PN Student Clinical Handbook

2017-2018

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Clinical Overview

Clinical rotations are a crucial portion of the learning experience at Tulsa Technology Center and you will be spending many hours in the clinical setting. Our school has contracts with multiple facilities in the area and as a student of the Practical Nursing Program, you are held to the expectations stated within these contracts. Local, state and federal regulations and accrediting agencies also drive the policies and procedures for much of the PN program.

This handbook, along with the PN Student Handbook, provides the framework for clinical expectations and your responsibilities as a student. Each student will be held accountable for all information stated within and any new information as it arises. Failure to comply with these standards will result in probationary status and may lead to dismissal from the class or program. Therefore, it is vital that each student familiarize himself/ herself with this information.

Expectations

Students will be held to the highest standards of professionalism while in the clinical setting. While you are in uniform or representing the nursing program in any way, you will be expected to maintain dignity, integrity and behave in a manner that is flattering to the program, the profession and yourself as a future practitioner. While professionalism is expected at all times and covers all areas, specific examples under key topics are outlined in this handbook.

A. **Communication**- general expectations include being dignified and courteous at all times, assisting peers when appropriate and resolving conflicts in a professional manner. Avoid loud talking or laughing. Inappropriate conversations will not be tolerated.

1. When interacting with clients:

   a. Always knock on the door of a patient room before entering.

   b. Address a patient by surname with the proper (Mr., Mrs., Miss, etc.) prefix unless the age of an individual makes this out of place or the patient requests differently.

   c. Maintain a cheerful, friendly, empathetic but professional manner with patients and do not discuss:

   - Your social activities
   - Your hospital duties
   - Other personnel's or patient's health
   - Your personal health
   - Your opinions of the hospital or hospital staff.

2. When interacting with faculty and clinical site staff:

    a. Treat them with courtesy, respect and cooperation.
    b. Call by surname, unless otherwise requested.
    c. When constructive correction is given, students will understand this is a part of the process to ensure that unsafe or unprofessional behaviors are not practiced.

3. When interacting with visitors of the facility:

    a. Each student while on duty is to conduct oneself as a host/hostess to visitors.
    b. In each case, she/he should treat the individual courteously and try to assist as possible.

B. **Confidentiality**

1. Students are responsible for maintaining a standard of strict confidentiality according to HIPAA laws, facility policies and clinical guidelines. Do not remove any paperwork from the hospital containing patient information. This is a breach of confidentiality.

2. Discussion of hospital staff, patients or events during the rotation and other potentially confidential information should be used for learning purposes only and occur in private areas.

3. Utilizing social media such as Facebook, Twitter etc., to convey confidential information or discussing clinical events will result in disciplinary actions and may result in failure of the course and/or removal from the program.

General Clinical Expectations

1. Students are responsible for understanding the clinical handbook, facility policies, scope of practice issues and any information received from faculty or facility staff.
2. Students will be assigned to patients and are responsible to report information to both clinical site staff members and faculty.
3. Though faculty and staff members are present, students are ultimately responsible for their actions and are expected to utilize critical thinking in all situations.
4. Specific site expectations and polices will be given prior to each rotation. Students are expected to attend all orientations, including computer, equipment training and any other orientations the clinical facilities or faculty deem necessary.
5. Students will park in assigned areas. Tickets, towing or "boot" placement may result from parking in other areas and may result in loss of clinical privileges.
6. Use of tobacco products (including e-cigs, smokeless tobacco) is not allowed at clinical sites. This includes parking areas.
7. Students are expected to report ***any*** incidents to the clinical site staff and the faculty immediately.

8. Cell phones must be turned to silent while at the clinical site. In some cases, they will not be allowed at all. Students may not be on the phone in patient care areas.
9. Students may not take physician orders, including by telephone, verbal or in other manner.
10. Students may not use facility supplies for personal use.
11. Students are responsible for understanding what procedures they may perform and for direct instructions received from faculty or staff. Students are expected to ask for clarification of any instructions they are unsure of.
12. Students may not be the sole receiver of any report about clients/patients.
13. Students may not sign official documents without faculty approval.
14. Students may not have personal visitors at the clinical setting.
15. Gum, candy, etc. are not allowed.

Dress and Hygiene

Equipment:

Students are expected to have basic nursing equipment with them at all rotations: a watch with a second hand, bandage scissors, pen light, calculator, black ink pens and a pocket sized notebook. Faculty may request that students have other items for specific clinical rotations.

Uniform:

1. Students not dressed in proper clinical attire ***will be sent home and counted as a clinical absence.*** Uniforms are expected to be of the proper fit (no low riding pants, no low cut tops, pants hemmed to the appropriate length), in good repair and free from wrinkles, odors and visible dirt. Scrubs should not be tight fitting and roomy enough to bend, lift and sit without exposing the mid-section (front or back).
2. Cherokee Brand Red is the only approved uniform color for the program. A solid black lab/scrub jacket of any brand may be worn- that is the only type of jacket allowed.
3. Any *style* of Cherokee red scrubs are acceptable, though no embellishments (decorative trim, accent colors, cuffed bottoms, etc.) will be allowed. At least 3 pairs are recommended.
4. A plain solid white, black or matching red undershirt may be worn under scrub top.
5. The uniform patch must be ***sewn*** (not stapled, glued or other non-permanent method) on the left sleeve of the uniform and lab/scrub jacket. Extra patches are available at the current price in the bookstore.
6. Shoes must be made of solid leather or vinyl and completely enclose the foot. No mesh or boots are allowed. White, black or red are the allowed colors. The shoes may have a combination of these colors (i.e.- a white Nike with a red "swoosh", but no busy designs are allowed. Plain solid white or black socks or hose will be worn.
7. ID badges will be visible at all times, at the neck or chest level.

Personal Appearance:

1. Fingernails must be trimmed short. Only clear or very light nail bed color may be worn and must not be chipped. No artificial nails are allowed. In some settings, no polish/shellac will be allowed.

2. Makeup should be natural looking with no heavy or extreme looks (i.e.- thick eyeliner, bright or non-natural lipstick, heavy or vivid colored eye shadow, etc) . Heavy perfumes/colognes are not permitted. **All** tattoos must be covered at all times with appropriate coverings that match the uniform or skin color.

3. Hair and body must be clean and free from odors. Hairstyle must be short or restrained in such a manner that when leaning forward it does not fall into the face. No extravagant hair accessories (which include decorative or hair-processing type scarves, bandanas, large headbands, etc), non-natural colors or extreme hairstyles will be allowed. Facial hair must be neatly trimmed, close to the face.

4. Appropriate jewelry only- one pair of earrings that are studs (no hoops or dangling items), a watch and one ring (must be flat – large stones are apt to scratch patients, harbor germs or become lost/damaged). No other visible piercings are allowed- ***all*** other sites must be covered or have a clear spacer in place.

The instructors and clinical site staff reserve the right to send a student home/back to school based on any violation of the dress/hygiene standards and the student will be counted absent.

Paperwork

1. Clinical paperwork expectations will be explained prior to each rotation. Late paperwork in most cases will not be accepted as this is considered part of clinical preparation. Unprepared students will be sent home/ back to school and counted as absent.

2. Students are responsible for maintaining their clinical folders and coming prepared with proper paperwork daily. It is suggested that you have multiple copies of paperwork at all times, as the staff or faculty will not make copies at the clinical site.

3. Students may be required to rewrite any unsatisfactory paperwork. Additional assignments may also be required.

4. Failure to complete paperwork or to submit paperwork by due date may lead to failure of the course.

Attendance

1. The importance of clinical attendance cannot be stressed enough. Attendance during clinical rotations will be monitored closely. As clinical space is at a premium, in some instances, even one absence may result in failure of the rotation.

2. Students are expected to arrive to the clinical site leaving enough time to find parking and meet at the designated area. Tardiness will be tracked and a student may be sent home/back to school if they have arrived late (refer to *Program Violation form in the PN Student Handbook*).

3. When assigned to an area, a student is expected to be there the entire scheduled time. Students must notify the facility staff and faculty prior to leaving the assigned area for ***any reason***, including breaks. Leaving early will also be tracked. Leaving the site/area without permission or notifying the instructor and staff correlates to patient abandonment and will not be tolerated.

4. If a student will be late or absent, they must call the assigned faculty member prior to the beginning of the shift. Failure to do so is referred to as a "No call No show" and carries a 2 Step penalty.

5. A student may not miss more than 10% of a course. If absences are due to a documentable situation (refer to the PN Student Handbook), an attempt **may** be made to arrange make up hours, based on space availability. It is important to realize that if make-up hours can be arranged, they will be during a time when the student is not already in class or clinical. Faculty are under no obligation to arrange make-up days for undocumented absences.

6. Absences/tardies will be reflected on the Evaluation tool comments.

7. Refer to the PN Student Handbook Student Attendance section and Program Violation form.

Grading

Students will be graded at least weekly in the clinical setting using the Clinical Evaluation Tool (see Appendix). Students will be graded in 5 main areas and receive a score of 0-2 in each area. If a student scores three or more "1"'s or a "0", they will be placed on probation with a remediation plan established. If a student scores two or more "0"'s the student will fail the clinical rotation. The objectives that fall under the 5 main areas are defined in the Clinical Objectives Reference Sheet (see Appendix) and vary for each course.

Health, Safety, Mental and Physical Requirements

In general, students are ultimately responsible for their own health and safety.
Students may face hazards from caustic chemicals, radiation and infectious diseases such as hepatitis. They are subject to back injuries when moving patients or to a shock from electrical equipment. Students often must deal with the heavy workloads, both physically and mentally. The patients may be confused, irrational, agitated or

uncooperative. Mental capacity and emotional control must be maintained in the high stress field of nursing. Students will be required to meet certain criteria in order to participate in clinical experiences for the safety of themselves and others:

A. Immunizations/CPR/Background checks-

Immunizations/CPR/background checks must be current and remain so during the entire program. Students will be removed from the clinical setting should **any** immunization/CPR/background check expire and not allowed to return until corrected. This may result in removal from the course and/or class.

B. Illness/Injury/Surgery/Restrictions

1. Students are expected to use common sense and professional judgment with regards to attending clinical while ill. If a student is found in the clinical setting with an infectious disease, this is considered Unsafe Behavior (see page 10). If a student is out more than 3 consecutive days due to illness, a note from a physician clearing the student for full clinical duty is required before returning to clinical (see sample Student Medical release form in appendix).

2. Students that have/had an injury, surgery or any other medical condition are required to provide physician documentation stating they are cleared for clinical, have no restrictions and are able to perform duties described under item E-Physical Requirements. An example of this clearance can be found in the Appendix.

3. Any condition that requires special accommodation will need to be addressed with the PN Coordinator. A plan will be developed with the student and other faculty/staff if possible.

4. While pregnancy does not by any means exclude a student from attending clinical, it can in some instances limit the patient assignments (i.e. patients receiving chemotherapy, certain diseases, etc.). While not required, it is recommended that students inform the instructor of pregnancy in order to make appropriate assignments. Time missed due to pregnancy will be treated as any other absence and a medical release note from the physician will be required in order to return.

5. If a student becomes unable to perform the requirements for clinical or makes statements related to their inability to do so, a medical release note will be required. The student will be prohibited from attending clinical until such time that a full medical clearance is provided. There is no "light duty" designation in the program (see Physical Requirements at item E, page 9).

C. Safety

Safety encompasses all aspects of nursing care, from utilizing patient identifiers and wiping up spills to verifying orders and following procedure. Students are responsible for reviewing safety videos prior to each clinical rotation.

1. Sharps

Sharp instruments are essential tools for providing quality health care. Exposure to these “sharps” is a fact of life for most health care workers. Exposure may include: hypodermic needles, IV needles, razors, scalpels, or broken glass. Injuries from sharps are often called needle-stick injuries, puncture wounds or needle punctures. These injuries are a major cause of infection and may have serious results. The greatest risk is from Hepatitis B. However, there are other infections to be concerned about such as HIV, staphylococcus, or herpes simplex. Each student is responsible for knowing the "sharps” policies for each facility and for practicing safety measures at all times.

2. Moving/Lifting and Use of Equipment

Students will practice proper body mechanics and patient transfer techniques at all times. Students will ensure that electrical equipment is properly grounded, in good repair and will follow policies at all times. Students will attend training, practice in the skills lab or request assistance when using unfamiliar equipment.

3. PPE/Specialty safety equipment

Students will utilize appropriate PPE (personal protective equipment) and any required special safety equipment at all times.

4. Emergency Procedures

All facilities have policies and procedures for fire, natural and man-made situations/disasters, codes and other occurrences. Students will be oriented to each facility and is responsible for understanding these procedures.

5. Accidents/Incidents

Students are expected to report any accident or incident immediately to the instructor. Students may be asked to complete reports based on the nature of the accident/incident. If a student is injured while at clinical, most facilities will provide treatment but it is important to understand that the treatment will be at the student’s cost.

D. Mental/Emotional Requirements

Students will be expected to demonstrate skills in communication, critical thinking/clinical reasoning problem solving, decision making and conflict resolution. Students will maintain professionalism even in stressful situations. At no time will profanity, angry outbursts, malicious gossip or any other unprofessional manner of communication be tolerated. Students must be able to take constructive correction, leave personal problems at home, encounter difficult situations without becoming emotionally involved and maintain focus on clinical priorities at all times. Refer to the LPN Student handbook for specific professionalism expectations.

E. Physical Requirements

The physical expectation for nurses is be able to exert up to 100 lbs. force occasionally, and/or 50 lbs. frequently, and/or 20 lbs. constantly. Students are frequently required to lift and/or carry objects of 30 pounds or greater. They must transport items heavier than 50 lbs. with the use of carts, dollies or assistance. They must support, lift and move patients of all heights and weights. The work occasionally requires climbing and/or balancing, stooping, kneeling, crouching, reaching, handling, pushing and pulling. All extremities must be able to perform full range of motion (casts, boots, slings, splints etc. are not allowed). Students must be able to complete a 6-8 hour shift normally and longer in some cases. ***There are no "light duty" arrangements that can be made for students.***

Unsafe Behavior

A student that practices any unsafe behavior will be in jeopardy of failing the rotation and possibly being removed from clinical, the class and/or the program. ***Unsafe behavior includes, but is not limited to:***

- Being under the influence of drugs or alcohol.
- Attending clinical with a possibly communicable infectious process.
- Performing procedures without training and/or permission of instructor.
- Performing any invasive procedure without instructor/staff nurse present.
- Accessing Central/PICC lines.
- Administering IV push medication
- Failure to use Standard Precautions at all times.
- Failure to apply basic safety rules.
- Unsupervised access to any device requiring employee login.
- Failure to report an abnormal finding or incident.
- Failure to follow specific directions of instructor.
- Failure to follow the "rights" while administering medications.
- Practicing skills outside the Scope of Practice for LPNs.
- Any action or failure to act that would jeopardize safety.
- Any blatant violation of school or clinical facility policy.
- Sleeping at the clinical site.

Appendix

Sample Clinical Evaluation Tool

STUDENT NAME: _____

CLINICAL COURSE: _____

Faculty Signature(s): _____

_____

_____

RATING SCALE
(Refer to Clinical Objective sheets):

2 = Satisfactory – **Meets objectives with minimal supervision/correction**

1 = N**eeds Improvement** – **Needs moderate supervision/correction to meet objectives**

0 = **Unsatisfactory** –**Requires maximum supervision/correction OR shows no improvement from previous week**

***If a student receives ≥ 3 '1's or a '0' the student will be placed on clinical probation and a remediation plan will be established.**

***If a student receives ≥ 2 '0's, the student will fail the clinical rotation.**

		Data Collection & Assessment	Planning	Implementation	Evaluation	Professional Behavior & Accountability	
	Dates						
Week 1	**Site:**	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	**Obj. #'s covered:** _____ _____ Faculty Initials: _____ Student Initials: _____
Week 2	**Site:**	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	**Obj. #'s covered:** _____ _____ Faculty Initials: _____ Student Initials: _____
Week 3	**Site:**	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	**Obj. #'s covered:** _____ _____ Faculty Initials: _____ Student Initials: _____
Week 4	**Site:**	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	**Obj. #'s covered:** _____ _____ Faculty Initials: _____ Student Initials: _____
Week 5	**Site:**	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	**Obj. #'s covered:** _____ _____ Faculty Initials: _____ Student Initials: _____
Week 6	**Site:**	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	**Obj. #'s covered:** _____ _____ Faculty Initials: _____ Student Initials: _____

Clinical Course Objectives Reference Sheets Clinical 1 – Basic Nursing

Standard	Specific Objectives
Data Collection and Assessment	1.Plan focused assessment with vital signs including subjective and objective data from the patient; gather lab and diagnostic data; recognize/report abnormal data to instructor and/or nursing staff; clarify/question unclear data prior to providing care; and gather pertinent data from the Kardex and patient's history and physical information in the chart 2.Identify/report potential hazards for patients and staff including patient symptoms of communicable diseases, and follow standard precautions. 3.Identify all roles of the nurse and identify/ integrate age and developmental stages in providing care throughout the lifespan (pediatrics through geriatric adults). 4.Identify family roles, dynamics and stressors for the patient and family members, including spiritual/religious/value system of patient and impact on providing care. 5. Identify risk factors for disease/illness, complications associated with diagnosis, patient abilities/limitations in self-care, and unhealthy behaviors for preventing complications through patient teaching. 6. Gather medication information as directed by instructor.
Planning	7. Develop problem statement/modify plan of care based on data collection, including age-specific and developmental aspects, and anticipation of patient needs based upon patient condition/medical diagnosis. 8. Identify, participate and begin to prioritize problems based on data collection and patient condition in planning care comprising the physical, psychological, social, cultural and spiritual needs of the patient; begin to review and revise plan of care as needed. 9. Identify scope of practice of assistive personnel. 10. Participate in educational activities/attend multidisciplinary patient care confernces.
Implementation **(includes skills and documentation)**	11. Utilize developed care plans to provide care for patients experiencing a variety of common health alterations. 12. Provide practical nursing care for the patient experiencing a health alteration commonly found in the elderly. 13. Perform and prepare patient for a complete focused assessment, including mental exam and vital signs with correct documentation following facility policies/procedures, correct notification of staff/instructor of changes in patient status (abnormal data); and participate in discharge planning. 14. Perform prioritized interventions based on problem statement/plan of care; provide confidentiality/privacy with patient; and use safe, cost effective measures when providing nursing care. 15. Provide correct body alignment/assistance with ROM exercise/ambulation; provide non-pharmacological management of pain; schedule activities to promote rest; and implement interventions to prevent neurological, cardiovascular, respiratory, endocrine, and urinary complications, reporting complications to physician as necessary. 16. Demonstrate knowledge/correct use of precautionary measures necessary to prevent organism transmission and use of sterile and aseptic technique. 17. Review accuracy of patient orders following facility's policies to prevent treatment errors and perform all invasive and non-invasive skills safely (see Skills Performance objectives). 18. Identify professional limitations and scope of practice and perform all roles of the nurse (see Skills Performance and Documentation objectives). 19. Use effective communication skills with patient, family members, and staff; alternative communication devices/assistive devices for patient and family; 20. Identify legal and ethical issues affecting patient/family and staff members;

	21. Identify community resources available to patient and family; and assist in resolving conflicts with patient, family members, and staff. 22. Establish a trusting nurse-patient relationship assisting the patient in identifying behaviors that could influence health; identify patients' rights based upon law, including refusal of treatment/procedures; and intervene in unsafe patient situations. 23. Provide, monitor and maintain special diet for patient based on diagnosis/nutritional needs, including supplements. 24. Participate and/or identify appropriate person to obtain/provide informed consent and identify situations regarding incident reports following facility policy to complete accurate incident reports; and report situations of abuse, neglect and injury based upon facility policy and law. 25. Follow plan to assist patient in meeting safety needs related to diagnosis and prescribed treatments including verification of patient identity prior to performing interventions on patient; follow facility policies and inspection of equipment for safety; and provide patient with appropriate methods to signal/call staff members. 26. Perform age-specific and developmental aspects necessary for care based on patient abilities; identify personal values/beliefs and respect differing personal choices/lifestyle of patient; and manage patient valuables according to facility policy. 27. Provide a safe environment for patient, family members, and staff; recognize safety and environmental hazards; follow procedures for handling biohazardous materials; and assist in facility evacuation policies for internal and external disasters. 28. Provide least restrictive environment and follow facility policies regarding initiation, monitoring and documentation of restraint use. 29. Perform postmortem care for patient. 30. Skills: 31. Perform nursing skills safety using appropriate steps as identified in skills checklist. 32. Documentation: 33. Report and record pertinent observations in all areas of the nursing process in a timely manner. 34. Use correct medical terminology and approved abbreviations giving an accurate reflection of patient status. 35. Document accurate focused assessment data collection. 36. Document correctly, using the appropriate facility and school forms.
Evaluation	37. Evaluate nursing interventions and offer suggestions for modification of the nursing care plan by the RN. 38. Evaluate methods used to control infectious agents. 39. Evaluate communication techniques for patient, family members, staff and understanding of patient confidentiality. 40. Evaluate components of informed consent, invasive procedures performed for the patient, and potential complications of medical treatments.
Professional Behavior and Accountability	41. Attend full clinical day without being tardy or leaving earlier; maintain professional appearance; bring all necessary equipment. 42. Demonstrate professional and ethical behavior; work within current scope of practice; follow specific instructions given by instructor and staff. 43. Communicate appropriately with patients, staff and instructors; manage stressful situations appropriately; actively seek learning opportunities.

Clinical II - Med Surg I

Standard	Specific Objectives
Data Collection and Assessment	1.Apply theories of nursing, growth and development, and patient needs to patient situations. 2.Demonstrate basic clinical skills with a dual-patient load. 3.Utilize information from patient's chart, electronic records, Kardex and existing care plans. 4.Collect accurate objective and subjective data and identify deviations from normal. 5.Complete ongoing patient assessment.
Planning	6.Contribute to the plan of care by providing objective, subjective, and diagnostic patient data 7.Collaborate with health care team members during patient care. 8.Determine patient and family understanding of patient rights and treatment plan 9.Utilize problem-solving techniques when analyzing data.
Implementation (includes skills and documentation)	10. Monitor patient, including vitals, visual or auditory cues, intake and output. 11. Competently execute nursing interventions in an organized, timely, safe and efficient manner. 12. Adapt nursing care in response to changes in patient condition. 13. Administer medications and parenteral therapies accurately and safely, using the six rights of medication administration. 14. Provide accurate patient and family teaching within your current scope of practice. 15. Notify appropriate faculty or staff of significant data, including changes in patient condition. 16. Proactively manage hazards in the patient environment.
Evaluation	17. Accurately document patient care. 18. Evaluate patient's response to nursing care and determine if needs have been met. 19. Provide input on effectiveness of patient and family teaching.

Professional Behavior and Accountability	20. Maintain safe, respectful and confidential environment for patient, self and others. 21. Comply with professional standards in appearance, attitude and behavior appropriate clinical settings. 22. Display good judgment, seeking appropriate guidance as needed. 23. Appropriately respond to direction and constructive feedback. 24. Demonstrate professional and ethical behavior, functioning within your current LPN/LVN student scope of practice. 25. Maintain effective communication and interpersonal relationships with patients, family, facility staff, faculty and students. 26. Serve as a positive role model, encouraging teamwork and cooperation among health care team members. 27. Demonstrate resourcefulness, using initiative and displaying good critical thinking and problem-solving skills. 28. Demonstrate cultural competency in patient care related to patient's physical, psychosocial, cognitive and moral needs. 29. Employ appropriate practices to manage stress and to encourage proper self-care. 30. Displays excellent time management skills. 31. Effectively and efficiently, manage limited resources and contain costs. 32. Actively participate in learning activities, including clinical and educational opportunities. 33. Actively seek new learning opportunities

Clinical III – Med Surg II

Standard	Specific Objectives
Data Collection and Assessment	1. Demonstrate basic clinical skills with a multi-patient load. 2. Utilize patient's chart, electronic records, Kardex and existing care plans. 3. Interpret accurate objective and subjective data collection 4. Complete ongoing patient assessment. 5. Recognize deviations from baseline assessment.
Planning	6. Incorporate patient data in contributing to the plan of care 7. Modify nursing plan of care, according to the nursing process. 8. Prioritize patient care according to Maslow's Hierarchy of Needs, using critical thinking and creative problem solving techniques.
Implementation (includes skills and documentation)	9. Utilize developed care plans to provide care for clients experiencing a variety of multiple health alterations. 10. Provide practical nursing care for the client experiencing a multiple health alterations commonly found in the elderly. 11. Execute nursing interventions in an organized, timely, safe and efficient manner. 12. Provide nursing care to the medical surgical patient. 13. Adapt nursing care in response to changes in patient condition and based on age- appropriateness. 14. Administer medications accurately and safely, utilizing the Six Rights of Medication Administration. 15. Assist with accurate patient and family teaching within your current scope of practice. 16. Facilitate continuity of care in all documentation and communication. 17. Notify appropriate faculty or staff of significant data, including changes in
Evaluation	19. Report any variances, incidents or irregular occurrences. 20. Provide input on the patient's response to interventions, determining if patient needs have been met. 21. Provide input on the modifications made to nursing plan of care for effectiveness. 22. Provide input on the patient and family knowledge obtained from patient teaching

Professional Behavior and Accountability	23. Maintain safe, respectful and confidential environment for patient, self and others. 24. Demonstrate management and supervisory skills. 25. Demonstrate professional responsibility and dependability by complying with facility and clinical policies. 26. Comply with professional standards in appearance, attitude and behavior appropriate clinical settings. 27. Display good judgment, seeking appropriate guidance as needed. 28. Appropriately respond to direction and constructive feedback. 29. Demonstrate professional and ethical behavior, functioning within your current LPN/LVN student scope of practice. 30. Maintain effective communication and interpersonal relationships with patients, family, facility staff, faculty and students. 31. Serve as a positive role model, encouraging teamwork and cooperation among healthcare team members. 32. Demonstrate resourcefulness, use initiative and display critical thinking and problem-solving skills. 33. Demonstrate cultural competency in patient care related to patient's physical, psychosocial, cognitive and moral needs. 34. Employ appropriate practices to manage stress and to encourage proper self-care. 35. Constructively use extra time to maximize care, update patient information, and identify further learning opportunities. 36. Effectively and efficiently, manage limited resources and contain costs. 37. Actively participate in learning activities, including clinical and educational opportunities.

Clinical Maternal

Standard	Specific Objectives
Data Collection and Assessment	1. Demonstrate clinical skills for maternal and newborn patients. 2. Utilize patient's chart, electronic records, Kardex and existing care plans. 3. Interpret objective and subjective data. 4. Contribute to ongoing patient assessment. 5. Recognize changes in patient status.
Planning	6. Incorporate patient data in contributing to the plan of care 7. Modify nursing plan of care, according to the nursing process. 8. Prioritize patient care according to Maslow's Hierarchy of Needs, using critical thinking
Implementation (includes skills and documentation)	9. Execute nursing interventions in an organized, timely, safe and efficient manner. 10. Adapt nursing care in response to changes in patient condition and based on age- appropriateness. 11. Perform skills associated with maternal and newborn care. 12. Administer medications accurately and safely, utilizing the Six Rights of Medication Administration. 13. Provide accurate patient and family teaching within your current scope of practice. 14. Facilitate continuity of care in all documentation and communication. 15. Notify appropriate faculty or staff of significant data, including changes in patient condition or staffing.
Evaluation	17. Report responses to nursing care. 18. Report any variances, incidents or irregular occurrences. 19. Collaborate with members of the healthcare team to modify plan of care.

Professional Behavior and Accountability	20. Maintain safe, respectful and confidential environment for patient, self and others. 21. Delegate care appropriately. 22. Demonstrate professional responsibility and dependability by complying with facility and clinical policies. 23. Comply with professional standards in appearance, attitude and behavior appropriate clinical settings. 24. Display good judgment, seeking appropriate guidance as needed. 25. Appropriately respond to direction and constructive feedback. 26. Demonstrate professional and ethical behavior, functioning within your current LPN/LVN student scope of practice. 27. Maintain effective communication and interpersonal relationships with patients, family, facility staff, faculty and students. 28. Serve as a positive role model, encouraging teamwork and cooperation among health care team members. 29. Demonstrate resourcefulness, using initiative and displaying good critical thinking and problem-solving skills. 30. Demonstrate cultural competency in patient care related to patient's physical, psychosocial, cognitive and moral needs. 31. Employ appropriate practices to manage stress and to encourage proper self-care. 32. Constructively use time to maximize care, update patient information, and identify further learning opportunities. 33. Effectively and efficiently, manage limited resources and contain costs.

Clinical Pediatric

Standard	Specific Objectives
Data Collection and Assessment	1.Demonstrate clinical skills for pediatric patients. 2.Utilize patient's chart, electronic records, Kardex and existing care plans. 3.Interpret accurate objective and subjective data collection 4.Contribute to ongoing patient assessment. 5.Recognize changes in patient status.
Planning	6.Incorporate patient data in contributing to the plan of care 7.Modify nursing plan of care, according to the nursing process. 8.Prioritize patient care according to Maslow's Hierarchy of Needs, using critical thinking and creative problem solving techniques.
Implementation (includes skills and documentation)	9.Execute nursing interventions in an organized, timely, safe and efficient manner. 10. Adapt nursing care in response to changes in patient condition and based on age-appropriateness. 11. Perform skills associated with maternal and newborn care. 12. Administer medications accurately and safely, utilizing the Six Rights of Medication Administration. 13. Provide accurate patient and family teaching within your current scope of practice. 14. Facilitate continuity of care in all documentation and communication 15. Notify appropriate faculty or staff of significant data, including changes in patient condition or staffing. 16. Proactively manage hazards in the patient environment.
Evaluation	17. Report responses to nursing care. 18. Report any variances, incidents or irregular occurrences. 19. Collaborate with members of the healthcare team to modify plan of care.
Professional Behavior and Accountability	20. Maintain safe, respectful and confidential environment for patient, self and others. 21. Delegate care appropriately. 22. Demonstrate professional responsibility and dependability by complying with facility and clinical policies. 23. Comply with professional standards in appearance, attitude and behavior appropriate clinical settings. 24. Display good judgment, seeking appropriate guidance as needed. 25. Appropriately respond to direction and constructive feedback. 26. Demonstrate professional and ethical behavior, functioning within your current LPN/LVN student scope of practice. 27. Maintain effective communication and interpersonal relationships with patients, family, facility staff, faculty and students. 28. Serve as a positive role model, encouraging teamwork and cooperation among health care team members. 29. Demonstrate resourcefulness, using initiative and displaying good critical thinking and problem-solving skills. 30. Demonstrate cultural competency in patient care related to patient's physical, psychosocial, cognitive and moral needs. 31. Employ appropriate practices to manage stress and to encourage proper self-care. 32. Constructively use time to maximize care, update patient information, and identify further learning opportunities. 33. Effectively and efficiently, manage limited resources and contain costs. 34. Actively participate in learning activities, including clinical and educational opportunities.

Clinical Mental

Standard	Specific Objectives
Data Collection and Assessment	1. Demonstrate clinical skills for mental health patients. 2. Utilize patient's chart, electronic records, Kardex and existing care plans. 3. Interpret accurate objective and subjective data collection 4. Contribute to ongoing patient mental health assessment. 5. Recognize changes in patient mental health status. 6. Recognize signs and symptoms of acute and chronic mental illness. 7. Identify signs and symptoms of impaired cognition of patient. 8. Identify changes in patient mental status. 9. Monitor patient and family responses to interventions and treatment plan. 10. Monitor patient and family for signs and symptoms of abuse/neglect. 11. Identify patient risk factors for domestic, child, elder abuse/neglect and sexual abuse. 12. Recognize patient and family risks for abuse/neglect. 13. Identify patient signs and symptoms of alcohol/drug dependency, withdrawal and toxicity. 14. Monitor mental status of patient. 15. Identify patient and family in crisis. 16. Identify patient potential for self-injury. 17. Identify patient orientation to reality 18. Monitor changes in patient appearance, mood and psychomotor behavior. 19. Monitor patient and family responses to treatment plan. 20. Monitor effectiveness of behavioral/therapeutic interventions
Planning	21. Incorporate patient data in contributing to the plan of care 22. Modify nursing plan of care, according to the nursing process. 23. Prioritize patient care according to Maslow's Hierarchy of Needs, using critical thinking and creative problem solving techniques. 24. Assist family in planning care for patient with impaired cognition. 25. Assist in planning care for patient with acute or chronic mental illness.

Implementation (includes skills and documentation)	26. Execute nursing interventions in an organized, timely, safe and efficient manner. 27. Adapt nursing care in response to changes in patient condition and based on age-appropriateness. 28. Perform skills associated with the mental health patient. 29. Promote a safe environment for the patient. 30. Reinforce patient and family teaching on substance abuse and coping strategies to help prevent future abusive situations. 31. Support victims/suspected victims of abuse and their families. 32. Document patient substance abuse. 33. Encourage patient and family to participate in support groups. 34. Encourage counseling for patient with drug/alcohol dependency. 35. Provide care to patient experiencing alcohol/drug withdrawal or toxicity. 36. Review patient and family reactions to chemical dependency diagnosis. 37. Assist in teaching patient and family about diagnosis and signs and symptoms of mental illness. 38. Recognize cultural issues that could affect patient and family understanding/acceptance of diagnosis. 39. Assist patient in developing and using strategies to decrease anxiety. 40. Assist patient with acute or chronic mental illness in self-care activities. 41. Develop and maintain therapeutic relationships with patient and family.

	43. Set limits on inappropriate patient behaviors. 44. Use crisis intervention techniques as appropriate for patient. 45. Use interventions to assist patient in controlling behavior. 46. Use therapeutic interventions to increase patient understanding of own behavior. 47. Orient patient to reality. 48. Participate in community meetings. 49. Participate in group therapy sessions for patient with psychosocial disorder. 50. Administer medications accurately and safely, utilizing the Six Rights of Medication Administration. 51. Provide accurate patient and family teaching within your current scope of practice. 52. Facilitate continuity of care in all documentation and communication. 53. Notify appropriate faculty or staff of significant data, including changes in patient condition or staffing.
Evaluation	55. Report any variances, incidents or irregular occurrences. 56. Provide input into the patient's response to interventions, determining if patient needs have been met. 57. Provide input into the modifications made to nursing plan of care for effectiveness. 58. Provide input into the patient and family knowledge obtained from patient teaching sessions. 59. Monitor patient adherence to treatment plan. 60. Monitor patient alterations in mood, judgment, cognition and reasoning. 61. Monitor patient and family reactions to diagnosis
Professional Behavior and Accountability	62. Maintain safe, respectful and confidential environment for patient, self and others. 63. Delegate care appropriately. 64. Demonstrate professional responsibility and dependability by complying with facility and clinical policies. 65. Comply with professional standards in appearance, attitude and behavior appropriate clinical settings. 66. Display good judgment, seeking appropriate guidance as needed. 67. Appropriately respond to direction and constructive feedback. 68. Demonstrate professional and ethical behavior, functioning within your current LPN/LVN student scope of practice. 69. Maintain effective communication and interpersonal relationships with patients, family, facility staff, faculty and students. 70. Serve as a positive role model, encouraging teamwork and cooperation among healthcare team members. 71. Demonstrate resourcefulness, using initiative and displaying good critical thinking and problem-solving skills. 72. Demonstrate cultural competency in patient care related to patient's physical, psychosocial, cognitive and moral needs. 73. Employ appropriate practices to manage stress and to encourage proper self-care. 74. Constructively use time to maximize care, update patient information, and identify further learning opportunities. 75. Effectively and efficiently, manage limited resources and contain costs. 76. Actively participate in learning activities, including clinical and educational opportunities. 77. Reinforce patient teaching on violence prevention.

Sample Student Medical Release Form

Printed student name _____

I, the under signed health care provider, confirm that the above named student is fully released for school/clinical duties and has no restrictions that would limit their capacity to provide care in the healthcare setting. I understand that the student is required to meet the following requirements for the clinical setting:

The physical expectation is be able to exert up to 100 lbs. force occasionally, and/or 50 lbs. frequently, and/or 20 lbs. constantly. Students are frequently required to lift and/or carry objects of 30 pounds or greater. They must transport items heavier than 50 lbs. with the use of carts, dollies or assistance. They must support, lift and move patients of all heights and weights. The work occasionally requires climbing and/or balancing, stooping, kneeling, crouching, reaching, handling, pushing and pulling. All extremities must be able to perform full range of motion. Students must be able to complete a 6-8 hour shift normally and longer in some cases.

Physician Comments:

_____

Physician's Signature _____ Date _____

Please attach official script or work release from the health care provider's office.

By my signature, I assume full responsibility for my health and understand that if I am unable to meet the clinical requirements, the assigned instructor reserves the right to dismiss me from the clinical setting.

Patient/Student Signature_____ Date _____

Student Signature Sheet

I have received either in a hard copy, been shown where the documents are or have been provided with the location of electronic form of the following documents:

Health and Safety	Student Initials _____
Student Vehicle Use/SAIF	Student Initials _____
Curriculum Guides	Student Initials _____
Classroom MSDS	Student Initials _____
TTC Student Orientation PPT	Student Initials _____
PN Program Handbooks	Student Initials _____
TTC Policies	Student Initials _____

I understand that as an adult student, I am responsible for reviewing and understanding these documents. I understand that these policies may change throughout the school year and I will be made aware of them as they occur.

Printed Name _____

Signature _____

Date _____

Class # _____