MERCER COUNTY COMMUNITY COLLEGE
DIVISION OF SCIENCE AND HEALTH PROFESSIONS

NURSING PROGRAM

NRS240

TRANSITION TO NURSING PRACTICE

FALL 2012

HANDBOOK

FOR

RN PRECEPTORS AND STUDENTS

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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 registered nurse during the last semester of the Nursing Program. The RN Preceptor provides opportunity for the student 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 RN PRECEPTOR:

1. **CREDENTIALS**: current licensure as a registered nurse for a minimum of one year.
2. **EXPERIENCE** as a health care professional.
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 RN PRECEPTOR, STUDENT, ASSIGNED OVERSIGHT FACULTY 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

RN PRECEPTOR RESPONSIBILITY:

The following will be provided to each assigned RN RN Preceptor during the orientation meeting* with course coordinator:

1. **NRS 240 Transition To Practice Course Outline***
    1) Description of Clinical Laboratory
    2) Objectives for Precepted Clinical Experience
    3) Description of Student-RN Preceptor-Faculty Meetings
    4) Evaluation Guidelines
2. **RN Preceptor-Student Handbook***
3. **Dos and Don'ts for RN Preceptor Guide***
4. **Student Skills Checklist Form –** assigned student will complete and review with you.
5. **Evaluation Forms**
6. **Daily RN Preceptor Evaluation of Student Clinical Performance Form-** you will be asked to complete the checklist evaluation on a daily basis with any comments, then review with the student. Give to the student before Tuesday each week to submit in class. (found on the web site – copies will be provided).

The assigned oversight faculty member will incorporate input from your written and verbal communication will be used to complete the **NRS 240 Clinical Laboratory Performance Evaluation Form** (long and short form found at the end of *the course outline)*

7. Communicate weekly with MCCC assigned faculty about student performance.
8. Work with course coordinator/clinical faculty to plan, implement, and evaluate student learning experience.
9. Meet with student to set up clinical hours, review student skills checklist, and set goals based on increasing level of responsibility.
10. Provide ongoing clinical experiences allowing for appropriate and increasing levels of independence based on assessment of student readiness and safety.
11. Serve as a role model to the student demonstrating best clinical nursing practice
12. Provide positive learning experiences.
13. Maintain ongoing open communication with student, assigned MCCC Faculty, and Course Coordinator.
14. Notify student and clinical faculty of any short notice schedule change whereby the RN Preceptor will be unable to fulfill RN Preceptor responsibilities. *

*** Any change of RN Preceptor must be coordinated through the medical facility nursing education office and the course coordinator. Please contact via the course coordinator who will facilitate finding a temporary or new RN Preceptor.**

15. RN Preceptors are responsible to their Patients first, students second.

16. **Call course coordinator, Barbara Kunkel, RN, MSN, at 609-731-4368 immediately for any unsafe nursing practice or concern about the student's nursing practice.**

STUDENT REPONSIBILITY:

1. Students are responsible for their learning and all actions.
2. Apply legal, ethical, and nurse practice standards to determine own practice taking responsibility for own actions.
3. Complete *Skills Checklist* prior to meeting RN Preceptor. Submit to RN Preceptor at first meeting.
4. Contact RN Preceptor and set up clinical schedule, a copy of this is to be documented on the schedule form and submitted to the to the course coordinator and assigned oversight faculty member.
5. During orientation and throughout the experience, identify and communicate learning needs to course coordinator/assigned oversight faculty/RN RN Preceptor.
6. Complete hospital required orientation, including Joint Commission mandatory training and computer orientation before the end of the first week of the semester.
7. Work collaboratively with course coordinator/assigned oversight faculty/RN Preceptor.
8. Notify the assigned oversight faculty and course coordinator immediately of any short notice change in RN Preceptor's schedule, whereby the RN Preceptor will not be able to fulfill RN Preceptor responsibilities.*
   * **Any change of RN Preceptor must be coordinated through the medical facility nursing education office and the course coordinator.**
9. Utilize Clinical Laboratory Performance Evaluation form to self-evaluate meeting of learning objectives.
10. Complete *Worksheet for Daily Student Objectives* and review with RN Preceptor. Submit weekly at Tuesday Theory Class.
11. Meet daily with RN Preceptor to review progress as outlined on the *Daily RN Preceptor Evaluation of Student Clinical Performance*; compare with your completed *Daily Student Self Evaluation of Clinical Performance Form* prior to this meeting.
12. Attend a weekly conference with assigned oversight faculty on campus on Tuesdays on a weekly basis to evaluate the clinical preceptorship experience.
13. Attend two-hour clinical orientation meeting and one-hour summative meeting on campus led by Course Coordinator.
14. Complete an evaluation of RN Preceptor at course end using the *Student Evaluation of RN 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.

ASSIGNED OVERSIGHT FACULTY RESPONSIBILITY:

1. Set up a meeting and/or communication schedule with the RN Preceptor and student to be implemented on at least a weekly basis to monitor student progress and assist with resolving issues.
2. Clinical faculty to visit clinical faculty with RN Preceptor and student are on duty once prior to third week and once prior to the completion of the clinical RN Preceptorship.
3. Provide contact information to RN Preceptor of how to reach instructor via phone and email so RN Preceptor has access to instructor.
4. Plan debriefing meeting with assigned clinical students to be held on Tuesday weekly.
5. Based on input from RN Preceptor and observations, complete week three and week five student clinical evaluation. Submit prior to the end of the course to the course coordinator.
6. Notify the course coordinator of any situation whereby the RN Preceptor has short notice schedule changes or other situations whereby the RN Preceptor is unable to fulfill RN Preceptor responsibilities.
7. Report any concerns, issues, and problems to course coordinator.
8. Initiate an action plan as prescribed by MCCC Nursing Program Policy, as appropriate.

COURSE COORDINATOR RESPONSIBILITY

1. Plan clinical experiences with Director of Clinical Education of clinical sites.
2. Provide orientation to RN Preceptor of RN Preceptor concept, role and expectations outlined in the RN Preceptor/Student Handbook.
3. Provide hardcopy and on-line evaluation forms.
4. Provide ***Guidelines for Precepted Clinical*** hardcopy and on-line.
5. Provide information to students about connecting with RN Preceptor.
6. Assist in planning and collaborating on weekly student meetings on campus.
7. Facilitate successful clinical experiences designed to achieve clinical outcomes.
8. Coordinate all RN Preceptor – student assignments.
9. Maintain communication between college and clinical agencies.
10. Provide support to RN Preceptor, student, and assigned clinical faculty members.
11. Finalize all grades.

LEGAL ACCOUNTABILITY: A SUMMARY FOR RN 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 Patient care at the level required by the course competencies or poses a threat to Patient safety, faculty have a legal obligation to preserve the safety of the Patient 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 – RN 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 RN Preceptor has responsibility ***to delegate according to the student's abilities and to supply adequate supervision***
    d. The RN Preceptor has the responsibility to be ***clear about what the student can or cannot do. Ensure that the student skills checklist is carefully reviewed.***
    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; Should harm come to the patient, the student is personally liable. The RN 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.

RN PRECEPTOR GUIDE FOR STUDENT ASSIGNMENTS

The clinical component of this course consists of **108 hours** over a **five week** period (The clinical lab consists of **nine twelve-hour shifts (either 7Am to 7Pm or 7 Pm to 7 AM); 13.5 eight-hour shifts (days, evenings, or nights); or, a match of shifts that have been approved by the course coordinator, over five weeks** at the assigned clinical facility with assigned RN Preceptor including one clinical observation experience. (If necessary, the student can break up the clinical experience based on personal needs as compared to the RN Preceptor's schedule as long as the 108 hours are met).

The Mercer County Community College assigned oversight faculty member 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 RN Preceptor. Assigned oversight faculty will visit twice during the five-week period and communicate with students and RN Preceptor telephonically on at least a weekly basis.

The one-to-one relationship that the student has with the RN 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 RN Preceptor's typical Patient care assignment, including the delegation of care to others, and the supervision of the staff members as they implement the delegated aspects of Patient 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
    - Student reviews clinical skills checklist with RN Preceptor.
    - 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 RN Preceptor and observes implementation of the assignment.
        - Student observes RN Preceptor delegation
        - Observe giving and receiving report
        - Observe documentation including patient education, discharge and admission (if possible)
        - Observe collaboration with team members
        - Observe all other aspects of patient care management

2. **WEEK TWO**:

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

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

5. **WEEK FIVE**:
    - Day one: Assign student to four patients (including shift report, treatments, teaching, documentation, no medication). Participate in patient admissions, transfers, discharges.
    - Day two: Take same four patients 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 PATIENT 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 eight rights* of medication administration
5. Students must assess Patient's status related to specific drug therapy
6. Students must appropriately communicate assessments and evaluations with regard to medications to RN Preceptor
7. Students will make decisions with regard to withholding medications, continuing medications in cooperation with RN Preceptor
8. Student's will know current laboratory values/glucose levels pertinent to medications
9. Students will only sign out controlled medications with the 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 RN Preceptor for adding large volume intravenous therapy, secondary or piggyback intravenous therapy, subcutaneous injections, and intramuscular injections.
12. When competency has been established, student may administer – adding large volume intravenous therapy, secondary or piggyback intravenous therapy, subcutaneous injections, and intramuscular injections with RN supervision.
13. Students may observe the checking and hanging of blood and blood products.

STUDENTS MAY NOT ADMINISTER BLOOD OR BLOOD PRODUCTS.

14. Students may observe the administration of IV push medications.

STUDENTS MAY NOT ADMINISTER IV PUSH MEDICATIONS.

15. Students will DOUBLE CHECK each dose of any "high risk –Pinch" medications per hospital policy, to include, at a minimum: Potassium; Patient-controlled analgesia; insulin; narcotics; heparin; and, digoxin. High risk medications will be checked with the RN Preceptor before administration.
16. Students will check all dosage calculations with RN Preceptor before administering medications.
17. Students will check all newly transcribed medication orders with RN Preceptor before administering the medication.

STUDENTS MAY NOT TRANSCRIBE ORDERS.
STUDENTS MAY NOT ACCEPT VERBAL ORDERS.

18. Students will document all medication administration appropriately.
19. Students will provide appropriate Patient teaching regarding medications.

Students are expected to communicate any questions about administration of medications with the RN Preceptor.

Rights of Medication Administration

1. Right patient
    - Check the name on the order and the patient.
    - Use 2 identifiers.
    - Ask patient to identify himself/herself.
    - When available, use technology (for example, bar-code system).

2. Right medication
    - Check the medication label.
    - Check the order.

3. Right dose
    - Check the order.
    - Confirm appropriateness of the dose using a current drug reference.
    - If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route
    - Again, check the order and appropriateness of the route ordered.
    - Confirm that the patient can take or receive the medication by the ordered route.

5. Right time
    - Check the frequency of the ordered medication.
    - Double-check that you are giving the ordered dose at the correct time.
    - Confirm when the last dose was given.

6. Right documentation
    - Document administration AFTER giving the ordered medication.
    - Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

7. Right reason
    1. Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
    2. Revisit the reasons for long-term medication use.

8. Right response
    - Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
    - Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.

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DAILY STUDENT SELF-EVALUATION OF CLINICAL PERFORMANCE

STUDENT NAME: _____ Week of _____

The following is a daily check list to be completed by the student and reviewed with the RN Preceptor.
Please fill in the date and the number of student hours under the respective day of the week
Evaluate clinical performance for each clinical day using the following:

E = Excellent; S = Satisfactory; NI Needs Improvement

Any *areas needing improvement* need goals set for improvement – document under goals.

Daily Evaluation	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Date:								
Number of Student Hours:								
1. Subject Knowledge								
2. Professional Behavior								
3. Patient Interaction								
4. Psychomotor/Clinical Skills								
5. Safe Performance								
6. Organization								
7. Time management								
8. Collaboration								
9. Flexibility								
10. Clinical Judgment/Critical thinking								
11. Level of involvement in learning								

Goals for Improvement:

Date	Goal(s) – continue on reverse side as needed

Signature of STUDENT: _____ Date: _____

Signature of RN PRECEPTOR: _____Date: _____

Created Dec, 2010; Revised Jan 2012

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RN RN PRECEPTOR EVALUATION OF STUDENT CLINICAL PERFORMANCE

STUDENT NAME: _____ Week of _____

The following is a daily check list to be completed by RN Preceptor and submitted weekly.
Please fill in the date and the number of student hours for the respective day of the week.
Evaluate clinical performance for each clinical day using the following:

E = Excellent; S = Satisfactory; NI Needs Improvement

Please comment on student progress on improvement goals in the area below.

Daily Evaluation	**Sun**	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Fill in date for clinical hours:								
Number of Student Hours:								
12. Subject Knowledge								
13. Professional Behavior								
14. Patient Interaction								
15. Psychomotor/Clinical Skills								
16. Safe Performance								
17. Organization								
18. Time management								
19. Collaboration								
20. Flexibility								
21. Clinical Judgment/Critical thinking								
22. Level of involvement in learning								

Progress on Improvement Goals:

Signature of STUDENT: _____ Date: _____

Signature of RN PRECEPTOR: _____ Date: _____

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STUDENT EVALUATION OF RN PRECEPTOR

Student: _____ Semester and year: _____

RN Preceptor: _____ Clinical Facility: _____ Clinical Unit: _____

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

The RN Preceptor **1: strongly agree; 2: agree; 3: disagree; 4: strongly disagree**

#	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 mode 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:

GUIDE FOR STUDENTS DURING PRECEPTED CLINICAL 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 RN Preceptor. Share this completed assessment with your RN 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 RN 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. Patient 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 Patient 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 computerized and hardcopy chart, kardex, and report sheets to give report.

Checklist:

1. Patient's name, diagnosis, hospital day / postoperative day (as applicable), attending physician, Code Status.

2. Assessments:
   a) physical (Head-to-toe by exception: abnormal findings: neuro, respiratory, cardiovascular, gastrointestinal, genitourinary, skin, mobility status, comfort - whatever is relevant to the client's problem(s).
   b) emotional responses, as appropriate.
   c) Describe findings not just "good" – used descriptive adjectives (e.g., coarse rales LLL), specific amounts (e.g., 350 thick green NG output), and percentages (e.g., ate 50% of lunch tray) when reporting on patient outcomes.

3. Fluid status:
   a) intake totals, including:
      (1) po--how much and how tolerated; enteral feedings.
      (2) IVs--how much in, type, rate, amount left in bag, site (date inserted) and system condition.
   b) output: self, Foley, chest tube drainage, diarrhea; totals (include if need prn catheterization - when last done, how much obtained).

4. Nursing interventions and responses:
   a) effects of critical procedures (e.g. blood transfusion, special medications, radiologic or surgical procedures).
   b) effects of interventions, medications.
   c) any unexpected outcomes.
   d) any diagnostic value of abnormal range, reported, orders obtained, and how the lab value or treatment affects treatment regime.
   e) Diagnostic tests: dates and times scheduled, related special orders, tests completed in the last 24 hours, observations, medications or unusual reactions.
   f) Report by exception – do not review report on routine care procedures or normal vital signs (unless this is a change).

5. Any unusual occurrences/changes in client's condition.

6. Medications: new meds or changes, reason ordered, potential side effects, problems with administration, prn meds with last time given and frequency required

7. Patient/family learning needs identified, teaching completed and client responses/progress. Special teaching, return demonstration, follow-up and discharge teaching such as medications and dressing changes.

8. Newly identified nursing needs: interventions initiated, changes suggested in care plan.

9. Dressing and drainage: amount, color, consistency, character, recommendations for care and frequency of dressing change.

10. Changes in physician's orders and patient responses.

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.

10. Status of patient's social support system, family, any visits; special concerns.

11. Summarize priorities for next shift, including anything left undone from your shift – 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

PATIENT DATA COLLECTION FORM

Students should copy one of these forms for each assigned patient.
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 Mercer Online website under Resources. It is the student's responsibility to make enough copies for the clinical experience.

HOW TO ORGANIZE AND SET PRIORITIES WHEN CARING FOR MULTIPLE PATIENTS

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 Patients to see first based on priority assessments.
4. Make initial rounds on all assigned patients to check high priority needs. Repeat as frequently as necessary during shift.
5. Complete patient assessments/VS-document.
6. Check patient charts to identify new orders; check every hour.
7. Collect result of diagnostic tests, progress notes.
8. Make in-depth rounds on all patients and repeat as frequently as necessary during shift.
    - Pain assessment-document, reassessment-document.
    - VS-document.
    - I&O-document.
    - Administer medications-document
    - Manage IV therapy-document.
    - Feed Patients and record intake; return meal trays.
    - Maintain neat Patient unit.
    - Perform ordered treatments.
    - Update care plan.
    - Implement and coordinate patient care (am/pm care) with multidisciplinary team.
    - Assess patient's learning needs - provide patient teaching-evaluate patient teaching activities-document.
    - Provide for patient's psychosocial needs.
    - Evaluate patient care-document.
9. Assist physicians with patients.
10. Attend physician rounds on assigned Patients.
11. Coordinate patient care diagnostics with interdisciplinary team.
12. Admit new patients/transfer/discharge as assigned.
13. Give change of shift report.
14. Participate in patient conferences, quality improvement activities, and continuing education/in-service activities
15. Assure equipment safety

OBSERVATION GUIDELINES WHEN MAKING ROUNDS

Purpose: To observe, assess, plan, and coordinate the patient care needs for a group of patients.

Issues to be addressed during observational rounds include:

1. Observe the general condition and appearance of each Patient
   - Does the patient appear comfortable?
   - Is dyspnea, pain, edema present?
   - Is an IV present? Check site and status of current infusion. Plan time to add on-going large volume infusion. Time-tape infusion and have ready at nursing station.
   - Identify all equipment being used; check function (infusion pump, suction, urinary catheters, tubes, drains, and any other medical equipment)
2. Note approach that is effective when interacting with the Patient:
   - Is the patient receptive to having staff and visitors come into his or her room?
   - Is the patient apprehensive?
   - Do you detect the need to further assess patient mental status or mood?
3. Anticipate specific problems that may be encountered in the care of each patient:
   - Difficulty in moving the patient – impaired mobility – need to physical therapy.
   - Problems convincing patient of the importance of following instructions and participating in care.
   - Risk levels for pressure ulcers, inadequate nutrition, hydration, pain.
4. Take note of individual problems voiced by each patient:
   - Psychosocial issues.
   - Participation in plan of care.
   - Discharge planning.
   - Deficient knowledge.
5. Note facts about the patient that may need to be reported to the interdisciplinary team, particularly the patient's physician. Consider important elements of patient progress that are important to know should another health professional or physician inquire:
   - Pain/discomfort.
   - Need for sleep medication.
   - Adverse and toxic symptoms from ordered medication – **act and report immediately**.
   - Status of surgical site/dressing.
   - Quality/quantity of drainage from wound or tube.
   - Response to specific medical regimen (e.g., diet, medications) or nursing interventions.
   - Change in patient condition / abnormal lab values – **act and report immediately**.
6. Observe the type and quality of care being done by nursing and ancillary staff.
   - Do some appear to need help attending to certain aspects of patient care?
7. Does the care provided show attention to detail and concern for the patient?
8. Note the progress of care for patients assigned to your team:
   - Revise assignment if one staff member has been prevented from completing the care.
   - Consider suggestions to facilitate completion of patient care.
9. Observe the condition of the unit equipment and general state of housekeeping:
   - Refer problems of cleanliness to housekeeping, mechanical problems to Engineering/Maintenance (tag appropriately and remove from patient's room).

GUIDELINES FOR DELEGATING PATIENT CARE WHILE CARING FOR MULTIPLE PATIENT ASSIGNMENTS

1. Receive report from previous shift noting specific date, using Data Collection Form for each Patient. Note specific data
   - Special and/or immediate nursing care requirements of particular Patients (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 Patient 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 Patient 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 Patients
   - Provide caregivers with guidelines for ongoing reporting of data to you for documentation
3. Make rounds. Introduce self and/or delegated caregivers to Patients. Check critical factors in each Patient's situation (eg: IV's dressings, catheters, etc) Assess needs of each Patient. (Refer to Observation Guidelines When Making Rounds)
4. Implement assigned Patient care tasks (medications, IV's , dressings, etc)
5. Maintain ongoing communications with the charge nurse, caregivers, Patients
6. Maintain up to date awareness of medical and nursing plans of care
7. Maintain ongoing documentation on Patient who are assigned to nursing assistants/nursing techs
8. Make rounds with the physicians caring for Patients when possible
9. Anticipate teaching needs for individuals in your Patient group
10. Give report on Patients in your group at change of shift.

Decision Making Model Algorithm:

1. ***Is the act consistent with your scope of practice as defined by the Board of Nursing's statutes and regulations?*** *(This may be all the information you need to make your decision. If not, continue to the next step.)* Resource documents you might need include:

   a. Nursing Practice Statutes: N.J.S.A. 45:11-23, 11-23, 46.;
   b. Delegation Regulations: N.J.A.C. 13:37-6.2;
   c. Standards of Nursing Practice from your professional nursing organization;
   d. The agency's accrediting body's regulations.

14. ***Is the activity authorized by a valid order, an in accordance with established institutional/agency or provider protocols, policies and procedures?*** The nurse is accountable for clarifying any order or treatment regimen believed to be inaccurate or contraindicated by consulting with the licensed prescribing practitioner, and notifying the prescribing practitioner when the RN makes a decision not to administer the medicine or treatment. If NO, the act is NOT within your scope of practice without the above. If YES, continue to the next step.

15. ***Is the act supported by research data from nursing literature and/or research from a health related field? Has a national nursing organization issued a position statement on this practice?*** If NO, the act is NOT within your scope of practice without the above. If YES, continue to the next step.

16. ***Do you possess the knowledge and clinical competence to perform safely?*** Documentation to validate your educational and clinical competence should be maintained for a four year period. If NO, the act is NOT within your scope of practice without the above. If YES, continue to the next step.

17. ***Is the act to be performed within accepted "standards of care" which would be provided in similar circumstances by reasonable, prudent nurses with similar education and clinical skills?*** Nurses are accountable for knowing and conforming to their scope of practice in the Nursing Practice statutes, Board regulations, and any other State and Federal laws impacting their practice. If NO, the act is NOT within your scope of practice. Performance of the act may place the patient and the nurse at risk. If YES, continue to the next step.

18. ***Are you prepared to assume accountability for the provision of safe care?*** If NO, the act is NOT within your scope of practice. If YES, you may perform the act based upon a valid order in accordance with the institution/agency or provider's established protocols, policies and procedures.

Reference: New Jersey State Board Of Nursing Fact Sheet: *Decision Making Model for Determining Scope of Nursing Practice June 4, 1999.*

GUIDELINES FOR MEDICATION ADMINISTRATION

1. Students must be knowledgeable about medication.
2. Students will use PDA resources to look up medication.
3. The student will look up the medication on a reputable on-line site or contact facility pharmacist in the case where the medication information is not available in PDA.
4. Students must follow the eight rights of medication administration.
5. Students must assess Patient's status related to specific drug therapy.
6. Students must appropriately communicate assessments and evaluations with regard to medications to RN Preceptor.
7. Students will make decisions with regard to withholding medications, continuing medications in cooperation with RN 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 RN Preceptor for administration of intravenous (adding large volume and secondary/piggyback solutions to an established intravenous line or capped IV), as well as intramuscular, and subcutaneous medication injections.
12. When competency has been established student may administer intravenous (adding large volume and secondary/piggyback solutions to an established intravenous line or capped IV), intramuscular, and subcutaneous medication injections with RN supervision.
13. Students may observe the checking and hanging of blood and blood productions.

STUDENTS MAY NOT ADMINISTER OR SIGN ADMINSITRATION FORMS FOR BLOOD OR BLOOD PRODUCTS.

14. Students may observe the administration of IV push medications.

STUDENTS MAY NOT ADMINISTER INTRAVENOUS (IV) PUSH MEDICATIONS.

15. Students will DOUBLE CHECK each dose of any "high risk" medication per hospital policy, to include, at a minimum the "PINCH" medications: potassium, insulin, narcotics/patient controlled analgesia, heparin, as well as digoxin. High risk medications will be checked and documented that check was completed with the RN Preceptor before administration.

STUDENTS MAY NOT ADMINISTER CHEMOTHERAPEUTIC AGENTS.

16. Students will check all dosage calculations with RN Preceptor before administering medications.
17. Students will check all newly transcribed medication orders with RN Preceptor before administering the medication.

STUDENTS MAY NOT TRANSCRIBE ORDERS.

STUDENT MAY NOT ACCEPT VERBAL ORDERS.

18. Students will document all medication administration immediately upon administration.
19. Students will follow the Institute for Safe Medication Practices (ISMP) *Acute Care Guidelines for Timely Administration of Scheduled Medications* to administer medications within 30 minutes before or after the scheduled time
20. Students will provide and document appropriate Patient teaching regarding medications.
21. Students are expected to communicate any questions about administration of medications with the RN 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
     - Patient behavior and mental status
     - Nursing care administered
     - Patient responses to medical and nursing care
     - Food and fluid intake
     - Preparation for discharge
     - Patient 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 Patient
   - 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 RN Preceptors should determine and comply with the co-signing policy of the hospital nursing service department
   - Verify accuracy and completeness of Patient documentation with RN Preceptor
   - For agencies with computerized information systems, students will review agency requirements and responsibilities for staff nurses and students during orientation