Northwest Technology Center
Practical Nursing
Clinical Nursing Guide

2020-2021

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GENERAL INFORMATION

The Practical Nursing of Northwest Technology Center has made an agreement with each agency's personnel regarding attendance, being familiar with the agency's rules and regulations, and by abiding by these rules and regulations when assigned nursing care in these agencies.

During the Practical Nursing, the student will have the opportunity to practice and build upon the principles and skills taught in the classroom and laboratory. Clinical experience will be obtained principally in nursing homes, hospitals, and clinics in Alva, Enid, Fairview and Okeene. A faculty member will be present in the facility at all times when students are practicing unless other arrangements have been made, in writing, by the program coordinator and the director of the clinical facility. Planned instruction and informal training opportunities will be provided daily. Students are expected to use initiative and be alert for learning experiences. Each student must put forth every effort to make the most of the clinical experience in order to gain greater knowledge in all areas of nursing.

A student may be reassigned to another clinical facility if it is deemed necessary for the optimal educational benefit of the student. This reassignment will be at the request of the faculty, not the student.

The first trimester will be devoted primarily to classroom and laboratory activities with limited experience in the clinical area. During the remaining two trimesters, the number of hours in the clinical area will be increased and the number of hours in the classroom will be deceased.

Counseling will occur as needed and evaluation reports will be given to the students to show their progress. Evaluations will be discussed between the clinical instructor and the student at each mid-trimester, at the completion of each trimester and as needed.

The faculty and students function under the guidelines of the care facility in which we practice:

- Random drug testing
- Universal/Standard precautions
- Students are responsible for their own behaviors

Assignment to Clinical Areas

Students may not change their clinical rotation assignments or clinical group.

Attendance

Communication with the faculty regarding an absence is critical in both the classroom and clinical site. Students should first contact the instructor prior to any absence/tardy. During a clinical rotation/assignment, the student must also contact the clinical facility per clinical instructor directions. Failure to do so may be documented by the faculty and may result in disciplinary action and be reflected in the student's evaluation/grade.

Students should document the date, time, name and title of the individual whom they notified, if speaking to an individual other than the instructor. Students may be requested to provide the instructor with this information (in writing) immediately upon return to school.

Unprepared or Unsafe Student

The nurse who is unprepared or unsafe puts not only self and other staff members at risk for injury but the patient as well. Examples of unprepared, unsafe, unprofessional and weak practice student are provided in the following paragraphs:

Unprepared Student

A student is considered unprepared if:

1. The student has not completed pre-clinical assignments.
2. The student does not have proper equipment in good working condition.
3. The student is not properly attired for rotation.

Unsafe Student

A student is considered unsafe if:

1. The student is unprepared for clinical rotation.
2. The student is practicing under the influence of any drug or alcohol that interferes with cognitive functioning.
3. The student is practicing outside the scope for their level of practice.
4. The student performs or attempts to perform procedures that have not be successfully checked off in skills lab and/or without supervision.
5. The student's actions could harm self and/or others.

Unprofessional Student

A student is considered to behaving in an unprofessional manner if:

1. The student fails to notify instructor or clinical facility if indicated of absence or tardiness.
2. The student performs in an unsafe manner.

3. The student violates patient's rights.
4. The student engages in activities that display disrespect of the client, facility, faculty, school or program.

Weak Practice Student

A student will be considered to have a weak practice if:

1. The student continues to have difficulty or inability to apply concepts to specific clinical situations.
2. The student is unable to organize care and document care.
3. The student is unable to prioritize care.
4. The student has difficulty or is unable to communicate with patient, family, peers or healthcare team members,
5. The student lacks preparation for skills or medication administration.
6. The student has difficulty or is unable to recognize significant laboratory or diagnostic results.

Procedure

Should a student be considered to be unprepared, unsafe, unprofessional and/or weak practice student, the following steps, but not limited to, will be followed:

1. The student may be removed from the clinical experience.
2. The student will receive a zero "0" for the clinical day.
3. The student will confer with the clinical instructor and/or PN Director.
4. An improvement plan will be implemented. The improvement plan will include:
   a. Explanation of specific problem.
   b. Action required to correct area of concern.
   c. Deadline for improvement plan. The length of plan will depend on severity of infraction.
   d. Action to be taken should the plan be met and area of concern be corrected.
   e. Acton to be taken should the plan not be met. The student will be subject to probation or dismissal.
   f. Signatures: student, Practical Nursing Instructor, Practical Nursing Director, and Assistant Superintendent should the situation warrant intervention.
5. The student will be placed on probation.
6. The student may be dismissed from the program immediately should the situation deem it necessary regardless of probation status.

If upon the request of clinical facility, a student may be removed from that clinical rotation. Should this request be based upon student's unpreparedness, unsafe or weak practice and/or unprofessional behavior, the above mentioned consequence and procedure will be followed.

Developed 6/2013; Revised 9/2014; 5/2015

Delegation of Responsibilities

The instructor in any one area is primarily responsible for students in that particular area.

When in a clinical area, students are responsible to the head nurse or the nurse in charge of the unit, as well as to the instructor or preceptor in that area.

The ultimate responsibility for the total nursing care of all patients and for the nursing service personnel is vested in the institution's Director of Nurses. The director's decisions are final in regard to patient care.

Performing New Procedures

When you are about to perform in the clinical area:

1. Read the procedure guidelines.
2. Assemble needed supplies.
3. Notify your instructor so that he/she will be present while you are performing the procedure.
4. Be prepared to explain step by step the procedure to your instructor and do so before entering the room. (NOT in the presence of the patient, client, resident, etc.)
5. Always keep the patient informed of what you are doing. The instructor will not talk for you.
6. Be prepared to debrief your performance with the instructor after you leave the patient's room.

Incidents and Errors

The following guidelines should be used in reporting incidents or errors:

1. All incidents or errors should be reported immediately to the instructor and to the nurse in charge of the unit. This is your ethical and legal responsibility.
2. The patient's doctor will be notified regarding the incident or error if deemed necessary by the nurse in charge or by the instructor. Comply and follow the agency or facility guidelines.
3. An incident or variance report will be completed by the student involved. This report goes to the designated clinical supervisor or administrator. A copy will be retained by the instructor and placed in the student's file.
4. If a student has a personal injury, he/she must report it to the instructor. An incident or variance report will be completed and copies filed with the cooperating

agency and the school. The student is responsible for all follow-ups and costs after an injury or exposure.

Remember it is vital to report incidents and errors immediately to the instructor and charge nurse. Contact the CDC for current body fluids/post-exposure guidelines. A Variance/Incident Report sample form is found on the following page. This will be used by the student should an incident or variance occurs.

VARIANCE/INCIDENT REPORT FORM

DATE_____
PLACE_____

DETAILED DESCRIPTION OF VARIANCE/INCIDENT

_____
_____
_____
_____

EXPLAIN HOW AND WHY VARIANCE/INCIDENT OCCURED

_____
_____
_____
_____

ACTION TAKEN CONCERNING VARIANCE/INCIDENT

_____
_____
_____
_____

SIGNATURE OF STUDENT DATE

_____

SIGNATURE OF INSTRUCTOR DATE

_____

SIGNATURE OF COORDINATOR DATE

Developed 6/2013

Student Participation and Contribution to the Clinical Area

Each student's primary goal should be to learn to be a safe, effective and dependable practical nurse. Evidence that the student is conforming to the following behaviors indicates the primary goal is being met:

1. Carry out those nursing duties which have been assigned by the instructor in a responsible, timely manner.
2. Be alert at all times to the needs and safety of patients. Report unusual conditions to your instructor and to the charge nurse.
3. Report all incidents and errors immediately to the instructor and nurse in charge and complete necessary documentation. This includes exposure to body fluids and blood-borne pathogens.
4. Follow all directions carefully. Take care to clarify any directions which were not understood.
5. Check with your instructor if you have any doubt about having knowledge, information, or skill necessary for an assignment.
6. Perform all procedures and skills under the supervision of the instructor until you have been authorized to perform the task alone; administer medications and perform invasive procedures only under the supervision of the instructor.
7. Make certain there is a written order on the patients' chart before you administer any treatments or medicines. This includes standing or routine orders.
8. Inform your instructor of procedures taught in class or laboratory that you have not had the opportunity to perform.
9. Confine eating to the designated area at the appropriate time. Maintain timely breaks.
10. Be responsible for finding and notifying the clinical instructor when you are wanting or needing to perform a new procedure, check on information, or be observed for a "check off" skill.
11. Use individual initiative to take the opportunity to learn.
12. Maintain a friendly and dignified professional relationship with patients/clients/ residents, families, peers, agency and facility supervisors, and school faculty.
13. Avoid social contact with patients and any non-professional discussion of patients.
14. Use the property of the health care facility correctly and carefully.
15. Contact the instructor when needing help or guidance in the clinical area.
16. Report to the instructor and the nurse that is in charge when leaving the clinical area. The student may not leave the clinical facility without the instructor's permission.
17. Follow the rules and regulations of the participating health agency.
18. Report on time to the appropriate clinical area. Students may be required to arrive at the clinical area before the regularly scheduled time in order to perform certain skills.
19. Maintain an up-to-date record of competencies (skills checklists).

20. Current copies of completed competencies will be on file.
21. Carry the clinical notebook with the skills performance list to the clinical area. If the list is lost, notify the instructor.
22. The instructor will verify skill competency at time of performance.
23. Demonstrate the ability to accept constructive criticism and profit from it.
24. Come prepared to the clinical area with all necessary equipment - pens, notebook, scissors, watch, and stethoscope, calculators, dictionary, functioning PDA, etc.
25. Restrict personal phone calls to emergency situations.
26. Cell phones for all personal calls may be used in designated areas during break times.
27. Initiate critical thinking and problem solving.
28. Under no circumstance will the student be allowed to take verbal orders from physician or primary care provider.

NOTE: The student may be scheduled for evening or night assignments with advance notice.

NOTE: The terms agency, facility and clinical may be used interchangeably in this handbook.

Clinical Appearance & Uniform Etiquette

The faculty at NWTC, in addition to teaching a marketable skill, contends that the school should help students realize that employers and society in general, demand personal characteristics in an individual, such as neatness and cleanliness. With that objective in mind, it is a requirement that all students be clean and neatly groomed at all times.

The student uniform has been designed to provide neat, comfortable attire which identifies you as a member of our school. The student uniform which is preselected will consist of:

1. A white T-shirt, tank top, or blouse may be worn under the uniform top. The top will also have the school insignia on it. The school insignia is to be placed on the left sleeve two inches below the shoulder seam.

   All nursing skirts must extend to the knee and all slacks or trousers must extend to the ankle. Slacks or trousers cannot have elastic bands or stretchy fabric at the ankles. Stirrup and/or cargo pants are <u>not</u> acceptable. All attire should be such that undergarments are not visible (avoid see-through material).

2. PN faculty will preapprove nursing shoes. No sandals, clogs, boots are allowed. If the student is uncertain as to whether certain shoes are appropriate, he or she should consult the faculty before purchasing the shoes.

3. The student should have at all times: a watch with a second hand, a pen, bandage scissors, a small notebook, and a stethoscope.

The Student Nurse Will:

1. Be neat and clean at all times.
2. Use good personal hygiene.
3. Wear the hair in a style that is **secured away from the face.**
4. Have hair that is neat and clean. Ponytail holders, bows, nets, snoods, and clasps that are overly decorative and brightly colored are not allowed.
5. Keep the fingernails short and well filed. Wear only light colored nail polish.
6. Maintain good posture.
7. Avoid wearing any type of large earrings and/or visible body pierced jewelry as well as cover body art. Body art such as tattoos will be covered. The student may use Band-Aids, clothing or cosmetics to cover body art.

The Student Nurse Shall Maintain a Professional Appearance:

1. The uniform should be clean and well pressed.
2. Undergarments are to be appropriate color to skin tone.
3. Stockings and socks must be free from holes and runners and immaculately clean.
4. Shoes and laces must be spotlessly clean. No clogs, sandals, open toed or open back shoes will be allowed.
5. School insignia and name identification must be worn during clinical experiences and community service activities related to Northwest Technology Center Practical Nursing Program.
6. Males must avoid an unshaven appearance. Beards and mustaches must be close-cropped and neatly trimmed in compliance with the regulations in the health care facilities.
7. If a lab coat is necessary, wear school lab coat only. This should be considered a part of the student uniform and maintained the same as the uniform. It should be clean, neat, and wrinkle-free at all times.
8. Uniforms are to be worn only in the classroom, clinical area, and to school-related activities. Protective clothing will be required in designated clinical areas (OB & Surgery)
9. If uniform etiquette is not appropriate, the student will be notified of such by the faculty and may be asked to leave the clinical area. He/she may be counted absent. The student will receive an administrative notice. The next offense will result in probation for the remainder of the school year. Continued offenses may result in dismissal.

The Student Will Not:

1. Use perfume, strongly perfumed body lotion, hair spray, or after-shave.
2. Chew gum in the clinical area.
3. Wear jewelry except for a watch and wedding ring and pair of small (1 carrot or less) stud earrings.

4. Use heavy make-up. (Lipstick and rouge should be a light shade and used sparingly.
5. Use snuff or chewing tobacco in the presence of the patient or when performing nursing procedures.
6. Wear artificial nails to the clinical area.

Blood Borne Pathogens

Please refer to the Exposure Control Plan.

Confidentiality

While the student is enrolled in the practical nursing program, the student will have clinical rotations. It is during these clinical rotations that the student will be exposed to confidential health information of clients. The student is responsible for maintaining a standard of strict confidentially in every respect of client care. The student must comply with the Health Information Privacy and Portability Act (HIPAA). The act sets standards for protecting client privacy. The student will receive HIPAA training and will abide its standards.

The student should not discuss or post any information about clients, family members, or any clinical facility on any electronic venue (i.e.: MySpace, Facebook, Twitter, cell phones, smart devices, etc.) The student will not save any client, family, or clinical facility information on any technology device. Client information may be discussed with the instructor and during pre/post conference. Students should keep all client-related discussions confidential.

It is the policy and responsibility of health care providers to protect the confidentiality of all client information to ensure that the interests of the client/resident are protected. During your clinical rotation time you will have access to confidential information of clients, physicians, and/or employees. This information is to be respected and not discussed in any manner with other clients, employees, or those outside the hospital.

Any information concerning the client's admission to a health care facility, care by a health care provider, condition of the client/resident, client chart or medical record information, the physician's orders, or the nursing care received by the client is not to be disclosed under any circumstances.

Any infraction of this policy is considered to be poor conduct, unacceptable, and a breach of ethics.

During my clinical time at assigned health care facilities, I understand and agree that I must hold client/resident information in strict confidence and not disclose any confidential information concerning clients, physicians, employees, and others. (Your signed HIPAA statement of understanding is kept by the program coordinator)

Substance Awareness Policy

Please refer to the Practical Nursing Handbook, pages 40-44.

Clinical Course Syllabi

Clinical Nursing 1

Course Title: Clinical Nursing 1

Course Allocation: 72 hours

Course Description:
Clinical Nursing I is an introduction to the clinical setting. It provides an opportunity for the student to apply knowledge and skills acquired in theory to the holistic care of the patient. Care will be provided to patients across the lifespan with a focus on the geriatric. Supervised clinical experiences may be provided in long term care, acute care and extended care facilities. These experiences include mastery of basic nursing skills.

Clinical Objectives:
1. Provide holistic care throughout lifespan.
2. Protect the health and rights of the patient.
3. Apply principles of patient confidentiality.
4. Communicate with patients incorporating interpersonal and therapeutic communication skills.
5. Comply with ethical, legal and regulatory frameworks of nursing and the scope of practice that is consistent with the Oklahoma Nurse Practice Act.
6. Assist in the implementation of established plans of care.
7. Implement nursing process to prioritize basic health care needs.
8. Perform skills at the expected competency level.
9. Identify nursing practice that supports safety and quality.
10. Provide basic health teaching.
11. Observe interdependent relationship among other health care team members.
12. Utilize information technology to provide care, reduce errors, and support nursing interventions.

Supervised Clinical Experience
Supervised clinical experience teaching methods include coaching/modeling, small group discussions and informal discussions with interdisciplinary team. Other methods include videos, instructional pamphlets, demonstration, re-demonstration and resources available at the clinical sites.

Methods of Evaluation:
Students are evaluated in the clinical setting in several ways:

A. The student will receive a skill rating. The instructor evaluates skills performed by the student in the clinical area. The instructor must check off skills during the clinical rotation. The student must receive a satisfactory rating to progress.

B. The student is required to turn in clinical forms on an assigned client(s) weekly. These are evaluated by the clinical instructor and are incorporated in their clinical evaluation grade.

C. Performance points are given on clinical evaluation forms. The performance grade is based on the nursing process. An 78 % or above must be obtained to successfully pass Clinical Nursing I and failure will result in dismissal from the PN Major.

Evaluation of students will include:
50% clinical performance
50% written assignment

Grades will be assigned within the parameter listed below:

A= 92-100	Outstanding
B= 84-91	Above Average
C= 78-83	Average
D or F = 77 or below	Not Passing
I	Incomplete

Developed 6/2013
Revised 3/2014; 1/2016

Clinical Nursing II

Course Title: Clinical Nursing II

Course Allocation: 228 Hours

Course Description: Clinical Nursing II focuses on the care in clients across the life span. The nursing care will coordinate with the concepts taught in the course, Nursing Care Across the Life Span 1. Clinical rotations will include: long term care, community health, and acute care.

Clinical Objectives:

1. Assists in the implementation of established plans of care.
2. Provides client centered care for clients throughout lifespan with non-complicated diagnoses with sensitivity, empathy and respect for the diversity of the human experience.
3. Protects the health, safety and rights of the client.
4. Provides basic health teaching for clients using established teaching plans.
5. Communicates with clients incorporating interpersonal and therapeutic communication skills.
6. Observes client confidentiality and professional boundaries.
7. Uses nursing process to make decisions and prioritize basic health care needs.
8. Shares an interdependent relationship with other health care team members for the purpose of improving client outcomes.
9. Supervises care provided by unlicensed assistants.
10. Participates in group process to promote the provision of nursing care.
11. Maintains competence and professional growth through life-long learning.
12. Participates in collecting client outcomes data.
13. Complies with ethical, legal and regulatory frameworks of nursing and the scope of practice that is consistent with the Oklahoma Nurse Practice Act.
14. Incorporates moral concepts and respect for diverse values and beliefs.
15. Communicates identified ethical dilemmas.
16. Participates as a team member in implementing standardized practice that supports safety and quality reducing harm to self and others.
17. Supports members of the health care team to be forthcoming about errors and near misses.
18. Implements principles of quality in carrying out basic care.
19. Performs skills in the competency level within the scope of practice for the practical nurse.
20. Utilizes information technology to provide care, reduce medical errors, and support health care interventions.

Supervised Clinical Experience
Supervised clinical experience teaching methods include coaching/modeling, small group discussions and informal discussions with interdisciplinary team. Other methods include videos, instructional pamphlets, demonstration, re-demonstration and resources available at the clinical sites.

Methods of Evaluation:
Students are evaluated in the clinical setting in several ways:

C. The student will receive a skill rating. The instructor evaluates skills performed by the student in the clinical area. The instructor must check off skills during the clinical rotation. The student must receive a satisfactory rating to progress.

D. The student is required to turn in clinical forms on an assigned client(s) weekly. These are evaluated by the clinical instructor and are incorporated in their clinical evaluation grade. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey will be integrated into the clinical reflection component.

C. Performance points are given on clinical evaluation forms. The performance grade is based on the nursing process. An 78 % or above must be obtained to successfully pass Clinical II and failure will result in dismissal from the PN Major.

Evaluation of students will include:
50% clinical performance
50% written assignment

Grades will be assigned within the parameter listed below:

A= 92-100	Outstanding
B= 84-91	Above Average
C= 78-83	Average
D or F = 77 or below	Not Passing
I	Incomplete

Developed 6/2013

Revised 3/2014

Clinical Nursing III

Course Title: Clinical Nursing III

Course Allocation: 216 Hours

Course Description: Clinical Nursing III focuses on the care in clients across the life span. The nursing care will coordinate with the concepts taught in the course, Nursing Care Across the Life Span 2. Clinical rotations will include: long term care, community health, and acute care.

Clinical Objectives:

1. Assists in the implementation of established plans of care.
2. Provides client centered care for clients throughout lifespan with non-complicated diagnoses with sensitivity, empathy and respect for the diversity of the human experience.
3. Protects the health, safety and rights of the client.
4. Provides basic health teaching for clients using established teaching plans.
5. Communicates with clients incorporating interpersonal and therapeutic communication skills.
6. Observes client confidentiality and professional boundaries.
7. Uses nursing process to make decisions and prioritize basic health care needs.
8. Shares an interdependent relationship with other health care team members for the purpose of improving client outcomes.
9. Supervises care provided by unlicensed assistants.
10. Participates in group process to promote the provision of nursing care.
11. Maintains competence and professional growth through life-long learning.
12. Participates in collecting client outcomes data.
13. Complies with ethical, legal and regulatory frameworks of nursing and the scope of practice that is consistent with the Oklahoma Nurse Practice Act.
14. Incorporates moral concepts and respect for diverse values and beliefs.
15. Communicates identified ethical dilemmas.
16. Participates as a team member in implementing standardized practice that supports safety and quality reducing harm to self and others.
17. Supports members of the health care team to be forthcoming about errors and near misses.
18. Implements principles of quality in carrying out basic care.
19. Performs skills in the competency level within the scope of practice for the practical nurse.
20. Utilizes information technology to provide care, reduce medical errors, and support health care interventions.

Supervised Clinical Experience
Supervised clinical experience teaching methods include coaching/modeling, small group discussions and informal discussions with interdisciplinary team. Other methods include videos, instructional pamphlets, demonstration, re-demonstration and resources available at the clinical sites.

Methods of Evaluation:
Students are evaluated in the clinical setting in several ways:

E. The student will receive a skill rating. The instructor evaluates skills performed by the student in the clinical area. The instructor must check off skills during the clinical rotation. The student must receive a satisfactory rating to progress.

F. The student is required to turn in clinical forms on an assigned client(s) weekly. These are evaluated by the clinical instructor and are incorporated in their clinical evaluation grade. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey will be integrated into the clinical reflection component.

C. Performance points are given on clinical evaluation forms. The performance grade is based on the nursing process. An 78 % or above must be obtained to successfully pass Clinical II and failure will result in dismissal from the PN Major.

Evaluation of students will include:
50% clinical performance
50% written assignment

Grades will be assigned within the parameter listed below:

A= 92-100	Outstanding
B= 84-91	Above Average
C= 78-83	Average
D or F = 77 or below	Not Passing
I	Incomplete

Developed 6/2013
Revised 3/2014

Clinical IV

Course Title: Clinical IV

Course Allocation: 96 Hours

Course Description: Leadership and delegation skills are enhanced as the student functions in the role of team leader. The course will prepare the student to independently assume the role of the LPN in professional practice; a preceptor rotation assists in the completion of this transition.

Specific Clinical Objectives:

1. Practices under the supervision or direction of a registered nurse or licensed physician.
2. Contributes to the assessment of the health status of individuals and groups.
3. Participates in the development and modifications of the plan of care.
4. Implements the appropriate aspects of the plan of care.
5. Delegates such tasks as may safely be performed by others, consistent with education preparation and that do not conflict with the Oklahoma Nurse Practice Act.
6. Provides safe and effective nursing care rendered directly or indirectly.
7. Participates in the evaluation of response to interventions.
8. Teaches basic nursing skills and related principles.
9. Performs additional nursing procedures in accordance with knowledge and skills acquired through education beyond nursing preparation.
10. Delegates those nursing tasks as defined in the rules of the Oklahoma Board of Nursing that may be performed by and advance unlicensed assistive person.

Transition into Practice Clinical:

Transition into practice clinical includes coaching and modeling, small group discussion and informal discussion with nursing staff and other health care providers as well as client care.

Methods of Evaluation:

The student will receive a performance grade. The performance evaluation will be completed by the clinical instructor with preceptor input. The performance grade is based on the nursing process. A 78 % or above must be obtained to successfully pass nursing clinical IV and failure will result in dismissal from the PN Major.

Evaluation of students will include

100% clinical performance

Grades will be assigned within the parameter listed below:

A= 92-100	Outstanding
B= 84-91	Above Average
C= 78-83	Average
D or F = 77 or below	Not Passing
I	Incomplete

Developed 6/2013
Revised 3/2014

Appendices

Appendix A – Facility Selection

Northwest Technology Center
Practical Nursing
Criteria for Selection of Clinical Facilities

Name of clinical facility _____

Date _____

Criteria	Yes	No
1. Subscribe to the mission of the program.		
2. Document proof of accreditations by an accrediting agency.		
3. Maintain an adequate daily census of clients with problems/ conditions in areas needed to meet the individual/program objectives.		
4. Supply adequate staff to care for clients and serve as role models for students.		
5. Maintain current reference manuals and allow students access to them. Includes students in on going staff education.		
6. Promote the development of rapport between the agency and the program.		
7. Communicate with the school on absentees and performance according to performance criteria		
8. Accept students without regard to race, national origin, gender, age, marital or veteran status or other qualified disability.		
9. Require expectations of students that are within the school philosophy and objectives.		
10. Provide an orientation to faculty and students prior to clinical experience.		
11. Provide adequate supplies and current equipment for student use.		
12. Maintains a written clinical agreement with the program.		
Comments:		

Adopted 5/2013; Revised 6/2013

Appendix B – Preceptor Selection

Northwest Technology Center
Practical Nursing
Criteria for Selection of Preceptor

Name of preceptor _____

Date _____

Criteria	Yes	No
1. Subscribe to the mission of the program.		
2. Current unencumbered licensure as a LPN.		
3. At least one year of experience in nursing.		
4. Current written clinical agreement with facility employed.		
5. Willing to supervise student.		
6. Maintains professional conduct.		
7. Communicate with the school on absentees and performance according to performance criteria		
8. Accept students without regard to race, national origin, gender, age, marital or veteran status or other qualified disability.		
9. Require expectations of students that are within the school philosophy and objectives.		
Comments:		

Developed 6/2013

Appendix C – Observation Objectives

STUDENT GUIDE FOR OBSERVATION CLINICAL EXPERIENCE

Responsibilities:

1. Faculty will assume primary responsibility for guiding student learning and evaluation of the student.
2. Staff will assist faculty in guiding student learning, supervising student practice, and evaluation of student.
3. Staff will assume primary responsibility for patient care.
4. Student's role is primarily observational. The student does not assume responsibility for patient care.
1. Student will write a paper answering the objectives. The student will write anecdotal notes about this rotation which will include:
   a. assisting with what procedures
   b. procedures observed
   c. what you liked and disliked about this area
   d. what you learned from this area
5. Student will reflect on the experiences through the reflective journal.
6. Student will ask the staff to utilize the professional rubric to communicate student's performance.
7. Student will turn in objectives, reflective journal and professional rubric in at a time designated by the instructor.
8. Student will notify the instructor and the facility if they are going to be absent or late.
9. Student will have a thirty minute lunch.

Developed 1/14
Revised 1/2017

Clinical Area: Home Health Care

Objectives: After completion of this rotation, the student with at least 78% accuracy will be able to:

1. Discuss the philosophy of home health care.
2. Explain eligibility requirements for home health.
3. Discuss how services can be obtained.
4. Discuss how services are implemented.
5. Discuss who pays for the services.
6. Explain what services are available, (i.e. neurological, cardiopulmonary, organ transplant, home ventilator)
7. Describe the role(s) of the personnel that are used in a home health setting.

Developed 1/14
Revised 1/2017

Appendix D –Supervised Clinical Objectives (Disciplinary Departments)

STUDENT GUIDE FOR SUPERVISED CLINICAL EXPERIENCE

Responsibilities:

1. Faculty will assume primary responsibility guiding student learning, supervising student practice, and evaluation of student.
2. Clinical staff will assist faculty in guiding student learning, supervising student practice, and evaluation of student.
3. Clinical staff will assume primary responsibility for patient care.
4. Student's role is primarily observational. The student does not assume responsibility for patient care.
5. Student is to assist clinical staff with procedures.
6. Student will notify instructor and facility if he/she is going to be late or absent.
7. Student will have a thirty minute lunch.
8. Student will write a paper answering the objectives. The student will write anecdotal notes about this rotation which will include:
   e. assisting with what procedures
   f. procedures observed
   g. what you liked and disliked about this area
   h. what you learned from this area
9. Student will reflect on the experiences through the reflective journal.
10. Student will ask the staff to utilize the professional rubric to communicate student's performance.
11. Student will turn in objectives, reflective journal and professional rubric in at a time designated by the instructor.

Developed 1/14
Revised 1/2017

Cardiac Catheterization Lab

Objectives: For Observational Clinical Rotation (1-4) For Supervised Clinical Rotation (1-8)

1. Review cardiac anatomy.
2. Describe hemodynamic monitoring.
3. Research protocols utilized for pre and post procedure assessment of the client.
4. Identify the role of the nurse in the cardiac cath lab.
5. Assist in determining client's physical and psychological readiness for cardiac catheterization.
6. Determine client's knowledge level of procedure.
7. Use therapeutic measures to decrease fear and anxiety in the client.
8. Assist with client care throughout the diagnostic procedure and recovery.

Cardiac Infusion

Objectives: For Observational Clinical (1-4) For Supervised Clinical (1-8)

1. Review cardiovascular anatomy.
2. Discuss the medications used in unit.
3. Describe the following:
    a. Indications
    b. Contraindications
    c. Complications.
4. Identify the role of the nurse in the cardiac infusion unit.
5. Assist the nurse in initiating, maintaining and discontinuing infusion.
6. Participate in the client assessment during prescribed therapy.
7. Determine client's knowledge of treatment.
8. Provide client education for health promotion and maintenance.

Developed 1/2017

Cardiac Rehab

Objectives: For Observational Clinical (1-4) For Supervised Clinical (1-8)

1. Review cardiac anatomy.
2. Identify the role of the nurse in the cardiac rehab.
3. Discuss the role of the client and family in rehabilitation.
4. Differentiate between acute and rehab phase of care.
5. Assist in determining client's physical and psychological readiness for cardiac rehab.
6. Participate with nurse in assess client during prescribed exercise.
7. Determine criteria used to initiate, continue or discontinue rehab session.
8. Provide client education for health promotion and maintenance.

Developed 1/2017

Emergency Department

Objectives:

1. List the services provided by the department.
2. Identify the responsibilities of the nurse to this service. How can he/she facilitate response to treatment?
3. Describe the recordings (charting) and /or requisitions involved in the service.
4. Describe **three** types of treatments observed and their purposes.
5. Identify infection control measures that are used in this department to prevent spread of disease.
6. Describe how to set up and administer O^2.
7. Describe the following procedures or treatments.
    a. EKG
    b. Trauma Assessment
    c. Hemorrhage

   d. Advance Life Support
8. Describe the disinfection and cleaning of equipment.

Developed 1/14
Revised 1/2017

Endoscopy

Objectives: For Observational Clinical (1-4) For Supervised Clinical (1-8)

1. Review normal gastrointestinal anatomy.
2. Identify the role of the nurse in the endoscopy unit.
3. Describe the function of the equipment.
4. Discuss the following:
   a. Indications
   b. Contraindications
   c. Diagnostic techniques
   d. Therapeutic techniques.
   e. Complications.
5. Differentiate the following types of scopes:
   a. Gastroscopy
   b. Colonoscopy
   c. Bronchoscopy
   d. ERCP (Endoscopic Retrograde CholangioPantography)
6. Participate in the preparation and recovery of the patient.
7. Prepare specimens collected.
8. Provide client education for health promotion and maintenance.

Developed 1/2017

Mental Health – Adult

Objectives:

1. Describe the role and responsibilities of the Licensed Practical Nurse in the inpatient/outpatient mental health facility.
2. Identify and describe one mental health disorder observed during this rotation, including behavioral characteristics, medical treatment, prognosis, and nursing interventions.
3. Describe the importance of therapeutic communication and the therapeutic relationship.
4. Define the term “therapeutic environment (milieu)”.
5. Describe the criteria for inpatient admission to a mental health facility.
6. Identify the components of the mental status examination.

Developed 1/2017

Mental Health - Pediatric Behavioral Unit

Objectives:

1. Identify 1 client per day to observe.
2. Demonstrate at least 5 communication techniques utilized to develop a therapeutic relationship with client.
3. Submit a 3-5 minute process recording with identify clients.
4. Discuss each of the following:
    a. Daily routines
    b. Counseling
    c. Client's security/safety
    d. Techniques used for behavior modification
    e. School attendance
    f. Play/activities
5. Provide medication information with nursing interventions for each medication prescribed for the identified clients.
6. Attend activities that identified client attends.
7. Provide a summary of each activity attended.

Developed 1/2017

Obstetrics/Gynecology

OB Teaching Plans

Instructions: To be prepared for clinical rotation in L&D, newborn and postpartum, you will write a teaching plan for each of the following topics. Be sure that each topic is covers all teaching points. You may write your information on index cards. As stated above the teaching plans must be completed and reviewed by clinical instructor prior to clinical rotation. If plans are not done or not done satisfactorily the student will not be allowed to clinical.

Teaching Plans:

1. Breast feeding
2. Bottle feeding
3. Umbilical cord care
4. Circumcision care
5. Newborn bathing/diapering
6. Postpartum care for vaginal birth
7. Postpartum care for cesarean birth

Developed 1/2014
Revised 1/2017

Operating/Recovery Rooms

Objectives:

1. Identify **three** preoperative drugs you observed being used and their actions.
    a. Describe how they affected the patient.
    b. What side effects might you expect from these drugs?
    c. What side effects, if any did you see from the drugs?
    d. List nursing implications for each drug. (May use pharm sheets)
2. Discuss the duties of the circulating nurse.
3. Discuss the duties of the scrub nurse.
4. Describe surgical procedures seen each day.
5. Explain purpose of mayo stand and back table.
6. Describe **four** basic safety precautions you observed being utilized intraoperatively.
7. Write a definition of surgical asepsis.
8. Give a description of recovery process in the patient who has been given a general anesthetic.
9. Identify three medications administered in the recovery room to include types of medications, routes of administration, dosages, actions, side effects, and nursing implications.
10. Write a brief general assessment of a recovery room patient including the following:
    a. Dressing
    b. Airway
    c. Level of consciousness
    d. IV
    e. Equipment
    f. Oxygen
    g. Vital signs
    h. Drains
    i. Medications
    j. Doctor orders
    k. N/G tubes
11. Discuss application of basic nursing skills in the care of the recovery room patient.
12. Discuss application of assessment skills in recovery room setting.
13. Discuss observation of staff nurses in the recovery room setting to include duties performed and nursing skills required.
14. Identify **four** basic safety precautions you observed being utilized in the recovery room.

Pharmacology

Objectives:

1. Explain what is meant by a controlled substance, and methods commonly used to safeguard controlled substances in the pharmacy.
2. Identify drugs that commonly require automatic stop orders with their classification and use.
3. Describe how the label of a drug container is checked with the medication order and how an obscured label should be changed.
4. List the information required in a medication order or prescription.
5. Explain the functions of the pharmacy, the role/responsibilities of the pharmacist and the pharmacy technician.
6. Identify quality assurance/control utilized by the pharmacy with regard to the client's medication administration.
7. Explain the differences between the chemical, generic, official, and brand names of medicine.

Developed 1/2017

Wound Care

Objectives:

1. Describe the protocol for treatment of a venous stasis ulcer.
2. Describe the protocol for treatment of an arterial ulcer.
3. Describe the protocol for treatment of various stages of pressure ulcer.
4. Describe the protocol for treatment of a diabetic foot ulcer.
5. Describe the protocol for treatment of a skin tear.
6. Describe the protocol for wound cleansing.
7. Contrast dressing materials (oasis, epigraft, skin grafting)
8. Explain the procedure and benefit of hypobaric oxygen therapy in wound management.
9. Discuss certifications for a wound care nurse. (What is required and optional)

Developed 1/2017

Appendix E – Professional Behavior Rubric

Northwest Technology Center
Practical Nursing
Professional Behavior Grading Rubric

Performance Levels: 0=Unacceptable (evidence indicates partial skills, ability, and/or knowledge base)
1=Acceptable (evidence indicates basic skills, ability, and/or knowledge base)
2=Competent (evidence indicates comprehensive skills, ability, and/or knowledge base)

Observation	Target	Level		
		0	1	2
Punctuality Organization Strives to meet expectations	✓ Attends work ✓ Arrives on time* ✓ Consistently prepared* ✓ Is focused and attentive			
Attitude Initiative Flexibility	✓ Demonstrates enthusiasm* ✓ Goes beyond minimum expectations* ✓ Accepts opportunities for improvement ✓ Takes responsibility for actions ✓ Is willing to engage in self-evaluation and reflection			
Poise Confidence	✓ Demonstrates confidence, poise, and body language*			
Works with and/or cares for Diverse Population	✓ Demonstrates a commitment to work with and effectively care for individuals of diverse social, ethnic and/or religious groups			
Appearance	✓ Dresses in clean, neat, and professionally appropriate attire			
Communication	✓ Speaks and writes clearly, using proper grammar, spelling, and punctuation ✓ Clearly conveys ideas when speaking or writing			
Professional Involvement	✓ Takes advantage of professional opportunities ✓ Seeks out opportunities for self-improvement*			
Professional Ethics	✓ Treats others with respect* ✓ Adheres to policies* ✓ Maintains an atmosphere of professionalism* ✓ Maintains confidentiality regarding client information*			
	Overall Performance			

*10 Things that require zero talent. Secrets2success.

Student Signature/Date Instructor/Preceptor/Date (if appropriate)
Revised 9/16

Appendix F – Student Performance

Northwest Technology Center
Practical Nursing
Clinical Nursing
Clinical Performance

Student _____ Week of _____

Criteria	2 = Meets criteria. Has need for minimal improvement. Requires occasional assistance.	1 = Meets criteria. Has need for moderate improvement. Requires frequent assistance.	0 = Does not meet criteria. Is unprepared or unsafe.
Data Collection			
℘ Performs head to toe data collection ℘ Recognizes normal vs. abnormal data ℘ Identifies sign and symptoms related to medical diagnosis			
Planning			
℘ Determines realistic client outcomes ℘ Plans interventions for abnormal signs/symptoms ℘ Prioritizes appropriate care to promote positive client outcomes (7 days for STG or with change)			
Implementation			
℘ Provides interventions safely ℘ Utilizes therapeutic communication ℘ Implements evidence-based practice in client care			
Evaluation			
℘ Applies clinical reasoning to address client health status			

℘ Clearly demonstrates nursing process (DPIED) in the provision of client care ℘ Intervenes on behalf of the client within professional boundaries of current level of education			
Documentation			
℘ Utilizes appropriate charting system to document client care provided ℘ Locates critical information in client's medical record ℘ Reports change in client status immediately ℘ Protects client rights involving health care			

- 5 points will be deducted per day for lateness. Assignments will be not accepted after 3 days late.

Total points _____/10 = %

_____ _____

Student/Date Instructor/Date

Revised 9/16

Appendix G – Reflective Journal

Practical Nursing Reflective Journaling Rubric

Week of _____

Category	Point Values 2	1	0
Content	Entry contains complete answers to ALL questions prompts.	Entry significantly misses key question prompts or does not answer important questions.	Entry has no connection to week's learning activities or clinical experiences.
Fluency	Entry has no more than 2-3 simple or basic grammatical errors.	Entry contains one or more sentence fragments, run-on sentences, or serious grammatical problems.	Entry contains several sentence fragments, run-on sentences, or serious grammatical problems.
Quality and Mastery of content	Answers reflect honest, thoughtful responses that are linked to the student's own life and experiences AND that go beyond just answering the questions by connecting the student's experiences to the chapter/course material.	Answers are vague, but appear to be sincere attempts to answer the questions; they demonstrate some understanding of course material, but the journal does not clearly connect the student's life to course content.	Answers are superficial and do not reflect thoughtful consideration or reflect important aspects of the student's life or experiences or are irrelevant to the issues in the journal or the chapter.
Submission	Journal submitted before or by deadline.	Journal submitted 24 hours after deadline.	Journal not submitted.

Score: Content (2 max. points) _____
Fluency (2 max. points) _____
Quality (2 max. points) _____
Submission (2 max. points) _____

Total: _____/8 = ____%

_____ _____
Student Signature/Date Instructor/Date

Revised 9/16

Name _____

My Reflective Journal for the week of _____

My “Ah hah” Moment (describe the moment)

Main Issue (explain the main issue)

Feelings, values, meaning (discuss your feelings, value conflict, and what this will mean to you)

Intent, actions, consequences (develop your plan of action to include your intention and consequences for failure to follow your plan.)

Impact on nursing practice (how will you use this opportunity to impact your nursing practice)

Revised 9/16
Appendix H – Documentation

Northwest Technology Center
Practical Nursing - Clinical Nursing– Holistic Care

Student Name _____ Week of _____

Criteria				Points Earned
Data Collection (20 points)				
System	Head to toe assessment	Yes	No	
Every 2 hours	Focused assessment	Yes	No	
Patient Interventions	Treatments, etc.	Yes	No	
Medical Diagnosis (1 primary)	Pathophysiology, signs and symptoms and treatment	Yes	No	
Medication	Purpose, drug action, top 5 side effects	Yes	No	
Laboratory (within the year)	Results with interpretation	Yes	No	
Planning (20 points)				
Nursing Diagnosis (2)	Did you discuss with your instructor? Does your data collection support the diagnosis?	Yes	No	
Short Term Goal (1 for each nursing diagnosis)	Is the goal objective, patient centered, measureable and timed.	Yes	No	
Long Term Goal (1 for each nursing diagnosis)	Is the goal objective, patient centered, measureable and timed.	Yes	No	
Implementation (20 points)				
Nursing Interventions (3 for each goal)	Are you taking action?	Yes	No	
Evaluation (20 points)				
Each goal evaluated	Was it met? How? Was not met. Why?	Yes	No	
Documentation (20 points)				
Goal Rationales	Did you explain why you chose that goal for this particular patient.	Yes	No	
Charting	Did you document data collected and each intervention with patient response?	Yes	No	
Total Points：Due the Monday at 8:30 am. 5 points per day will be deducted for lateness. Assignment will not be accepted after 3 days late.				

Comments:

_____ _____

Student/Date Instructor/Date

Revised 9/16