email Policy:

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

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

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

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

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

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

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

Telephone Calls in the Clinical Setting

PROCEDURE:

1. If an emergency arises, the student's family MUST call the SPC Vocational Nursing Office at 806-716-4405. A message will be relayed to the student in clinicals. **However, there may be times that no one is available to take the emergency message. Students should arrange with other adults to act on behalf of the student for emergencies!**
3. **It is the student's responsibility to inform family members and assure that this policy is followed.** The clinical facilities do not have access to your records or schedules and will not be able to assist your family member in locating you!
4. When answering the phone on a unit, be courteous at all times. When you answer the phone, you must identify the unit, your name, and your title.
   Example: "East 5, Sue Smith, Student Vocational Nurse."
5. If you are able to answer the request, please indicate to the caller that you will do the request and complete that request as soon as possible.
6. If you are unable to answer a request, refer the matter to the charge nurse. Be sure to explain any delays to the person calling.
7. **NEVER** give out patient information over the phone, take a doctor's order, lab reports, reports from critical care or surgery, pre-op orders from surgery. **NEVER** phone the physician for orders or to give lab results. (Remember HIPAA.)

Smoking in Clinical Setting

There is NO SMOKING for students while at Covenant!

Violation of the smoking policy may be grounds for dismissal from the VNP.

PROFESSIONAL CONDUCT AND SAFE/UNSAFE/UNSATISFACTORY CLINICAL PERFORMANCE

Students are expected to follow the ethics and rules of professional conduct as outlined in the student handbook. Unprofessional conduct on the part of a student as outlined in the student handbook is UNSAFE nursing practice and results in dismissal from the program.

Students are expected

(1) to demonstrate growth in clinical practice through application of knowledge and skills from previous and concurrent courses.
(2) to demonstrate growth in clinical practice as they progress through courses and to meet clinical expectations as outlined in the clinical objectives.
(3) to prepare for clinical practice in order to provide SAFE, COMPETENT care.
(4) to continuously practice skills to achieve 100% proficiency.

UNSAFE clinical practice is any behavior that places the patient or staff in either physical or emotional jeopardy. Emotional jeopardy means that the student creates an environment of anxiety or distress which puts the patient, family, or staff at risk for emotional or psychological harm.

Physically unsafe practices include (but are not limited to):

(a) violations of previously mastered principles/learning objectives in carrying out nursing care skills and/or delegated medical functions.
(b) assuming inappropriate independence in actions or decisions.
(c) failing to recognize own limitations, incompetence and/or legal responsibilities.
(d) failing to accept moral and legal responsibility for his/her own actions.
(e) noncompliance with all aspects in the VN Student Handbook and Clinical guidelines.
(f) violating confidentiality or HIPAA violations in ANY VNP situation.
(g) being unprepared to answer instructor or staff questions regarding patient's medications, doctor's orders, progress notes, H&P, and current status of patient.
(h) Exhibiting unprofessional conduct as outlined in the student handbook

UNSAFE clinical practice is an occurrence (one event) or a pattern of behavior involving unacceptable risk!

CLINICAL EXPECTATIONS OF PREPARATION:

The student is expected to be prepared for clinical experience on a daily basis. The student will

1. Attend report & get information from report
2. Check patient, obtain VS, perform comfort measures
3. Assess patient
4. Complete chart review: physician's orders, progress notes, history & physical, lab, diagnostics, MAR, nurse's notes (ISBAR and morning paperwork should be complete prior to accessing the computer)
5. Meet with instructor to discuss patient care
6. Answer call lights
7. Assist TPC nurses
8. Perform procedures (only after being checked off in the lab and with appropriate supervision)
9. Report off any time leaving the unit, including lunch and end of shift
10. Maintain documentation.

Time Management of Clinical Day

Clinical Day 1

Time Frame:	**Task/Skill/Activity**
0630-0745	Go with Assigned Nurse for Report a) Note: Name, age, physician, diagnoses, safety level, allergies, code status, voiding/BM status, activity, diet, oxygen, incisions/wounds/drains, IV sites-solutions, rates; Ordered tests, results from previous tests, Accudatas on diabetics

Assigned Patient(s)

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

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

0715-0900 Assessment, AM Care

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

0900-0930 Seek instructor to present information

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

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

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

d) Look at orders: Note orders that will affect your care.
Ex.- TEDs, SCDs, Dressing changes, Diet, Fluid Restrictions, Accudatas…

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

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

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

Witnessing Documents

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

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

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

Rules and regulations relating to the students at South Plains College are made with the view of protecting the best interests of the individual, the general welfare of the entire student body and the educational objectives of the college.

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

CONFIDENTIALITY/HIPAA

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

In the Vocational Nurse's Pledge, we pledge:

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

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

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

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

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

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

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

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

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

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

Failure to maintain confidentiality is grounds for dismissal.

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

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

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

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

COURSE DISCLAIMER

COVID-19

If you are experiencing any of the following symptoms, please do not attend class and either seek medical attention or get tested for COVID-19.

- Fever or chills
- Cough, shortness of breath, difficulty breathing
- Sore throat
- Congestion or runny nose
- Muscles or body aches
- New loss of taste and smell
- Fatigue
- Headache
- Nausea or Vomiting
- Diarrhea

Please also notify DeEtte Edens, FNP-C, Associate Director of Health & Wellness, at dedens@southplainscollege.edu or 806-716-2376

1. SPC will follow the recommended 3-day isolation period for individuals that test positive.
    a. **Please note that day 0 is the date of positive test. Day 1 begins the first full day after the date of positive result.**
2. COVID reporting
    a. Please have students and employees notify DeEtte Edens, FNP-C if they have tested positive to verify dates before returning to class or work.
    b. The home tests are sufficient but students need to submit a photo of the positive result. The date of test must be written on the test result and an ID included in the photo. If tested elsewhere (clinic, pharmacy, etc.), please submit a copy of the doctor's note or email notification. Results may be emailed to DeEtte Edens, FNP-C at dedens@southplainscollege.edu.
    c. A student is clear to return to class without further assessment if they have completed:

- The 3-day isolation period, symptoms have improved and
- they are afebrile for 24 hours without the use of fever-reducing medication.

d. HEATH SCIENCE PROGRAMS ONLY: Due to clinical requirements, students in health science programs returning to class or clinical from a positive test will be required to wear a mask in the health sciences areas including offices, hallways, and classrooms, as well as in the clinical setting for a 10-day period from date of positive test.

3. Please instruct students and employees to communicate with DeEtte Edens prior to their return date if still symptomatic at the end of the 3-day isolation.

4. Exposed individuals will not be required to quarantine. If exposed, SPC does request individuals closely monitor themselves. If an individual does become symptomatic, please do not attend class or work and be tested.

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

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

FOUNDATION SKILLS

BASIC SKILLS–Reads, Writes, Performs Arithmetic and Mathematical Operations, Listens and Speaks

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

THINKING SKILLS–Thinks Creatively, Makes Decisions, Solves Problems, Visualizes and Knows How to Learn and Reason

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

PERSONAL QUALITIES–Displays Responsibility, Self-Esteem, Sociability, Self-Management, Integrity and Honesty

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

SCANS COMPETENCIES

C-1 **TIME** - Selects goal - relevant activities, ranks them, allocates time, prepares and follows schedules.
C-2 **MONEY** - Uses or prepares budgets, makes forecasts, keeps records and makes adjustments to meet objectives.
C-3 **MATERIALS AND FACILITIES** - Acquires, stores, allocates, and uses materials or space efficiently.
C-4 **HUMAN RESOURCES** - Assesses skills and distributes work accordingly, evaluates performances and provides feedback.

INFORMATION - Acquires and Uses Information

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

INTERPERSONAL–Works With Others

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

SYSTEMS–Understands Complex Interrelationships

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

TECHNOLOGY–Works with a Variety of Technologies

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

Clinical Course Schedule—refer to Black Board

VNSG 1160 Syllabus Contract

PRINT NAME: _____

(Please print, read, sign and return this syllabus contract during clinical orientation; the student may not attend clinicals if this contract is not submitted).

I have read the VSNG 1160 syllabus and understand the course requirements. I have had the opportunity to ask questions. I can comply with all requirements found in this syllabus and the Student Vocational Nurse Handbook.

SIGNED: _____ Date: _____