

MERCER COUNTY COMMUNITY COLLEGE
DIVISION OF SCIENCE AND
HEALTH PROFESSIONS
NURSING PROGRAM

NRS240 TRANSITIONS TO NURSING PRACTICE

SPRING 2011

HANDBOOK
FOR
PRECEPTORS AND STUDENTS

Coordinator: Sue Minkel RN, BSN, MA in Nursing Education

Contact information:

Email: sueminkel@comcast.net (preferred)

minkels@mccc.edu

C: 215-962-4996

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These guidelines were developed in collaboration with faculty from Gloucester County Community College, Brookdale Community College, and Ocean County College.

GUIDELINES FOR PRECEPTED CLINICAL

DEFINITION OF PRECEPTED CLINICAL:

A precepted clinical involves a one-to-one relationship between a senior nursing student and an experienced nurse during the last semester of the Nursing Program. The preceptor provides an opportunity for students to live the life of a nurse for five weeks making the learned theory become more of a reality.

GOALS OF PRECEPTED CLINICAL:

1. Prepare students for the demands and realities of nursing practice
2. Ease the transition of graduate to RN role
3. Increase confidence and competence

QUALITIES AND CRITERIA FOR PRECEPTOR:

1. **CREDENTIALS:** current licensure as a registered nurse for a minimum of one year
2. **EXPERIENCE** as a health care provider
3. **PHILOSOPHY** of nursing in agreement with that of the Mercer County Community College Nursing Program
4. **CRITERIA:**
 - a. Has excellent clinical skills
 - b. Has excellent time management skills
 - c. Has the ability to teach
 - d. Has positive communication skills
 - e. Is a professional role model
 - f. Demonstrates previous and current ability to work effectively with students
 - g. Willing to guide, facilitate, and supervise the student in achieving the clinical objectives
 - h. Willing to supervise the student's performance of skills to maintain safe practice
 - i. Willing to collaborate with faculty to review student progress based on learning objectives
 - j. Willing to provide feedback to the student regarding clinical performance
 - k. Willing to contact faculty if there is a problem with student performance
 - l. Willing to collaborate with faculty to develop written evaluation of student

RELATIONSHIP BETWEEN PRECEPTOR, STUDENT, CLINICAL INSTRUCTOR AND COURSE COORDINATOR:

This relationship will have positive student learning when all of the following exist:

1. Mutual trust
2. Mutual respect
3. Defined expectations
4. Excellent communication
5. Committed collaboration

PRECEPTORS RESPONSIBILITY:

Review the following found on Nursing Program website: www.mccc.edu/nursing
Accessed as follows: Go to above website. On first page click on Student Info, click on Course Information, click on NRS 240, click on Course Outline. All information needed is available for printing:

A. NRS 240 Transition To Practice Course Outline

- 1) Description of Clinical Laboratory
- 2) Objectives for Precepted Clinical Experience
- 3) Description of Student-Preceptor-Faculty Meetings
- 4) Evaluation Guidelines

B. Preceptor-Student Handbook

C. Dos and Don'ts for Preceptor Guide

D. Student Skills Checklist Form

E. Evaluation Forms

- 1) Daily Preceptor Evaluation of Student Clinical Performance Form
- 2) NRS 240 Clinical Laboratory Performance Evaluation Form (long and short form found at the end of the course outline)

F. Work with Course Coordinator/Clinical Faculty to plan, implement, and

- 1) evaluate student learning experience

G. Meet with student to set up clinical hours, review student skills checklist, and set goals based on increasing level of responsibility

H. Provide ongoing clinical experiences allowing for appropriate and increasing levels of independence based on assessment of student readiness and safety

I. Provide student with a daily summary on Daily Preceptors Evaluation of Students Clinical Performance Form (found on the web site)

J. Communicate weekly with Clinical Instructor about student performance

K. Serve as a role model to the student demonstrating best clinical nursing practice

L. Provide positive learning experiences

M. Maintain ongoing open communication with student, Clinical Faculty, Course Coordinator

N. Preceptors are **responsible to their clients first, students second**

O. **CALL CLINICAL INSTRUCTOR IMMEDIATELY FOR ANY UNSAFE PRACTICE**

STUDENT'S RESPONSIBILITY:

1. Students are responsible for their own learning and actions
2. Utilize legal, ethical, and nurse practice standards to determine own practice taking responsibility for own actions
3. Complete Skills Checklist prior to meeting preceptor. Take to preceptor meeting.
4. Contact preceptor and set up clinical schedule, a copy of this is to be sent via email to Clinical Faculty and Course Coordinator

5. During Orientation and throughout the experience identify and communicate learning needs to Course Coordinator/Clinical Faculty/preceptor
6. Complete hospital required orientation expectations (JACO mandatory expectations and computer orientation) the first week of the semester
7. Work collaboratively with Course Coordinator/Clinical Faculty/preceptor
8. Utilize Clinical Laboratory Performance Evaluation form to self evaluate meeting of learning objectives
9. Complete Worksheet for Daily Student Objectives and review with preceptor
10. Document a weekly journal entry for Clinical Faculty input on Angel course website
11. Meet daily with preceptor to review progress as outlined on the Daily Preceptor Evaluation of Student Clinical Performance; complete the Daily Student Self Evaluation of Clinical Performance Form prior to this meeting
12. Attend a weekly post conference led by Clinical Faculty on campus on Tuesdays
13. Attend two hour clinical orientation meeting and two hour summative meeting on campus led by Course Coordinator
14. Complete an evaluation of preceptor at course end (Student Evaluation of Preceptor Form)
15. Complete a clinical site evaluation at course end
16. Complete a course evaluation at course end
17. Complete faculty evaluations at course end

CLINICAL FACULTY RESPONSIBILITY:

1. Set up a meeting/communication schedule with the preceptor weekly to monitor student progress and assist with resolving issues
2. Provide contact information to preceptor of how to reach instructor via phone and email so preceptor has access to instructor when student has clinical
3. Plan weekly debriefing meeting with assigned clinical students
4. Review weekly journal submissions via email by student based on rubric
5. Utilizing input from preceptor, complete week three and week five clinical evaluation of the student
6. Report any problems to Course Coordinator and document an action plan

COURSE COORDINATOR RESPONSIBILITY

1. Plan clinical experiences with Director of Clinical Education of clinical sites
2. Provide orientation to preceptors of preceptor concept, role and expectations via Preceptor/Student Handbook
3. Provide forms for daily student evaluation on line and all other information needed to guide precepted clinical
4. Provide Guidelines for Precepted Clinical on line
5. Provide information to students about connecting with preceptor
6. Assist in planning of weekly student meetings on campus
7. Facilitate successful clinical experiences designed to achieve clinical outcomes
8. Maintain communication between college and clinical agencies
9. Provide support to preceptor/student/clinical instructor
10. Finalizes all grades

LEGAL ACCOUNTABILITY: A SUMMARY FOR PRECEPTORS

The Nurse Practice Act in New Jersey provides for the **delegation of nursing tasks to subordinates** commensurate with their level of skill and understanding (Title 13, Chapter 37, section 6.2). It is specified that it is the **responsibility of the delegating nurse to determine the level of competence of the subordinate**. This requirement to supervise the safe practice of subordinates applies to clinical nursing instructors and students.

Faculty can delegate to clinical students only those activities for which they could reasonably be expected to demonstrate competence and what is identified in course competencies.

If a student demonstrates an inability to deliver safe client care at the level required by the course competencies or poses a threat to client safety, faculty have a legal obligation to preserve the safety of the client and dismiss the student within the parameters of the academic grading policy.

THE FOLLOWING GUIDELINES SHOULD BE FOLLOWED IN DELEGATING NURSING TASKS TO THE STUDENTS:

1. STUDENT PRECEPTOR RELATIONSHIP:

- a. **The student is not working on your license. No one can work under another's license.** The student has the right by law to practice incidental to the education process. The standard of care must be the same as that rendered by the RN because everyone has a right to expect competent nursing care, even if provided by a student as part of clinical training (measured against conduct of other reasonably prudent RN's with similar knowledge and experience under same circumstances)
- b. Under the law, **each person is responsible for his own actions.**
- c. The preceptor has responsibility **to delegate according to the student's abilities and to supply adequate supervision**
- d. The preceptor has the responsibility to be **clear about what the student can or cannot do**
- e. **When students do not possess the skills needed to carry out an assigned function, acting with reasonable care requires them to refuse to perform the function, even at the risk of appearing insubordinate:**
Example: you ask a student to perform tracheostomy suctioning. The student is too embarrassed to tell you she has never done it; If harm comes to the patient, the student is personally liable. The preceptor would be liable if she delegated with knowledge of student's inexperience.

2. DEALING WITH THE RESPONSIBILITY:

- a. At the very beginning find out what the student can and cannot do
- b. Let students know that they must inform you if they are unsure and need help or supervision
- c. Delegation to students is based on the student's abilities, and adequate supervision
- d. CHECK THINGS CAREFULLY AT FIRST: THIS IS A NEW SITUATION FOR BOTH OF YOU. TAKE MORE RISKS AS THE EXPERIENCE PROGRESSES.

PRECEPTOR GUIDE FOR STUDENT ASSIGNMENTS

The clinical component of this course consists of **120 hours** over a **five week** period (10 twelve hour shifts, or 15 eight hour shifts) during which a student works one-to-one with a hospital staff nurse who has agreed to participate as a preceptor or mentor for the student.

The Mercer County Community College clinical instructor is available during these clinical experiences; faculty does not have the usual direct instructional role with students on the clinical unit. The faculty serves in a resource and support role for the student and the preceptor. Faculty visit on a daily basis and communicate with students, preceptors verbally and electronically.

The one-to-one relationship that the student has with the preceptor and the real life clinical day provides students with additional opportunities to develop professional and clinical skills. Each day of the clinical experience the student gradually assumes responsibility for the preceptor's typical client care assignment, including the delegation of care to others, and the supervision of the staff members as they implement the delegated aspects of client care. Students will practice and refine skills in clinical decision-making and collaboration.

SAMPLE GUIDELINES FOR CLINICAL RESPONSIBILITIES AND ASSIGNMENTS

1. **WEEK ONE:**

- Students complete course clinical orientation
- Students complete agency, hospital, and unit specific orientation
 - Computer documentation
 - Medication administration
 - Review of hospital policies
 - Unit tour, meet staff and Nurse Manager
- Student follows preceptor and observes implementation of the assignment.
 - Student observes preceptor delegation
 - Observe giving and receiving report
 - Observe documentation including client education, discharge and admission (if possible)
 - Observe collaboration with team members
 - Observe all other aspects of client care management

2. **WEEK TWO:**

- **Day one:** Assign student to two clients (including shift report, treatments, teaching, documentation, no medication). Participate in client admissions, transfers, and discharges.
- **Day two:** Take same two clients with same responsibilities, add medications with the nurse.

3. **WEEK THREE:**

- Day one: Assign student to three clients (including shift report, treatments, teaching, documentation, no medication). Participate in client admissions, transfers, discharges.
- Day two: Take same three clients with same responsibilities, add medications with the nurse.
 - Student may begin to delegate part of the assignment to other nursing team members according to the nursing unit's model of care

4. **WEEK FOUR:**

- Day one: Assign student to four clients (including shift report, treatments, teaching, documentation, no medication). Participate in client admissions, transfers, discharges.
- Day two: Take same four clients with same responsibilities, add medications with the nurse.
 - Student communicates/collaborates with other health team members
 - NO VERBAL ORDERS CAN BE TAKEN FROM PHYSICIANS

5. **WEEK FIVE:**

- Day one: Assign student to four clients (including shift report, treatments, teaching, documentation, no medication). Participate in client admissions, transfers, discharges.
- Day two: Take same four clients with same responsibilities, add medications with the nurse.

NOTE: THIS SAMPLE PROGRESSION OF EXPERIENCES MAY PROGRESS AT DIFFERENT RATES DEPENDING UPON READINESS OF THE INDIVIDUAL STUDENT, THE CLIENT POPULATION AND ACUITY, THE TYPE OF NURSING UNIT AND THE DELIVERY OF CARE ON THE NURSING UNIT.

GUIDELINES FOR MEDICATION ADMINISTRATION

1. Students must be knowledgeable about medication.
2. Students will use PDA resources to look up medication.
3. If medication information is not available in PDA reference then the student will look up the medication on a reputable on line site or call the pharmacist.
4. Students must follow the six rights of medication administration
5. Students must assess client's status related to specific drug therapy
6. Students must appropriately communicate assessments and evaluations with regard to medications to preceptor
7. Students will make decisions with regard to withholding medications, continuing medications in cooperation with preceptor
8. Student's will know current laboratory values/glucose levels pertinent to medications
9. Students will not pull controlled medications without RN present
10. Students will follow facility policy for recording and wasting narcotics with RN present
11. Students will be checked for competency by instructor or preceptor for administration of IV, IM, SC medications. This includes changing IV bags.
12. When competency has been established student may administer IV's, IVPB's, IM's, SC's with RN supervision.
13. Students may observe the checking and hanging of blood and blood productions
14. Students may observe the administration of IV push medications
15. Students will DOUBLE CHECK each dose of heparin, lovenox, digoxin, and insulin with the preceptor before administration
16. Students will check all dosage calculations with preceptor before administering medications
17. Students will check all newly transcribed medication orders with preceptor before administering the medication. STUDENTS CANNOT TRANSCRIBE ORDERS.
18. Students will document all medication administration appropriately
19. Students will provide appropriate client teaching regarding medications

Students are expected to communicate any questions about administration of medications with the preceptor

EVALUATION FORM

MERCER COUNTY COMMUNITY COLLEGE
 DIVISION OF SCIENCE AND HEALTH PROFESSIONS
 NURSING PROGRAM
 TRANSITION TO PRACTICE NRS240
 Daily STUDENT SELF EVALUATION OF CLINICAL PERFORMANCE

STUDENT NAME: _____

The following is a daily check list to be completed by the student and shared with the preceptor.

Any areas needing improvement need goals set for improvement

	Daily Evaluation	Excellent	Satisfactory	Needs Improvement
1.	Subject Knowledge			
2.	Professional Behavior			
3.	Client Interaction			
4.	Psychomotor Skills			
5.	Safe Performance			
6.	Organizational/Time management skills			
7.	Collaboration			
8.	Flexibility			
9.	Critical thinking skills			
10.	Level of involvement in learning			

GOALS:

Signature of STUDENT: _____ Date: _____

Signature of PRECEPTOR: _____ Date: _____

Created December 2010

MERCER COUNTY COMMUNITY COLLEGE
 DIVISION OF SCIENCE AND HEALTH PROFESSIONS
 NURSING PROGRAM

TRANSITION TO PRACTICE NRS240

Daily PRECEPTOR EVALUATION OF STUDENT CLINICAL PERFORMANCE

The following is a daily check list to be completed by the preceptor and shared with the student. This information will be used to summarize the student’s performance at week 3 and week 5.

Any areas needing improvement need to be shared with student immediately and a plan for improvement needs to be discussed. This needs to be reported to the clinical instructor immediately.

	Daily Evaluation	Excellent	Satisfactory	Needs Improvement
1.	Subject Knowledge			
2.	Professional Behavior			
3.	Client Interaction			
4.	Psychomotor Skills			
5.	Safe Performance			
6.	Organizational/Time management skills			
7.	Collaboration			
8.	Flexibility			
9.	Critical thinking skills			
10.	Level of involvement in learning			

Attendance: (circle what is appropriate) present not present

Student arrived on time: (circle what is appropriate) yes no

Comments by preceptor including Goals to be achieved:

Signature of preceptor: _____ Date: _____

Signature of student: _____ Date: _____

Created December 2010

MERCER COUNTY COMMUNITY COLLEGE
 DIVISION OF SCIENCE AND HEALTH PROFESSIONS
 NURSING PROGRAM
 NRS 240 TRANSITION TO PRACTICE
 STUDENT EVALUATION OF PRECEPTOR

Student: _____ Semester and year: _____

Preceptor: _____

Preceptor's Clinical Facility: _____ Clinical Unit: _____

Based on the following scale please indicate how you feel the preceptor met the following objectives by placing a mark in the appropriate box:

1: strongly disagree; 2: disagree; 3: agree; 4: strongly agree

The Preceptor:

#	Objectives	1	2	3	4
1.	Possessed clinical knowledge and expertise in area of specialty				
2.	Demonstrated high level of clinical competence in area of specialty				
3.	Stimulated personal and professional growth in nursing				
4.	Utilized effective teaching strategies facilitating the learning experience				
5.	Created an accepting, supportive and positive learning environment				
6.	Was physically present and available as a resource at all times while in the clinical setting				
7.	Was a professional role model in providing effective, efficient, and safe nursing care				
8.	Observed and assisted in the performance of simple and complex procedures while adhering to agency policy and procedures				
9.	Provided positive and constructive feedback at the daily evaluation meetings setting goals for improvement				

COMMENTS:

GUIDES FOR STUDENTS DURING PRECEPTED EXPERIENCE

WORKSHEET FOR DAILY STUDENT OBJECTIVES

DIRECTIONS: Use this outline as a framework to think about your personal needs as you develop daily objectives with your preceptor. Share this completed assessment with your preceptor each day. Print one for each day you are in clinical and fill out prior to the clinical day. Take with you, sharing your goals with your preceptor.

1. Communication with:

- _____ A. staff nurses
- _____ B. doctors
- _____ C. ancillary staff
- _____ D. staff from other departments

2. Organization:

- _____ A. assignments
- _____ B. delegation to others
- _____ C. time management
- _____ D. receiving and giving report
- _____ E. computer documentation

3. Specific Nursing Skills:

- _____ A. nursing procedures
- _____ B. nursing assessment
- _____ C. client teaching
- _____ D. clear and comprehensive documentation
- _____ E. critical pathways (if applicable)
- _____ F. collaboration
- _____ G. discharge planning
- _____ H. computer or Kardex record system

4. Hospital Rules and Regulations:

- _____ A. proper use of policy and procedure manual
- _____ B. work safety procedures
- _____ C. medication safety procedures

5. Miscellaneous:

- _____ A. self-confidence
- _____ B. assertiveness
- _____ C. conflict resolution
- _____ D. assuming primary responsibility for identifying own learning needs

CHANGE OF SHIFT REPORT GUIDELINES

PURPOSE:

1. To report to the oncoming personnel about the condition of each client and the nursing care given during the previous shift
2. To keep the nursing staff informed concerning methods of treatment, nursing care, current teaching plans, psychosocial issues, critical problems
3. To identify priority concern

The nurse uses the kardex, report sheets and chart information to give report

Checklist:

1. Client's name, age, room number, doctors, hospital day post admission or postop, chief complaint, diagnoses, surgical procedures or reason for admission, and any changes in the above
2. Mental status and orientation; summary of critical elements of physical assessment
3. Focus of nursing care that must be given over the next 24 hours (eg: increased ambulation, encouraging ADL's, teaching)
4. Changes in the client's condition or treatments within the last 24 hours
5. Emphasis on nursing care needed within the next 2 hours: special symptoms to be observed (increased temperature, bleeding), special treatments (IV's, force fluids, NPO, prn or single medications, specimens to be obtained)
6. Medications: new meds or changes, reason ordered, potential side effects, problems with administration, prn meds with last time given and frequency required
7. Treatments: new orders, rationale for treatment, time scheduled, and client response
8. Diagnostic tests: dates and times scheduled, related special orders, tests completed in the last 24 hours, observations, medications or unusual reactions
9. Dressing and drainage: amount, color, character, recommendations for care and frequency of dressing change
10. Learning needs and progress: pre-op and post-op teaching, return demonstration, follow-up and discharge teaching such as medications and dressing changes
11. Plans for discharge and continuity of care agency referral
12. Need for in-house referral; status of referral and forms
13. Consultation with other members of the health care team; recommendations for physical therapy, scheduling of tests, need for social services
14. Status of support network, family; any visitations; special concerns

PATIENT DATA COLLECTION FORM

Students should copy one of these forms for each patient assigned.
It should be used to collect data throughout the shift period to be utilized rather than notebooks, loose leaf binders, etc.
It is then used to give shift report.

Data Collection Form is found on the Nursing website. It is the student's responsibility to make enough copies for the clinical experience.

GUIDELINES ON HOW TO ORGANIZE AND PRIORITIZE CARE TO GROUPS OF CLIENTS

PURPOSE: to assist student in organizing and prioritizing the basic workload of a staff nurse

ORGANIZING STEPS:

1. Obtain assignment
2. Receive report from previous shift.
3. Identify priority alterations based on report and understanding of medical diagnosis; Identify which clients to see first based on priority assessments
4. Complete client assessments/VS
5. Check client charts to identify new orders; check every few hours
6. Collect result of diagnostic tests, progress notes
7. Make rounds on all clients and repeat as frequently as necessary during shift.
 - Perform client care (AM/PM care):
 - VS and document
 - I&O and document
 - Feed clients and record intake; return meal trays
 - Maintain neat client unit
 - Perform ordered treatments
 - Update care plan
 - Safely administer medications
 - Manage IV's and document
 - Provide client teaching/document
 - Provide for client's psychosocial needs
 - Pain assessment, reassessment, document
8. Assist physicians with clients
9. Attend physician rounds on assigned clients
10. Admit new clients/transfer/discharge as assigned
11. Give change of shift report
12. Participate in client conferences, quality improvement activities, and inservice activities
13. Assure equipment safety

OBSERVATION GUIDELINES WHEN MAKING ROUNDS

Purpose: To observe, assess, plan, and direct nursing care to fulfill the needs of a group of clients

Issues to be addressed during observational rounds include:

1. Observe the general condition and appearance of each client
 - Does the client appear comfortable?
 - Is edema, dyspnea, pain present?
 - Is an IV present? Check site and status of current infusion, Plan to add a new bag bottle. Determine when it will be due
 - Identify all equipment being utilized; check function (infusion pump, suction, urinary catheters, tubes, drains, etc)
2. Note approach that is effective when interacting with the client
 - Is the client glad to have people come in to see him/her
 - Is the client apprehensive?
 - Do you detect the need to further assess client mental status or mood?
3. Anticipate specific problems that may be encountered in the care of each client
 - Difficulty in moving the client
 - Problems convincing client of the importance of following instructions and participating in care
 - Risk levels for pressure ulcers, inadequate nutrition, hydration
4. Take note of individual problems voiced by each client
 - Psychosocial issues
 - Participation in plan of care
 - Discharge planning
 - Deficient knowledge
5. Note facts about the client that may need to be reported to other health professionals including the doctor. Also consider important elements of client progress that are important to know should another health professional or physician inquire
 - Pain/discomfort
 - Need for sleep medication
 - Toxic symptoms from ordered medication
 - Status of surgical site/dressing
 - Quality/quantity of drainage from wound or tube
 - Response to specific medical regimen or nursing interventions (tolerating activity or diet)
 - Change in client condition
6. Observe the type and quality of work being done by nursing and ancillary staff
 - Do some appear to need help attending to certain aspects of client care?
 - Does the finished work show attention to detail and concern for client satisfaction and comfort?

7. Note the progress of work for clients assigned to your care
 - Revise assignment if one worker has met situations or emergencies that have prevented him or her from completing the work assigned
 - Consider suggestions to facilitate completion of client care
8. Observe the condition of the unit equipment and general state of housekeeping
 - Refer problems of cleanliness to housekeeping, mechanical problems to Engineering/Maintenance

GUIDELINES FOR DELEGATING CLIENT CARE WHILE CARING FOR MULTIPLE CLIENT ASSIGNMENTS

1. Receive report from previous shift noting specific data, using Data Collection Form for each client. Note specific data
 - Special and/or immediate nursing care requirements of particular clients (eg: critical laboratory values, dyspnea, hypoglycemia, pain control, incontinence, fever, etc)
 - Changes in physical/psychosocial status
 - Problems requiring new or renewed medical orders
 - Scheduled diagnostic/therapeutic procedures and status of client preparation
 - Status of IV therapy, tube feedings, treatments
 - Additional data outlined in the Change of Shift Report Guidelines
2. Make assignments considering the following:
 - Assign client care tasks to nursing personnel consistent with their legal and experiential limits (scope of practice): (eg: nursing assistant/nursing tech, LPN)
 - Clarify your expectations of the caregivers and identify components of care for which you will provide assistance or assume responsibility
 - Schedule breaks and meals so that adequate care is always available to clients
 - Provide caregivers with guidelines for ongoing reporting of data to you for documentation
3. Make rounds. Introduce self and/or delegated caregivers to clients. Check critical factors in each client's situation (eg: IV's dressings, catheters, etc) Assess needs of each client. (Refer to Observation Guidelines When Making Rounds)
4. Implement assigned client care tasks (medications, IV's , dressings, etc)
5. Maintain ongoing communications with the charge nurse, caregivers, clients
6. Maintain up to date awareness of medical and nursing plans of care
7. Maintain ongoing documentation on client who are assigned to nursing assistants/nursing techs
8. Make rounds with the physicians caring for clients when possible
9. Anticipate teaching needs for individuals in your client group
10. Give report on clients in your group at change of shift.

GUIDELINES FOR MEDICATION ADMINISTRATION

1. Students must be knowledgeable about medication.
2. Students will use PDA resources to look up medication.
3. If medication information is not available in PDA reference then the student will look up the medication on a reputable on line site or call the pharmacist.
4. Students must follow the six rights of medication administration
5. Students must assess client's status related to specific drug therapy
6. Students must appropriately communicate assessments and evaluations with regard to medications to preceptor
7. Students will make decisions with regard to withholding medications, continuing medications in cooperation with preceptor
8. Student's will know current laboratory values/glucose levels pertinent to medications
9. Students will not pull controlled medications without RN present
10. Students will follow facility policy for recording and wasting narcotics with RN present
11. Students will be checked for competency by instructor or preceptor for administration of IV, IM, SC medications. This includes changing IV bags.
12. When competency has been established student may administer IV's, IVPB's, IM's, SC's with RN supervision.
13. Students may observe the checking and hanging of blood and blood productions
14. Students may observe the administration of IV push medications
15. Students will DOUBLE CHECK each dose of heparin, lovenox, digoxin, and insulin with the preceptor before administration
16. Students will check all dosage calculations with preceptor before administering medications
17. Students will check all newly transcribed medication orders with preceptor before administering the medication. STUDENTS WILL NOT TRANSCRIBE MEDICATIONS.
18. Students will document all medication administration appropriately
19. Students will provide appropriate client teaching regarding medications

Students are expected to communicate any questions about administration of medications with the preceptor

DOCUMENTATION GUIDELINES

1. Become familiar with agency flow sheets, checklists. Use them appropriately
2. Determine type of note used for nurse's note.
 - For PIE note keep note problem specific
 - For narrative nurses note include the following:
 - Objective and subjective symptoms
 - Client behavior and mental status
 - Nursing care administered
 - Client responses to medical and nursing care
 - Food and fluid intake
 - Preparation for discharge
 - Client teaching
 - Visitors/doctor visits
3. Use only abbreviations that are approved by the agency
4. Basic charting reminders:
 - Errors should be noted according to agency policy; do not erase; do not scribble; draw horizontal lines to fill in blank spaces in the narrative note
 - Record only facts truthfully and completely
 - Use black ink, and write legibly
 - Chart concurrently rather than once at the end of the shift
 - Use notes from Patient Data Collection Form for each client
 - Document concerns about medical orders
 - Chart for yourself, not for someone else
 - In case of omission, add notation at the end of the note as an addendum
5. Co-signing:
 - Students and preceptors should determine and comply with the co-signing policy of the hospital nursing service department
 - Verify accuracy and completeness of client documentation with preceptor
 - For agencies with computerized information systems, students will review agency requirements and responsibilities for staff nurses and students during orientation