Grayson College
Vocational Nursing Program

VNSG 1360
Clinical I
Licensed Vocational Nurse Training

Fall 2020

This syllabus may be modified as deemed necessary by the instructor. Major modifications will be issued to the student in writing.

Revised 8-13-20 (AGC)

Grayson College
Vocational Nursing Program
VNSG 1360

Table of Contents

Course Hours: 3 credit hour course; 192 clinical contact hours.

Course Level: Beginning level, first semester vocational nursing course.

Course Description: A health-related work-based learning experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional.

WECM Course Outcomes: As outlined in the learning plan:
1. Apply the theory, concepts, and skills involving specialized materials, tools, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with the occupation and the business/industry and;
2. Demonstrate legal and ethical behavior, safety practices, interpersonal and teamwork skills, and appropriate written and verbal communication skills using the terminology of the occupation and the business/industry.

Differentiated Essential Competencies (DEC):   DEC are defined as Competencies determined by the Texas Board of Nursing on each level of nursing education that should typically be achieved by exit from the program. The competencies document the background knowledge which can be used upon exit from the program to progress from beginner to expert. The DEC framework consists of knowledge and clinical judgment and behaviors in the following four nursing roles: Member of the Profession; Provider of Client-Centered Care; Client-Safety Advocate; Member of the Health Care Team.
The GC VN Program utilizes the DEC in all clinical course evaluation tools and each level demonstrates progression in the clinical behaviors and judgments.
Information retrieved from http://www.bon.state.tx.us/nursingeducation/edudocs/dec-presentation.pdf on July 11, 2013

Course Outcomes:

Upon completion of VNSG 1360, the Vocational Nursing Student should have demonstrated ability to:
Member of the Profession:
1. Demonstrate beginning competency in the performance of basic, assigned nursing skills.
2. Demonstrate a beginning ability to use the nursing process a problem-solving concept.
3. Complete a care plan on an assigned client with the assistance of an instructor.
Provider of Client-Centered Care:
4. Provide basic nursing care to assigned client s in the long-term care setting under the supervision of a clinical instructor.
5. Apply nursing theory from VNSG 1502 to the care of client s in the long-term care setting.
Member of the Health Care Team:
6. Utilize basic communication skills in the laboratory and long-term care setting to communicate with others.
Client Safety Advocate:
7. Practice safe nursing practice in the laboratory and long-term care setting.
Differentiated Essential Competencies:
8. Achieve the Differentiated Essential Competencies for Level One as stated in the Summative Evaluation Tool.

Prerequisites:	Admission to the Vocational Nursing Program.
Co-requisite Courses:	VNSG 1502, VNSG 1304, VNSG 1360.

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Co-requisite Courses: VNSG 1502, VNSG 1304, VNSG 1360.
If a student is unable to complete one of the co-requisite courses, the student must drop/withdraw from all of the co requisite courses.
Students who fail one or more of the co-requisite courses must retake all of the co-requisite courses together again.
A student who fails a clinical course is not eligible to re-enter the Vocational Nursing Program.

Withdrawal/Drop Date: The last day to withdraw from this course is November 13, 2020
It is the student's responsibility to withdraw from the course by the final date in order to receive a "W" for the course. Students may receive a grade of "F" (fail) if they do not formally withdraw.

Required Texts:

Elsevier/Mosby
Chabner, D., (2018*). Medical Terminology a Short Course.* (8th ed.). St. Louis, MO., Mosby Elsevier. ISBN: 978-0-323-44492-7
deWit's. (2018). *Fundamental Concepts & Skills for Nursing.* (5th ed.). St. Louis, MO. Mosby Elsevier. ISBN: 978-0-323-39621-9.
Williams, (2019). *Basic Geriatric Nursing.* (7th ed). St. Louis, MO. Mosby Elsevier. ISBN: 978-0-323-55455-8.
Ladwig, G., & Ackley, B., (2016).
Mosby, (2016). *Mosby's Dictionary of Medicine, Nursing and Health Professions.* (10th ed.) St. Louis, MO., Mosby Elsevier. ISBN: 978-0-323-22205-1.
Skidmore, L. (2019). *Mosby's 2020 Drug Reference Book, 30ed.* St. Louis, MO. Mosby Elsevier. ISBN: 978-0-323661362.

Prentice Hall/Pearson
Burke, K., LeMone, P., Mohn-Brown, E., & Eby, L., (2015). *Medical-Surgical Nursing Care.* (8th ed.). Upper Saddle River, NJ. Pearson Education, Inc. ISBN: 978-0-13-338978-4.

F.A. Davis
Leeuwen, A., Poelhuis-Leth, D., & Bladh, M., (2016*). Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications.* (6th. ed.). FA Davis., Philadelphia, PA. ISBN: 978-0-8036-7495-0.

Cengage/Thomson – Delmar
Pickar, G.D.,Abernethy, A., (2013) *Dosage Calculations.* (9th ed.). Clifton Park, NY. Thomson Delmar Learning, ISBN: 978-1-4390-5847-3.

Wolters Kluwer/Lippincott, Williams & Wilkins
Nettina, S., (2018). *Lippincott Manual of Nursing Practice.* (11th ed.). Philadelphia, PA. Lippincott, Williams & Wilkins. ISBN: 978-1-496379948.
Kurzen, C., (2017). *Contemporary Practical/Vocational Nursing.* (8th ed.) Philadelphia, PA. Lippincott, Williams & Wilkins. ISBN: 978-1-4963-0764-4.
Timby, B. & Rupert, D., (2016). *Lippincott Review for NCLEX-PN.* (10th ed.). Philadelphia, PA. Lippincott, Williams & Wilkins. ISBN: 978-1-4698-4534-0.

Methods of Instruction: Instructor-supervised client care of adult clients in a long-term care facility; associated simulated clinical experiences in a laboratory setting; observation experiences in designated clinical sites, if assigned, and completion of clinical care paperwork; instructor-directed laboratory practice, demonstrations, and check-offs on nursing skills.

Clinical Hours: Clinical Hours are calculated for practice, demonstrations, check-offs, orientation, and all clinical days at the clinical facility. Therefore, clinical policies for attendance and tardies are applicable for all of these hours. Refer to the Attendance Policy in the Vocational Nursing Program Student Handbook.

Methods of Evaluation: 1. Clinical evaluations (weekly); Mid-term and Summative Evaluations, self-evaluations.

2. Direct clinical observation, feedback from Instructor, interdisciplinary team and clients at assigned facilities.
3. Laboratory practice and successful completion of check-offs within two attempts.
4. Ability to demonstrate competency in previously learned laboratory skills when working in the clinical facilities

Grading Criteria: **Pass/Fail Course**

Skills check-offs per criteria	Pass/Fail
Skills practice and demonstrations	Pass/Fail
Mandatory practice demonstrations	Pass/Fail
Daily Clinical Evaluation Tools	Pass/Fail
Mid-Term Evaluation	Pass/Fail
Summative Evaluation	Pass/Fail
Clinical Paperwork	Pass/Fail

Grading Scale: **Pass or Fail:**

Pass is defined as completion of all the criteria with a grade of pass or with a grade of satisfactory. Additionally, the student has adhered to the policies of the Vocational Nursing Program and of the clinical institution.

Fail is defined as inability to complete all of the criteria with a grade of pass or with a grade of satisfactory and/or the student failed to adhere to the policies of the Vocational Nursing Program and/or of the clinical institution.

Skills Lab Evaluation:

1. All skills demonstrations (check-offs), practice sessions and assignments must be satisfactorily completed within the designated time frame.
2. A passing lab grade includes successful demonstration of skills. Students are allowed two (2) attempts at successful skill check-off demonstration. A student will be allowed a third (3rd) attempt on two (2) skills in each semester.
3. Students who are unsuccessful on the second check-off attempt and are eligible for a third (3rd) attempt must complete documented remediation and wait until at least the following day to perform the third attempt.
4. A student who requires a third attempt will be observed and evaluated by two (2) faculty members.
5. Inability to successfully pass skills check-off demonstration within the allowed number of attempts will result in the requirement of the student to withdraw from all co-requisite courses in the VN program. Failure to withdraw by Grayson College's last drop date will result in a failing grade in the clinical course.
6. A student who withdraws from or fails a clinical course due to a Skills attempt failure will be eligible to reapply to the program the next year.

Mandatory Demonstrations: Mandatory demonstrations (demos) are not considered a formal check-off. However, if the student is unable to complete the demonstration adequately (based on the opinion and expertise of the clinical instructor and the criteria in deWit), the skill may then become a skills "check-off" that must be completed within two attempts.

VNSG 1360, Laboratory Skills
Check-offs and Forms   Master copies of all check-off forms are provided for students on Canvas.
Forms and equipment must be provided by the student.
Students who do not provide the correct equipment and forms will not be allowed to complete a check-off and the student will be credited for one unsuccessful attempt at check-off because of unpreparedness.

Long-Term Care Rotation: The assigned clinical rotation in the long-term care facility must be completed in its entirety. If a student is absent for one of the regularly scheduled clinical days, the student will be required to meet with the VN Program Director to schedule a make-up day or assignment prior to the end of the semester.

Course Schedule: The course schedule contains the laboratory practice times and check-off times and the clinical rotation days/times. The clinical/lab instructors will distribute the schedule during the first few days of this course. The semester calendar is posted on Canvas.

**Course Absence and
Tardy Policies:**   All policies on absences/tardies, as stated in the Vocational Nursing Program Student Handbook will be adhered to for VNSG 1360.
Students should access the handbook as needed during this course.

Special Needs Students: Students with special needs should contact the Disability Services Coordinator no later than the first week of classes, but as soon as possible. Please refer to the Grayson College 2019-2020 Catalog for further information**.**

Student Rights: Student rights are described in the GC Policy and Procedures Manual (Policy FL local) located on the college website at www.grayson.edu. A formal grievance procedure (Policy FLD local) is available if a student believes unfair treatment has occurred. The student should first meet with the course professor and then, if unable to resolve the differences, should file a written appeal to the Program Director or Health Sciences Chairperson in accordance with the grievance procedure. Whenever meeting with faculty or administrative personnel, students have the right to waive their privacy rights and request the presence of an additional person of their choice.

Title IX: GC policy prohibits discrimination on the basis of age, ancestry, color, disability, gender identity, genetic information, national origin, race, religion, retaliation, serious medical condition, sex, sexual orientation, spousal affiliation and protected veterans status.

Furthermore, Title IX prohibits sex discrimination to include sexual misconduct: sexual violence (sexual assault, rape), sexual harassment and retaliation.

For more information on Title IX, please contact:

- Dr. Molly M. Harris, Title IX Coordinator (903)463-8714
- Ms. Logan Maxwell, Title IX Deputy Coordinator - South Campus (903) 415-2646
- Mr. Mike McBrayer, Title IX Deputy Coordinator - Main Campus (903) 463-8753
- Website: http://www.grayson.edu/campus-life/campus-police/title-ix-policies.html
- GC Police Department: (903) 463-8777- Main Campus) (903-415-2501 - South Campus)
- GC Counseling Center: (903) 463-8730

For Any On-campus Emergencies: 911

Disclaimer: Grayson College is not responsible for illness/injury that occurs during the normal course of classroom/lab/clinical experiences.

Grayson College campus-wide student policies may be found at the following URL on the College website:
https://www.grayson.edu/currentstudents/Academic%20Resources/index.html

SCANS Competencies: **Appendix C**

Course Instructors:	Beverly Berni, RN, Full time Professor
	Lisa Fair, BSN, RN, Full time Professor
	Melinda Howard, RN, Full time Professor
	Colleen Coyle, BSN, RN, Adjunct Professor

Office Hours: As posted for each individual professor

Contact Numbers: Students may contact their clinical instructor via cell phone only for course related needs. Cell phone numbers will be issued to each clinical group, per Instructor discretion. Personal calls to instructors are not allowed.

Students should contact the VN Program Assistant at 903-415-2500 for assistance as needed.

APPENDIX A

STUDENT CLINICAL INSTRUCTIONS

CLINICAL FORMS

Students will provide nursing care for clients under the direction of a clinical instructor and should seek help from the instructor as needed.

Member of the Profession:
1. Demonstrate beginning competency in the performance of basic, assigned nursing skills.
2. Demonstrate a beginning ability to use the nursing process a problem-solving concept.
3. Complete a care plan on an assigned client with the assistance of an instructor.

Provider of Client-Centered Care:
4. Provide basic nursing care to assigned client s in the long-term care setting under the supervision of a clinical instructor.
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Member of the Health Care Team:
6. Utilize basic communication skills in the laboratory and long-term care setting to communicate with others.

Client Safety Advocate:
7. Practice safe nursing practice in the laboratory and long-term care setting.

Differentiated Essential Competencies:
8. Achieve the Differentiated Essential Competencies for Level One as stated in the Summative Evaluation Tool.

	Learning Activities/Behaviors
Behaviors to achieve the outcomes: Using Nursing Process: Physical Assessment	In the long-term care setting, each student will complete a daily physical assessment on one assigned client who will be referred to as the "Care-Plan" client. The physical assessment will be narratively documented. Students may be required to practice physical assessment skills on other residents per instruction of the clinical instructor.
Assessment of Cultural, Spiritual, Developmental, and Psychosocial Needs	Students will be required to assess and record the cultural, spiritual, developmental, and psychosocial needs of the care-plan client. These areas will be documented on provided forms Students must report changes in client status to the primary care nurse or the charge nurse in a timely manner.
Using Communication Skills: Reporting changes:	Students will initiate communication skills to receive report from the nurse and when assessing and caring for assigned clients. Students will report changes in the assigned clients to the primary care nurse in a timely manner. Students will communicate with assigned clients by initiating communication skills learned in the classroom setting.
Researching prescribed medications:	Students will research all prescribed medication on the care plan client and record on the Medication Form.
Gathering a Database Assessment: Report	Students will receive report on assigned clients using the provided form.

Assessment: Psychosocial	Students will complete a psychosocial assessment on the Care Plan Client.
Assessment: Medications	Students will review the MAR and make a list of medications on the Care Plan Client. Subsequently, students will research all medications and complete the required information in each medication as instructed.
Assessment: Chart Review	Students will complete a chart review on the Care Plan Client under the direction of the clinical instructor.
Problem Identification: Minimum Data Sheet, RN's Plan of Care	Students will locate the Minimum Data Sheet or the RN's Plan of Care and will identify the nursing diagnoses developed by the registered nurse.
Problem Identification: Identifying Abnormal Problems	Students will make a list of abnormal findings on the physical assessment form provided in the syllabus.
Problem Identification: Making a List of Problems	Students will make a list of problems identified by the registered nurse.
	Students will compile the data by listing the problems on the provided form in the clinical syllabus.
	Students will identify the two main disease processes and will complete the pathology window for each disease process under the direction of the nursing instructor.
Problem Identification: Prioritizing	Students will prioritize three problems using the provided schematic of Maslow's Hierarchy of Needs under the direction of the instructor.
Goals: Learning to set goals	Students will develop goals for the client that meet criteria for short-term goals.
Scientific Resources: Using research-based data Planning Nursing Care: Interventions	Students will use select interventions that are based on scientific evidence for each problem/diagnosis/goal.
Implementing: Implementing Nursing Care	Students will implement basic nursing care and skills in order to meet the goals and the needs of the client. Planned nursing interventions will be implemented. Students should follow the daily instructions of the clinical instructor.
Providing Basic Needs	Students in level one may provide the following care for clients in relationship to client needs: Hygiene, toileting, nutritional, hydration, mobility, activity, safety, skin, psychosocial, spiritual, cultural, developmental, and communication.
Implementing Basic Nursing Skills Safely	Students may safely implement any of the nursing skills learned in the level one nursing lab. First time invasive skills must be supervised directly by an instructor and can only be performed after successful check-off in the clinical laboratory setting.

Documentation	Students will document all care, using basic medical terminology using the format of the long-term care facility.
Implementing Policies and Procedures of Facility Following Agency Policies	Students will identify policy and procedure manuals in the long-term and acute care agencies and use them as needed when providing client care.
Client confidentiality/HIPAA	Students will maintain client confidentiality at all times and implement the HIPAA regulations concerning client privacy.
Positive Attitude	During the clinical rotations at the long-term care facility, students will maintain a positive attitude during their learning experiences.
Completion of required care plan	Students will demonstrate timeliness in preparing paperwork as assigned.
Summary of the role of the vocational nurse	Using the provided form, student will summarize the role of the vocational nurse in the long-term care setting.
Evaluation of short-term goals	After implementing the plan of care, the instructor and student will confer to determine if the short-term goals were met and if the nursing interventions helped the clients. Students will verbalize if the plan of care contributed to meeting the goals or did not. Students will verbalize how she/he would consult with the nurse in order to revise the goals and the plan of care.

Guidelines for Clinical Rotation at Long-Term Care Facility

ORIENTATION:	• Meet Client • Work with instructor to determine 2 main medical diagnoses for Pathology Windows	**Assignment of Care Plan Client** Complete Pathology Windows information on two main medical diagnoses
Week 1	• Get report, using Report form • Reintroduce self to client • Help with meals, hygiene, transporting, turning, etc. • Do FSBG as assigned • Perform a physical assessment each day • Document narrative daily physical assessments • Perform other skills under supervision of instructor • Create list of prescribed medications	**Assignment for Care Plan Client** **Submit Pathology Windows to Instructor** **on THURSDAY, OCTOBER 31** Research each prescribed medication and record information on Drug Form and submit to Instructor (Medication Sheet) **Submit Report Form and Medication Sheet(s) to Instructor** **on THURSDAY, NOVEMBER 7, 0830.**
Week 2	• Get report, use new form • Reintroduce self to client • Help with meals, hygiene, transporting, turning, etc. • Do FSBG as assigned • Perform physical assessment each day • Perform Psychosocial assessment • Document narrative daily physical assessments • Review chart for updates, save all data for care plan and record on form provided in syllabus • Perform other skills under supervision of instructor • Perform supervised check-off on physical assessment as assigned by instructor	**Assignment for Care Plan Client** **Due Next week:** Complete chart review and record information on the Data Sheet form Complete the Psychosocial Assessment Form All students should perform and document a daily physical assessment on their client by the end of each clinical day. **Submit all paperwork to Instructor** **on THURSDAY, NOVEMBER 14, 0830** **Other :** Check any performed skills on provided list. Research any abnormal data found in chart to gain understanding.

| Week 3 | • Get report, use new form
• Reintroduce self to client
• Help with meals, hygiene, transporting, turning, etc.
• Do FSBG as assigned
• Perform <u>physical assessment</u> each day
• Document narrative daily physical assessments
• Review chart for updates, save all data for care plan and record on form provided in syllabus
• Perform other skills under supervision of instructor
• Perform supervised check-off on physical assessment as assigned by instructor.
• Determine problem list using form provided in syllabus
• Determine 3 priority Problems
• Determine goals and nursing interventions for each problem while caring for client | **Assignment for Care Plan Client**
Due Next week:

Create a <u>problem list</u> and, using Maslow, or pertinent data,
Prioritize <u>three main problems</u>, using provided forms.

Select <u>goals/nursing interventions</u> for each problem identified that is appropriate for your <mark>pt.</mark> (client) You must be able to implement the nursing interventions on your client.

All students should perform and document a <u>daily physical assessment on their client</u> by the end of each clinical day.

Submit all paperwork to Instructor
on THURSDAY, November 21, 0830

<u>**Other:**</u>
Check any performed skills on provided list. Research any abnormal data found in chart to gain understanding. |
| Week 4 | • Get report, use new form
• Reintroduce self to client
• Help with meals, hygiene, transporting, turning, etc.
• Do FSBG as assigned
• Perform physical assessment each day
• Document narrative daily physical assessments
• Review chart for updates, save all data for care plan
• Perform other skills under supervision of instructor
• Perform supervised check-off on physical assessment as assigned by instructor | **Assignment for Care Plan Client**
Due Next week:

Implement and evaluate at least <u>2 nursing interventions for each problem identified.</u>

All students should perform and document a <u>daily physical assessment on their client</u> by the end of each clinical day.

Submit all paperwork to Instructor
on TUESDAY, DECEMBER 3, BY 1200 NOON.

Submit completed skills list to instructor for file. |

<u>**Reminders:**</u>

- Students must submit assignments on time. Failure to do so results in a clinical failure for the day.
- Students must complete all days of the long-term care rotation.
- Students cannot pass VNSG 1360 without completing the required days, hours and all assignments in a timely manner.
- Instructors will assist the students as needed. However, students will be expected to demonstrate initiative, and complete all assignments.

**These descriptions and timelines are subject to change at the discretion of the Professor.

Grayson College
Vocational Nursing Program
Care Plan Grading Criteria

Directions:

This is a pass/fail course. Grades are assigned to the care plan so that a determination can be made on whether the student was able to meet the criteria of 75% or higher on the care plan.

Students will be asked to redo the sections of the care plan if the initial grade falls below the 75% expected grade.
One attempt will be given. The student will be counseled on weaknesses prior to the second attempt in each section. However, no further attempts will be offered and the second grade will be final.

Any grade of 5 or a grade lower than 75% is a Fail (F) and will result in failure of VNSG 1360.

Grading Criteria on Care Plan Criteria and Paperwork Criteria:

All 8 = 100%   All 6 = 75%
All 7 = 88%   All 5 = 63%

Documents R/T Care Plan:

A grade of 8:	Submitted document (s) is complete, thorough, and provides sufficient information for safe client care.
A grade of 7:	Submitted document (s) is mostly complete and only lacking in a few areas of information for safe client care.
A grade of 6	Submitted document (s) lack completeness or sufficient information, and are not sufficient for safe client care and must be redone.
A grade of 5	Submitted document (s) was not submitted on time, contained little or no information, was not done and/or was poorly done indicating probable unsafe client care.

Grayson College
Vocational Nursing Program
Care Plan Grading Tool
Fall 2020

Student:_____ Date: _____

Students will be rated using the criteria tool on the previous page.

Criteria	8	7	6	5
Week 1 Assignments:				
Completed Report Form				
Completed two (2) Pathology Windows on client				
Completed Medication Sheets for list of medications				
Completed and documented head-to-toe physical assessment for each day				
Week 2 Assignments:				
Completed chart review and compiled on Data Sheet				
Performed Psychosocial Assessment and completed form				
Completed and documented head-to-toe physical assessment for each day				
Week 3 Assignments:				
Identified any changes of client condition on Report Form				
Created problem list using provided form				
Identified and prioritized 3 problems				
Selected goals and nursing interventions for each selected prioritized problem				
Completed and documented head-to-toe physical assessment for each day				
Week 4 Assignments:				
Identified any changes of client condition on Report Form				
Implemented at least 2 nursing interventions for each client problem				
Evaluated and revised, if necessary, Client Goals				
Completed and documented head-to-toe physical assessment for each day				

Comments:

Instructor Signature _____ Date _____

Student Signature _____ Date _____

Student: _____ **Date (s)**_____

Directions: Use this form on a *daily basis* and obtain the following information on your client in the long-term care facility **prior** to caring for the client. Request information from charge nurse or primary care nurse.

Major Medical Diagnoses: _____
_____
_____

Physical condition:

Interventions needed:

Safety needs:
Fall risk? Y   N

Safety interventions needed:

Psychosocial condition/orientation:

Psychosocial interventions needed**:**

Oxygen Needs:

Interventions for oxygenation:

Fluid Needs(Needs more/less fluids)

Interventions for fluids:

Nutritional needs, swallowing and/or ability to eat/special diets:

Interventions for nutritional needs:

Bowel/bladder needs:

Bowel/bladder interventions needed:

Mobility impairment/pain needs:

Mobility/pain interventions needed:

Hygiene needs:
Hygiene interventions for today: Bed bath, shower, whirlpool

Oral care

Peri-care:

Other:

Skin needs:

Current Skin Breakdown?   Y   N   Where?

Stage?

Interventions for skin:

Spiritual, social, cultural and developmental needs:

Spiritual needs and interventions:

Social needs and interventions:

Cultural needs and interventions:

Developmental needs and interventions:

Can the client communicate?

Interventions for communication:

Reminder: Problems identified on this report form will need to be prioritized and become part of the Problem list for your client.

Grayson College
Vocational Nursing Program
Psychosocial Assessment

Student :_____   **Date:** _____

Mental Status:	YES	NO
Able to communicate with nurse	_____	_____
Limited communication with nurse	_____	_____
Orientation:		
Person	_____	_____
Place	_____	_____
Time	_____	_____
Able to follow conversation with nurse	_____	_____
Recent memory intact	_____	_____
Long-term memory intact	_____	_____
Relationships:		
Family visits are regular	_____	_____
Eats with others	_____	_____
Able to join social events	_____	_____
Talks about family/friends	_____	_____
Cultural:		
Has specific cultural needs related to race	_____	_____
Has personal pictures and objects in room	_____	_____
Verbalizes about pictures and objects	_____	_____
Has specific patterns specific to client	_____	_____
Demonstrates masculinity or femininity	_____	_____
Spiritual:		
Religious objects are displayed in room	_____	_____
Speaks about spiritual issues	_____	_____

After caring for the client, determine if there are any Psychosocial problems and select a goal and 3 interventions for the client.

Grayson College
Vocational Nursing Program
Chart Review Data

Student: _____ _____ Date: _____

1.   Significant recent orders or medications changes in orders:

2.   Health Care Provider's most recent notes in chart:

3.   Most recent nurse's notes, significant data:

4.   Problems identified in chart for client (See minimum data sheet or nursing plan of care, etc) and summarize major problems:

Student: _____ **Date:** _____

5.   Lab Results, list most recent and only abnormal results (Research meaning later)

6.   Physical assessment, list only abnormal results:

7.   Mental Assessment, list only abnormal results:

Remember, an abnormal result or finding indicates <u>PROBLEMS</u> that affect the client and the care that the nurse must provide. Some of this information may be pertinent for the nursing plan of care.

Select the two most important medical diagnoses. Use the center pane for a brief definition of the disease. Use the remaining panes to record important data and nursing care from the required texts. Copy as needed.

Medications	Nutritional Aspects	Labs/Diagnostic Tests
Typical Causes	Name of Disease/Short Definition	Signs and Symptoms
Nursing Care Monitoring (Assessment)	Nursing Care Supportive Care (Interventions)	Nursing Care (Client Teaching)

Reference Source: Title of Text_____

Authors:_____

Students should use Burke as the primary resource for the pathology window. Lippincott Manual of Nursing Practice can be used in the clinical setting as a quick resource.

Permission must be obtained in advance from the Instructor to use other resources.

Grayson College
Vocational Nursing
Medication Sheet

Medication (generic name)	Classification and ACTION of drug	Nursing Interventions	Expected Outcome of medication	Priority Assessment(s) Prior to Administration

Grayson College
Vocational Nursing Program
Physical Assessment Guide

Use this as a guide for normal and abnormal assessment findings.

General observations/subjective data:

Normal Findings	Abnormals (Problems)
Awake, alert, oriented x3, speech clear, appropriate	Difficult to arouse Confused Comatose Drifts in and out of consciousness Speech garbled Speech clear, but inappropriate Not oriented to all 3 areas
Breathing relaxed, easy, regular, no oxygen, no apparent cough, no audible adventitious lung sounds	Breathing distressed, labored Works hard to get air Uses accessory muscles Uses oxygen Actively coughing Audible wheezing or congestion
Color pink or mucosa pink	Pale, ruddy (red), cyanotic
No distress or pain	C/O pain (assess) Grimacing or other indicates pain
Hearing intact No hearing aid	Cannot hear spoken word (assess degree of difficulty) Wears hearing aid.
Clean, well kept appearance, Appears well nourished	Disheveled, unkempt Has odor Thin, or very obese Frail
Moves, ambulatory	Appears to have difficulty with movement on initial survey Known bedbound or Wheelchair bound client

Head, Neck

Normal Findings	Abnormals
No visible facial drooping	Facial drooping
Eyes PEARRLA	Unequal pupils, non-reactive
No drainage, nose, ears	Drainage present
Oral cavity, pink, moist	Color pale, red, cyanotic
Turns neck side to side	Unable or limited neck movement

Chest: Lungs, Cardiovascular

Normals	Abnormals
Lungs clear, A, P and lateral Breathing, regular, Unlabored States no coughing	Crackles (fluid) Course (congestion) Wheeze (high-pitch, narrow Diminished Absent Cough, if so assess sputum, cough
Breathing unlabored, regular Normal: 12-20	Irregular: Fast, slow, shallow, Apnea periods
Chest shape normal	Barrel chest, scoliosis, kyphosis
Heart rate regular, strong 60-100 bpm, apical	Irregular, slow, fast, distant, bounding; difficult to auscultate
No murmur	Murmur (swish)
States no chest pain	Chest pain. If so, assess

Abdomen/Bladder/Bowels: Look, listen, feel

Normals	Abnormals
Flat, non-distended Describes recent BM No problem with urination No scars or wounds present	Appears distended, tight, firm Concave from malnutrition. Convex from obesity States pain, assess Problems stated with BM or urination Wound-if so assess Scar-if so, assess why
Active bowels sounds in All quads	Bowels sounds absent in any/all quads
Soft to palpation in all Quads, no stated pain, Bladder non-distended	Distention Pain-if so assess Bladder distended
No catheter No incontinence	Catheter present (Assess) Client incontinent (Assess)

Genitalia/Reproductive:

Normals	Abnormals
No redness, rash, odor, no stated pain	Areas are reddened States pain
No drainage from meatus, rectum, vagina	Drainage present (describe and get subjective data)
No odor from orifice (s)	Odor present
No wounds, drains	Has wound or drain
No catheter	Catheter present (assess Insertion area)

Periphery: Arms, Legs, Feet, Pulses, Mobility:
Genitalia/Reproductive:

Normals	Abnormals
Radial pulses present, hands warm, equally strong, Cap refill < 3 sec Has feeling in hands	Pulses 1+ or absent, hands cool, w weakness present Cap refill > 3 sec Numbness, tingling
Moves arms freely, ROM present	Limited ROM Cannot move at all Contractures Pain with movement, weakness Limited movement
No IV in either arm/hand	IV present (Assess site & fluids)
Pedal pulses present, feet warm, equally strong, Cap refill <3 sec Has feeling in feet	Pulses 1+ or absent, feet cool, w weakness present Cap refill > 3 sec Numbness, tingling
Moves feet/legs freely, ROM present	Limited ROM Cannot move at all Contractures Pain with movement, weakness Limited movement
Ambulatory Steady Gait	Bedbound, total care Up in chair only wheelchair without help Wheelchair with help Contractures Unsteady gait or fall risk

Skin/Nutrition/Fluid:

Normals	Abnormals
Assess all of skin for: Warmth, color, moisture, Breakdown, wounds, Special conditions	Cool, cold, hot Dry, diaphoretic, clammy Redness, break in skin of any kind, Any wound or pressure ulcer and any risk for wounds
Nutrition/Fluids Labs normal: albumen, CA, NA+, MG+, H & H, Cr, BUN, Iron, K+ Skin turgor (tongue) moist, pink, no furrows Takes meals, drinks fluids Blood glucose normal (70-110) Intake and output equal	Abnormal labs Tongue dry, furrowed Eating is poor with percentage low Unable to drink or drinks little Blood glucose low or high Diabetic Tube feedings Output approximately equal to intake
Body weight WNL and has not significantly ↑ or ↓	Body wt has ↑ or ↓ significantly

➢ Prioritize and list **10 important problems** from the database, include r/t and AEB for each.
➢ Use Maslow to choose these problems and include safety issues.
➢ **Then highlight the three most important problems, in your opinion, based on your client's data and assessment**

Directions: Circle yes or no and for the identified problem in this area. Review your entire database, including the physical assessment and medications in order to determine problems.

	Problem?		Evidence
Oxygen	Y	N	
Fluid	Y	N	
Nutrition	Y	N	
Safety	Y	N	
Skin	Y	N	
Bowel/Bladder	Y	N	
Mobility/Comfort/Pain (Circle)	Y	N	
Self care deficits	Y	N	
Spiritual needs	Y	N	
Cultural needs	Y	N	
Psychosocial needs	Y	N	

Fill in all areas completely.

<u>Problem 1</u>

Identified
Problem_____R/T_____
AEB
_____

Goal: Client will _____

By _____

Nursing Interventions to achieve goal:

Intervention   Rationale
1.

2.

3.

4.

5.

Meds/ labs/diagnostic tests R/T problems (List abnormal labs that relate to problem):

<u>Evaluation:</u>
Goal #1:
Did client meet the goal?   Y   N

If no, what needs to be changed so that client can improve in the problem area?

Problem 2

Identified
Problem_____R/T_____
AEB
_____

Goal: Client will _____

By _____

Nursing Interventions to achieve goal:

Intervention   Rationale
1.

2.

3.

4.

5.

Meds/ labs/diagnostic tests R/T problems: (List abnormal labs that relate to problem):

Evaluation:
Goal #2:
Did client meet the goal?   Y   N

If no, what needs to be changed so that client can improve in the problem area?

Problem 3

Identified
Problem_____R/T_____
AEB
_____

Goal: Client will _____

By _____

Nursing Interventions to achieve goal:

Intervention   Rationale
1.

2.

3.

4.

5.

Meds/ labs/diagnostic tests R/T problems: (List abnormal labs that relate to problem):

 Evaluation:
Goal #3:
Did client meet the goal?   Y   N

If no, what needs to be changed so that client can improve in the problem area?

Reference for interventions: Text:_____Author:_____

The following pages contain the weekly clinical evaluation form.
- Each nursing instructor will complete a weekly evaluation of the student at the end of the clinical week.
- **Students must also use the same form to submit a "self-evaluation" of each week's performance.**
- All clinical evaluation forms are "Pass" or "Fail". Students must receive a "Pass" on all weekly clinical evaluation forms in order to pass VNSG 1360.

<u>**Criteria for Pass and Fail:**</u>
"Pass" is defined as no more than 2 unsatisfactory grades by the instructor each day.

"Fail" is defined as <u>more than 2 unsatisfactory grades</u> by the nursing instructor **OR** failure to correct a previously identified unsatisfactory grade. <u>More than **two (2)** weekly evaluations with a grade of "Fail" will result in failure of VNSG 1360.</u>

The instructor will counsel all students receiving unsatisfactory scores and a probation form will be completed following all policies in the Grayson County Vocational Nursing Program Student Handbook. Progressive improvement to improve in all unsatisfactory areas must be demonstrated by the date designated on the probation form.

<u>**Scoring Criteria:**</u>

- **Satisfactory (S)** indicates that the student's overall performance for the assigned area and/or client was adequately performed for the first clinical level. No major problems occurred. The student performed professionally at a beginning level in all areas of nursing assessment, planning, implementation and evaluation of client s. Skills, if applicable, that were performed previously in lab were successfully performed on the nursing unit.

- **Needs Improvement (NI)** indicates that the student attempted to perform the assignment proficiently but lacked the ability to completely achieve desired goals for the shift. The student maintained professionalism, but needs to strengthen a few areas in nursing assessment, planning, implementation and/or evaluation of client s. Skills, if applicable, that were performed previously in the lab, were problematic when performed on the nursing unit. Comments to assist the student are helpful.

- **Unsatisfactory (U)** indicates that student's performance was inadequate in several areas of nursing assessment, planning, implementation and/or evaluation. Examples for this score include, but are not limited to: Unsafe client care, violation of institutional policies, unprofessional attitude, total inability to complete assignments, unpreparedness, failure to seek help as needed with client care, or failure to report a change in client status to the charge nurse or clinical instructor. Skills, if applicable, performed previously in the lab, were performed in an unsafe manner that compromised the safety of the client.

- **Not Applicable (NA)** indicates that the student was not assigned to perform the specific criteria of the evaluation form.

Student: _____   **Date(s)** _____

Please rate the performance in the following areas and make comments as needed. Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U) or Not Applicable (NA).

Criteria	S	NI	U	NA
Member of the Profession:				
Takes report from the nurse daily; Reports off to the nurse daily.				
Completes assigned assessment in a conscientious manner daily.				
Demonstrates assertiveness with communication when needed with the health care team.				
Communicates therapeutically with assigned client.				
Helps other students and members of the health care team.				
Works congenially with unlicensed assistive personnel.				
Reports to primary care nurse or charge nurse.				
Provider of Client-Centered Care:	S	NI	U	NA
Provides basic nursing care to clients in a safe manner following established guidelines.				
Demonstrates an ability to apply principles of physical assessment to assigned client.				
Documents physical assessment appropriately for client.				
Seeks help to identify abnormal physical assessment findings.				
Implements principles of hygiene, infection control and safety.				
Provides holistic care for assigned client.				
Implements steps of nursing process, as assigned, for care plan.				
Completes other assignments on nursing unit as required daily.				
Practices confidentiality.				
Reports problems and abnormal findings to nurse.				
Client Safety Advocate:	S	NI	U	NA
Maintains safe environment; identifies unsafe environment and corrects it.				
Reports unsafe conditions.				
Follows facility policies.				
Asks questions or seeks help as needed to practice safe nursing.				
Member of the Health Care Team:	S	NI	U	NA
Works under supervision of the nurse or clinical instructor.				
Seeks help from unlicensed assistive personnel when needed.				
Evaluates self on ongoing basis to improve performance.				
Demonstrates flexibility to changes.				
Follows facility policies; follows GC polices.				
Arrives on time each day.				
Submits required paperwork completed as instructed				

Continued

Please list skills that have been accomplished for this week and then record on Basic Skills List:

_____

_____

_____

_____

_____

_____

_____

Students must record the list of basic skills that have been accomplished by circling the skills on the Basic Skills List Form. This form will become part of the student's file.

Unusual occurrences or situations: (N/A IF NOT APPLICABLE)

_____

_____

_____

_____

_____

_____

_____

_____

Corrective plan of action: (N/A IF NOT APPLICABLE)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Re-evaluation or other action needed: (N/A IF NOT APPLICABLE)

_____

_____

_____

Instructor: _____**Date:** _____

Student: _____ **Date:** _____

The Clinical Instructor will complete the following graded form at the end of the long-term care rotation. The grading will be based on the daily/weekly evaluation forms, direct observation and on the submitted required paperwork. The grade must total 75% or higher in order to receive a "Pass" for the course. Students who do not achieve a 75% or higher on the summative evaluation will receive a "Fail" for the course. Students must also receive a "pass" on each daily/weekly evaluation form in order to pass this course.

Directions:
> Each student will have a graded evaluation of clinical performance at the end of the clinical rotation (summative evaluation).
> **Behavioral areas rated as "5" at midterm or at the end of the semester will automatically result in failure of VNSG 1360.**
> Students with scores of "6" in any of the behavioral areas will be counseled and remediated as deemed necessary by the clinical instructor.
> **Each student will also be required to do a self-evaluation using the same summative evaluation tool.**

Grading:
> The instructor will total the number of criteria for each student, excluding any N/A areas. This number should be multiplied by 8 for the total number of possible points.
> For the student's grade, the instructor will total all columns on each page, then add all page totals for a final total.
> This final total will be divided by the total number of possible points to determine the percentile grade.
> A letter grade be then be assigned according to the standard grading criteria of Grayson College VN Program. Students must receive 75% or higher in order to "Pass".
> Students are not issued a letter grade for VNSG 1360. The final grade will be pass or fail. The numerical grade or letter grade is issued to students to assist them in determining the quality of their performance during the clinical rotation.

Rating scale:
8: *Behavior for outcome demonstrated excellence and strengths that are above average. Student consistently performed above what is expected for a first semester student. Exceeded expectations.*

7. *Behavior for outcome is met. Student consistently performed professionally and met the objective. Meets expectations for first semester student.*

6. *Behavior for outcome is weak. Student had periods of inconsistency and lacked direction, knowledge and/or motivation. Does not meet expectations for first-semester student.*

5. *Behavior for outcome was consistently not met. Student was mostly inconsistent and did not demonstrate the level of a first-semester student.*

Examples of Grades:

All 8s = 100%   All 6s = 75%
All 7s = 88%   All 5s = 63%

Expected Clinical Behaviors Based on Differentiated Essential Competencies

Student: _____ Date: _____

Criteria:					
Member of the Profession	**8**	**7**	**6**	**5**	**NA**
Functions under the supervision of the clinical instructor and assigned charge nurse in the long-term care facility.					
Follows policies and procedures of assigned facility.					
Consults clinical instructor or charge nurse about policies, orders or procedures that may not be in the client's best interest.					
Displays an awareness of the policies of the assigned facility; locates policies as needed for reference and implementation.					
Performs a cultural, spiritual, and developmental assessment on assigned client using provided tool.					
Recognizes the role of the unlicensed assistive personnel and recruits assistance as needed from the UAP.					
Performs self-evaluation daily in order to improve performance.					
Identifies areas that require quality improvement or safety enhancement.					
Maintains professionalism in appearance, communication skills, competencies, and knowledge of legal aspects of nursing and standards of care.					
Provides holistic care to geriatric client s.					
Accepts constructive advice from other professionals readily and demonstrates flexibility to self-correct weak areas.					
Communicates in a collegial manner with the assigned unlicensed assistive personnel, medication aide, and other members of the health care team during client care.					
Recognizes the role of the vocational nurse in the long-term care setting and practices within boundaries of role, asking questions as needed for clarification.					
Helps others students and members of the health care team.					
Follows policies in Grayson College VN Student Handbook and VNSG 1360 syllabus.					
Provider of Client-Centered Care	**8**	**7**	**6**	**5**	**NA**
Demonstrates an ability to interpret a MAR, orders, organization of a chart, client history, and recording systems at the long-term care facility.					
Demonstrates an ability to use a structured tool to perform both physical assessment and focused assessment as needed.					
Reports significant abnormal findings from physical and focused assessments and validates findings with nurse or clinical instructor. Documents findings.					
Demonstrates a beginning ability to use the nursing process as a problem-solving approach for decision making regarding holistic client care by completing a first nursing plan of care on an assigned client with the help of the clinical instructor.					
Completes each section of the care plan on assigned days in a timely manner.					
Discusses need for changes or modifications to plan of care as needed with clinical instructor.					
Researches scientific data and current data on disease prevention and health promotion for plan of care using provided curriculum resources.					
Identifies priorities concerning basic, predictable health care needs for client s using Maslow's Hierarchy of Needs.					
	8	**7**	**6**	**5**	**NA**

	8	7	6	5	NA
Implements developed plan of nursing care to assist client s with basic physical and psychosocial needs.					
Performs previously learned nursing skills in a conscientious and correct manner on actual client (s) under supervision of instructor.					
Reports legal and ethical concerns as needed to the charge nurse, primary care nurse or clinical instructor.					
Demonstrates a beginning ability to recognize normal and abnormal symptoms and signs of crisis in the assigned long-term care client and seeks help when uncertain.					
Assists, as needed, with implementation of teaching plans for client s with predictable health care needs under the supervision of the nurse or clinical instructor.					
Demonstrates fiscal accountability through cost-containment efforts.					
Demonstrates an understanding of the role of the vocational nurse to work under the supervision of an RN when assigned to a long-term health care facility.					
Provides client care on one assigned client, assists with other students' client s as needed, and answers call lights.					
Determines the role of the charge nurse in the supervision of the vocational nurse and UAPs.					
If needed, initiates rapid, emergency care for client s and calls for help.					
Researches prescribed medications on assigned client using a standardized drug text and records data on medications on provided tool.					
Monitors for possible adverse effects of the prescribed medications.					
Uses technology in assigned facility effectively, if applicable.					
Maintains and facilitates client confidentiality.					
Demonstrates an ability to provide basic nursing interventions and skills in a safe manner following established guidelines in the following areas of need:					
A. Hygiene					
B. Toileting					
C. Nutrition/fluid					
D. Mobility					
E. Activity					
F. Safety					
G. Skin integrity					
H. Psychosocial, spiritual, cultural areas					
I. Communication					
Using evidenced based resources, determines measurable, reasonable outcomes that are short-term for the assigned client for the nursing plan of care.					
Confers with primary care nurse to evaluate client s, as needed, and to update nursing plan of care and interventions.					
Refers client to resources within the long-term care facility, as needed, for client's physical and psychosocial needs, with the help of the charge nurse.					
Client Safety Advocate	**8**	**7**	**6**	**5**	**NA**
Attends orientation for assigned facility and completes training on technological equipment, policies, and other equipment.					
Identifies unsafe environmental or client care conditions and reports them.					
Uses Standards of Nursing care, Texas Nursing Practice Act and Texas Board of Nursing rules as basis for practice in vocational nursing.					
Accurately identifies client s per policy prior to care, procedures, treatments, and nursing skills.					
Implements safety measures to prevent risk of harm to client s from errors or injury.					
Informs clients of plan of care to ensure consistency and accuracy in care.					
Assists in formulation of goals and outcomes to reduce the risk of infections at the facility.					
	8	7	6	5	NA

	8	7	6	5	NA
Implements measures to prevent exposure of self, client s, and others to infectious pathogens and communicable conditions.					
Implements infection control policies.					
Seeks help when encountering unfamiliar equipment or opportunities for implementing new nursing skills.					
Reports unsafe practices using appropriate channels of communication.					
Follows facility policies and locates policies on assigned unit.					
Member of the Health Care Team	**8**	**7**	**6**	**5**	**NA**
Initiates prepared teaching under supervision of clinical instructor, primary care nurse or charge nurse.					
Works and communicates with charge nurse, primary care nurse, unlicensed assistive personnel, and other members of the health care team as needed.					
Respects the privacy, dignity and confidentiality of client s. Implements HIPAA.					
Assists in quality improvement activities at assigned facility as required.					
Obtains report when reporting on and provides report when going off shift to provide transition in care.					
Manages conflict, if applicable, through correct channels of communication.					
Demonstrates flexibility in situational changes in work assignment or environment.					
Documents using paper charting and after approval from the clinical instructor if applicable.					

Was the student placed on clinical probation or counseled this semester?   Y   N

Was the probation or counseling effective and was the problem resolved?   Y   N

Was documentation on the probation or counseling completed?   Y   N

Comments regarding student performance during the semester, including strengths and weaknesses:
Clinical Absences:
Clinical Tardies:

Instructor: _____   **Date:** _____

Student: _____   **Date:** _____

Grayson College
Vocational Nursing Program
Clinical Procedures Policy

1. NO Medications may be administered during the first semester.
2. Procedures not marked (*) may be performed independently by the student following satisfactory lab/clinical practice and/or check-off.
3. All procedures marked with a (*) must be supervised by a clinical instructor until released for supervision by a Registered Nurse that has been approved by the clinical instructor.
4. Removal of any medical device must be supervised or approved by the clinical instructor.

Assessment of Client:	Implementation of client care: (Continued)
Immediate needs	Hot, cold treatments
Client problems	Use of Doppler for pulses
Vital signs	Shave preps
Physical assessment	Teaching/Supervising use of incentive spirometer
Chart documentation	Inserting NG Tube* , care
Database, Electronic or Chart research	Applying SCDs, TEDS
Psychosocial status	Stoma care, colostomy care *
Cultural, spiritual, developmental status, needs	Assisting the RN with teaching plans
Physical environment	Assisting with all activities of daily living
Medications	Monitoring chest tubes
History	Specimen collection
Planning:	Oxygen therapy
Collaborate with primary care nurse and/or RN	Supervise nebulizer therapy
Collaborate with client	Apply, supervise protective devices
Collaborate with other members of the health team	Dressing Change: Non-sterile Dressing Change: Sterile* Dressing Change: Central Line *
Review RN's plan of care for assigned clients	Connect client to electrodes for monitoring
Implementation of client care:	Maintain safety of clients
Hygiene, grooming, bed linens	Implement infection control measures
Oral care	Initiate and assist with CPR
Feedings, oral and per tube *	Review new orders
Toileting, removing impactions*	Chart client data
Administration of enemas *	Tracheostomy suctioning *
Positioning, ambulating, ROM	Tracheostomy care
Prosthesis care	Assist RN with implementation of RN's plan of care
Transferring client to and from bed	Monitor client during administration of blood/products
Transporting	**Evaluation:**
Monitoring intake and output	Evaluate after interventions, medications
Skin care, wound care, staple removal, steri-strips	Assist with modification of RN's plan of care
Nebulizer treatments	Evaluate therapeutic effect of medications
Oral suctioning *	
Foley catheter insertion *	
Foley catheter discontinuation *	
Cast care, traction	
Discontinue IV sites *	
Computerized charting	
Act as client advocate in collaboration with RN	
Report problems to RN or charge nurse	
Care for multiple clients, report problems	
Assess postpartum mothers	
Care for pediatric clients	

APPENDIX B

CRITICAL OFFENSE POLICY

Critical Offense Policy
(Unsafe/Unprofessional Nursing Practice)
(Vocational Nursing Student Handbook)

Nursing students are legally and ethically responsible for their own acts, whether by commission or omission, in the clinical area. It is the responsibility of the nursing faculty to evaluate unsafe student behavior and initiate dismissal from the clinical practicum when appropriate. Unsafe clinical behavior is defined as: any act, practice, or omission that fails to conform to accepted standards of nursing care and indicates that the student lacks knowledge, skill, judgment, or conscientiousness to such an extent that the student's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior.

Conduct or behavior which may be considered a critical offense secondary to unsafe or unprofessional conduct may include, but is not limited to:

1. Dishonesty
2. Theft from client, clinical site or school
3. Evidence of substance abuse (possession, use, sale or delivery)
4. Physical/verbal abuse of clients, peers, faculty, clinical staff
5. Violation of HIPAA Privacy and Security regulations/patient confidentiality
6. Violation of safety in patient care
7. Falsification of patient records
8. Commission or omission of patient care that endangers a patient's life
9. Life threatening medication error
10. Attendance in the clinical setting while impaired by alcohol or other chemical substances
11. Failure to act within accepted professional boundaries.

A student who is considered to be unsafe/unprofessional in nursing practice may be terminated from a clinical practicum at any time during the semester and receive a grade of "F" for the clinical course. Any student who commits one critical offense, as defined above, may be immediately dismissed from the nursing program. A failure in a clinical course related to a critical offense constitutes a permanent dismissal from the nursing program. The student may complete the other concurrent nursing theory and withdraw from skills lab courses but will not be allowed to return to the clinical course and will not be allowed to progress to the next nursing course level.

Procedure

When a student exhibits behaviors that may be considered a critical occurrence, the student may be required to leave the clinical facility immediately. The Program Director will be notified of the occurrence as soon as possible and the student will not be allowed to return to the clinical facility until decision about the student's standing in the program is made by the nursing faculty.

Appeal Process

If a student is dismissed from the program due to a critical offense, the student may request a hearing with the VN Faculty. This request must be submitted in writing to the VN Program Director within 5 working days of notification of the dismissal. The VN Program Director will be responsible for notifying the Dean of Health Sciences and Dean of South Campus of the decision. The student will be notified of the right to file a grievance, in accordance with the Grayson College Policy and Procedure Manual.

Critical Offense Probation/Dismissal Policy

Any violation pertaining to unsafe practice will result in a student conference and the initiation of a Faculty Committee meeting. A student may be placed on probation or recommended for dismissal from the Vocational Nursing Program by the clinical instructor.

Probation

If a determination is made to place the student on probation for a critical offense, the following procedure will be followed:

1. The student and the instructor will complete the requested information of the incident on the "Initiation of Probation" form.
2. The student will submit a written outline on how the incident occurred and how the incident will be avoided in the future.
3. The instructor will document the occurrence and make comments as needed. Typed statements can be attached.
4. A plan for improvement will be developed on the Initiation of Probation Form and a date will be set for re-evaluation of the student's performance.
5. The student will implement the plan.
6. Re-evaluation will occur on the designated date.
7. The instructor will initiate a "Release of Probation Form" if the student has demonstrated improvement in the identified area. Behaviors that document the improvement will be clearly stated by the student and confirmed by the instructor.
8. The instructor will initiate a "Recommendation for Dismissal Form" if the student was unable to correct the behavior causing the incident. Behaviors that document that the student was unable to change the behavior will be clearly stated by the instructor.
9. All forms should be signed by both the instructor and the student and dated.
10. All forms become part of the student's file.
11. An instructor should initiate a Faculty Committee meeting prior to dismissal of a student. Faculty will vote on dismissal and the majority of the vote will substantiate a decision. A student may be placed on probation without a faculty conference.
12. A student may not be placed on Critical Offense Probation for more than one occurrence each semester. If the student's behavior indicates the need for probation the second time in one semester, the student will be withdrawn from all current semester courses, and the student will be dismissed from the Vocational Nursing Program for unsafe behavior.

Dismissal From the Vocational Nursing Program

The faculty committee may dismiss a student from the VN program for the following reasons:

1. Critical offenses as defined above.
2. Serious clinical occurrence that has caused harm to a client.
3. Lack of ability to correct a critical clinical offense as stated above.
4. More than one clinical probation for a semester.

Grayson College
Vocational Nursing Program

Initiation of Probation Form

Student: _____

Date: _____

Student's outline/dates of occurrence: (May attach statement)

_____
_____
_____
_____
_____
_____

Instructor's comments: (May attach statement)

_____
_____
_____
_____

Plan for improvement agreed upon between student and Instructor: (Use measurable behaviors)

_____
_____
_____
_____
_____

Date for re-evaluation:

_____
_____
_____
_____

Consequences if behaviors do not improve:

_____

(Complete Release of Probation Form if and when applicable)

I understand that I may be placed on probation only once during a semester according to the policy in the Grayson County College Vocational Nursing Program Handbook. Further incidences requiring probation will result in dismissal from the program. I agree to the above terms of probation.

Instructor: _____ Date: _____

Student: _____ Date: _____

Reviewed by Director of Vocational Nursing: _____
Date: _____
(Give a copy to student, place a copy in student's file, give a copy to Director)

Grayson College
Vocational Nursing Program

Release from Probationary Status Form

The following student has met the conditions of the probation and is released from probationary status:

Student: _____

Date: _____

Date when probation was initiated: _____

Student's description of how behaviors improved as outlined in Initiation of Probation Form. Give examples:

_____

_____

_____

_____

_____

_____

Instructor's comments:

_____

_____

_____

_____

_____

_____

_____

_____

By signing below, I understand that I am released from probation. I understand that I may not be placed on probation again within the same semester. If this occurs, I will be dismissed from the Grayson County College Vocational Nursing Program.

Instructor: _____   Date:_____

Student: _____   Date:_____

Reviewed by Director:_____ Date:_____

Appendix C

SCANS Competencies

The Following SCANS competencies can be found in VNSG 1360:

Workplace Competencies:
- Allocation of staff, materials: recognizes levels of staffing and uses supplies for client care in cost effective manner
- Interpersonal skills: Works within the health care team; communicates with clients, families, staff
- Information: Acquires data on clients, organizes data through prioritization, interprets client data with help of the clinical instructor
- Technology: Manages basic health care equipment such as automatic blood pressure cuffs; computerized reports, lab reports, uses specialized equipment such as blood glucose monitoring equipment

Foundation Skills:
- Basic skills: Reads information on clients, calculates medication dosages, speaks and listens to clients, families, other members of the health care team
- Thinking skills: Uses the nursing process which is a problem solving model to plan nursing care at a beginning level; researches medications on assigned clients
- Personal qualities: Assumes responsibility for assigned clients; performs as a member of a profession

Resources:
- Manages time: Sets goals for clients and attempts to reach goals during shift
- Manages materials: Practices cost effectiveness in a health care facility

Interpersonal:
- Participates as a member of a team: Works with members of the health care team to provide holistic client care
- Teaches others: Provides basic teaching for clients and families
- Serves Client s: Provides holistic nursing care to assigned client
- Exercises leadership: Communicates needs to instructor or primary care nurse during assigned shift; Seeks help when needed
- Negotiates to arrive at a decision: Seeks the advice of experienced nurses when a decision needs to be made
- Works with cultural diversity: Provides care to men, women, and people of various culture

Information:
- Acquires and evaluates data: Gathers data on clients and evaluates data under the supervision of an instructor; evaluates physical assessment data
- Organizes data: Completes database and records on required clinical paperwork
- Interprets and communicates data: Reports significant findings to registered nurse
- Uses a computer to process information: Retrieves client data from computer

Systems:
- Understands systems: Becomes familiar with long-term care systems
- Monitors and corrects performance: Performs skills according policies of agencies

Technology:
- Selects technology: Uses hospital equipment and chooses equipment to use
- Applies technology to task: Operates basic facility equipment such as intercom systems, telephones, suction equipment, equipment used for vital signs
- Maintains and troubleshoots technology: Reports malfunctioning equipment

Reading:
- Reads charts, information in texts, prepares pathology window by reviewing pathology of diseases and selecting the most important information

Writing:
- Practices charting techniques, submits to instructor for approval, then writes information in chart using correct terminology
- Records intake and output on assigned clients on the graphic chart
- Correctly spells medical terms for charting
- Prepares paperwork for clinical assignments

Arithmetic:
- Performs calculations for oral medications

Listening:
- Listens to receive report from off-going nurse; Listens to client to obtain client data; Listens to instructor about requirements for clinical

Speaking:
- Organizes thoughts to teach client information on disease or medications; Adapts speech to cultural needs of client and to level of education and understanding of the client
- Asks questions of instructor or nurse as needed
- Gives verbal report to nurse at end of shift

Thinking Skills:
- Creative Thinking: Begins to make connection between data and client signs and symptoms; Relates pathology to client
- Mathematics: Calculates intake and output on assigned clients; Able to calculate medications
- Decision-Making: Considers what is best for client and initiates nursing care
- Problem-Solving: Uses nursing process to determine problems and what nursing care can assist with solving the problems
- Mental Visualization: Pictures disease pathology and correlates it to the symptoms of the client; Visualizes how disease process works in the body
- Knowing how to learn: Uses laboratory skills in the clinical setting; Is aware of areas that need improvement
- Reasoning: Discovers the relationship between the disease process and the actual client's signs and symptoms; Comes to a conclusion about client problems

Personal Qualities:
- Responsibility: Demonstrates effort and perseverance to achieve quality client care; works hard to develop skills in critical thinking, responsibility, and to multitask.
- Self-Esteem: Demonstrates an ability to provide care to multiple types of clients: Is aware of the need for professionalism in manner and dress.
- Sociability: Presents the image of the nurse as open, friendly, empathetic, and polite. Learns to adapt to changing situations with clients and families, and communicates appropriately; Shows interest in the client.
- Self-management: Assesses own knowledge in client care situations; acknowledges when further help is needed; monitors progress with self-evaluation at mid-term and at the end of each semester.
- Integrity/honesty: Adjusts nursing care to meet the needs of others who are culturally, spiritually or developmentally different than the nurse; admits to mistakes and errors in judgment in order to protect the client.