Plainview Center

Course Syllabus

COURSE: VNSG 2461.501 Clinical Practical Nursing Level III
SEMESTER: Summer 2025
CLASS DAYS: Wednesday-Friday
CLASS TIMES: May Vary-See Summer Semester Schedule

Name	Phone Numbers	Email	Office	Office Hours
STACEY KOELDER, LVN	806.716.4408 (o)	skoelder@southplainscollege.edu	104 E	M 9-12,1-3 T 2-3pm W -NONE Th. -NONE F- 1-2pm
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Facebook: https://www.facebook.com/SouthPlainsCollegeVocationalNursing

*Please note office hours above. If you need to meet with me, you may stop by my office during office hours and if I am available at that time, I will be happy to meet with you. The best way to meet with me is to email me for an appointment that will be verified/accepted via email.
** Some Fridays will be scheduled for skills checkoffs. These are required as part of this course.

Please Note: **The COVID 19 crisis may change the lecture format / lab demonstration and this syllabus. Please refer to the 2024 Student Handbook for the complete COVID POLICY.**

"South Plains College improves each student's life."

GENERAL COURSE INFORMATION

It is the responsibility of each student to be familiar with the content and requirements listed in the course syllabus.

Prerequisite courses: VNSG 1160, 1460
CO-requisite courses (concurrent): VNSG 2410, 1334, 1219, 1331

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 / instructor. Specific detailed learning objectives are developed for each course by the faculty. On-site clinical instruction, supervision, evaluation, and placement is the responsibility of the college faculty. Clinical experiences are unpaid external learning experiences. Course may be repeated if topics and learning outcomes vary. ATI will also be utilized to enhance the student's ability to critically think and provide safe and competent care.

STUDENT LEARNING OUTCOMES

At the completion of the semester students will: (based on the Differentiated Essential Competencies of Texas Board of Nursing [DECS])
1. Become a Member of the Profession
2. Provider of Patient-Centered Care
3. Be a Patient Safety Advocate
4. Become a Member of the Health Care Team

COURSE OBJECTIVES - Outline form (C-5, C-6, C-7, C-8, C-15, C-16, C-17, C-18, C-19, C-20) (F-1, F-2, F-7, F-8, F-9, F-10, F-11, F-12)

At the completion of this course the student will:
• Apply the theory, concepts and skills involving specialized materials, equipment, procedures, regulations, laws, and interactions within and among political, economic, environmental, social, and legal systems associated with Vocational Nursing
• Demonstrate legal and ethical behavior
• Demonstrate the ability to care for multiple patients in multiple patient-care situations
• Demonstrate safety practices within the health care setting
• Demonstrate interpersonal teamwork skills
• Communicate in the applicable language of health care
• Be prepared to practice within the legal, ethical, and professional standards of vocational nursing as a health care team member in a variety of roles
• Exhibit an awareness of the changing roles of the nurse
• Utilize the nursing process as a basis for clinical judgment and action
• Accept responsibility for personal and professional growth
• Be present and punctual for all clinical assignments and lab with no more than 2 absences.

COURSE COMPETENCIES: To exit this course and graduate from the Vocational Nursing Program (VNP), the student must

- Have a 76 average grade AND
- Complete and turn in all required clinical paperwork. Students who fail to turn in work fail the clinical course regardless of other grades.
- Maintain CPR and immunizations AND
- Complete 90% of the skills checklist 4 weeks prior to graduation AND
- Complete at least one sterile procedure (Foley catheter and sterile dressing change) AND
- Have no more than two absences this semester AND
- Pass the Summative Evaluation AND
- Practice within the score of practice for SVNs, demonstrating movement to the graduate level of practice and clinical judgment

EVALUATION METHODS

Weekly clinical performance evaluations, Paperwork/documentation evaluations, Clinical Judgment Process, and other assignments with a final Summative Evaluation at the end of the semester.

ACADEMIC INTEGRITY

It is the aim of the faculty of SPC to foster a spirit of complete honesty and a high standard of integrity. The attempt of any student to present as his own any work which he has not honestly performed is regarded by the faculty and administration as a most serious offense and renders the offender liable to serious consequences, possible suspension.

Cheating - Dishonesty of any kind on examinations or on written assignments, illegal possession of examinations, the use of unauthorized notes during an examination, obtaining information during an examination from the textbook or from the examination paper of another student, assisting others to cheat, alteration of grade records, illegal entry or unauthorized presence in the office are examples of cheating. Complete honesty is required of the student in the presentation of any and all phases of coursework. This applies to quizzes of whatever length, as well as final examinations, to daily reports and to term papers.

Plagiarism - **Plagiarism** - Offering the work of another as one's own, without proper acknowledgment, is plagiarism. Any student who fails to give credit for quotations or essentially identical expression of material taken from books, encyclopedias, magazines, websites such as: blogs, journals, or articles, other referenced works, from themes, reports, and/or other writings of a fellow student, is guilty of plagiarism. If there is any suspicion of work completed by Artificial Intelligence (A.I.), the student and their work may be questioned, and if proven that A.I. was used will be considered guilty of plagiarism.

Plagiarism Violations:

A student found guilty of plagiarism may be dismissed from the program.

VERIFICATION OF WORKPLACE COMPETENCIES

Successful completion of this course and all required concurrent theory courses entitles the student to receive a Certificate of Proficiency and to apply to write the examination for licensure (NCLEX-PN) to practice as a Licensed Vocational Nurse in the State of Texas.

BLACKBOARD

Blackboard is an e-Education platform designed to enable educational innovations everywhere by connecting people and technology. This educational tool will be used in this course throughout the semester as a reporting tool and communication tool. Students should be aware that the "total" points noted on this education platform does not reflect the actual grade of the student because it does not take in to consideration the percentages of each grade. Please calculate your grade according to the criteria in this syllabus.

FACEBOOK

The Vocational Nursing Program has a Facebook page at https://www.facebook.com/SouthPlainsCollegeVocationalNursingProgram in addition to the South Plains College website; this Facebook page will be used to keep students up-to-date on program activities, South Plains College announcements and will help with program recruitment. "Liking" the South Plains College Vocational Nursing Program Facebook page is not mandatory, nor are personal Facebook accounts, in order to access this page.

SCANS and FOUNDATION SKILLS

Refer also to Course Objectives. Scans and Foundation Skills attached.

SPECIFIC COURSE INFORMATION

LEVEL 3 CLINICAL OBJECTIVES: (Based on the TBON DECs)

During the clinical course, the competent vocational nursing student progresses to proficient graduate vocational nurse through the following:

I. Member of the Profession
The student vocational nurse who exhibits behaviors that reflect commitment to the growth and development of the role and function of nursing consistent with state and national regulations and with ethical and professional standards; aspires to improve the discipline of nursing and its contribution to society; and values self-assessment, self-care, and the need for lifelong learning.
A. Function within the nurse's legal scope of practice and in accordance with the policies and procedures of the employing health care institution or practice setting.
1. Function within a directed scope of practice of the vocational nurse with appropriate supervision.
2. Assist in determination of predictable health care needs of patients to provide individualized, goal-directed nursing care.
3. a. Practice according to facility policies and procedures and provide input in the development of facility policies and procedures.
b. Question orders, policies, and procedures that may not be in the patient's best interest.
B. Assume responsibility and accountability for the quality of nursing care provided to patients and their families.
1. Practice according to the Texas laws and regulations, agency policies and SPC policies.
2. a. Provide nursing care within the parameters of vocational nursing knowledge, scope of practice, education, experience, and ethical/ legal standards of care.
b. Participate in evaluation of care administered by the interdisciplinary health care team.
3. a. Practice nursing in a caring, nonjudgmental, nondiscriminatory manner.
b. Provide culturally sensitive health care to patients and their families.
c. Provide holistic care that addresses the needs of diverse individuals across the lifespan.
4.a. Use performance and self-evaluation processes to improve individual nursing practice and professional growth.
b. Evaluate the learning needs of self, peers, and others and intervene to assure quality of care.
5.a. Assume accountability for individual nursing practice.
b. Follow established evidence-based clinical practice guidelines.
6.a. Follow established policies and procedures.
b. Question orders, policies, and procedures that may not be in the patient's best interest.
c. Use nursing judgment to anticipate and prevent patient harm, including implementing Nursing Peer Review. invoking Safe Harbor.
7. Demonstrate professional characteristics that display a commitment to nursing care and to recognizing and meeting patient needs. Use communication techniques to maintain professional boundaries in the nurse/patient relationship.
8. Use communication techniques to maintain professional boundaries in the nurse/patient relationship.
9. Uphold professional behavior in nursing comportment and in following organizational standards and policies. Comply with professional appearance requirements according to organizational standards and policies.
10. Implement principles of quality improvement in collaboration with the health care team.
C. Contribute to activities that promote the development and practice of vocational nursing.

1. Identify historical evolution of nursing practice and issues affecting the development and practice of vocational nursing.
2. Work collegially with members of the interdisciplinary health care team.
3. Participate in activities individually or in groups through organizations that promote a positive image of the vocational nursing role.
4. Recognize roles of vocational nursing organizations, regulatory agencies, and organizational committees.
5. Practice within the vocational nursing role and Scope of Practice.
6. Serve as a positive role model for students, peers, and members of the interdisciplinary health care team.
D. Demonstrate responsibility for continued competence in nursing practice, and develop insight through reflection, self-analysis, self-care, and lifelong learning
1. Participate in educational activities to maintain/improve competency, knowledge, and skills.
**2. Participate in nursing continuing competency activities while within the program to prepare for licensure.*
3. Use self-evaluation, reflection, peer evaluation, and feedback to modify and improve practice.
4. Demonstrate accountability to reassess and establish new competency when changing practice areas.
5. Demonstrate commitment to the value of lifelong learning.
6. Engage in self-care practices that promote work-life balance.
II. Provider of Patient-Centered Care
The student vocational nurse who, based on educational preparation and scope of practice, accepts responsibility for the quality of nursing care and provides safe, compassionate nursing care using a systematic process of assessment, analysis, planning, intervention, and evaluation that focuses on the needs and preferences of patients and their families. The student vocational nurse incorporates professional values and ethical principles into nursing practice. The patients for SVNs (LVNs) individual patients and their families.
1. Use a problem-solving approach to make decisions regarding the care of assigned patients.
2.a. Organize care for assigned patients based upon problem-solving and identified priorities.
b. Proactively manage priorities in patient care and follow-up on clinical problems that warrant investigation with consideration of anticipated risks.
c. recognize potential care needs of vulnerable patients
3. Identify and communicate patient physical and mental health care problems encountered in practice.
4. Apply relevant, current nursing practice journal articles to practice and clinical decisions.
B. Assist in determining the physical and mental health status, needs, and preferences influenced by culture, spirituality, ethnicity, identity, and social diversity of patients and their families, and in interpreting health-related data based on knowledge from the vocational nursing program of study. of culturally, ethnically, and socially diverse patients and their families based on interpretation of health-related data.
1. Use structured assessment tool to obtain patient history.
2. Perform focused assessment to assist in identifying health status and monitoring change in patients.
3. Report and document focused patient assessment data.
4. Identify predictable and multiple health needs of patients and recognize signs of decompensation.
5. Share observations that assist members of the health care team in meeting patient needs.
6. Assist with health screening.
7. Differentiate abnormal from normal health data of patients.

8. Recognize healthcare outcomes and report patient status.
9. a. Recognize that economic and family processes affect the health of patients.
b. Identify health risks related to social determinants of health
C. Report data to assist in the identification of problems and formulation of goals/ outcomes and patient-centered plans of care in collaboration with patients, their families, and the interdisciplinary health care team.
1. Integrate concepts from basic sciences and humanities to deliver safe and compassionate care in delivery of patient care.
2. Identify short-term goals and outcomes, select interventions considering cultural aspects, and establish priorities for care in collaboration with patients, their families, and the interdisciplinary team.
3. Participate in the development and modification of the nursing plan of care across the lifespan, Including end-of-life care.
4. Contribute to the plan of care by collaborating with interdisciplinary team members.
5. Assist in the discharge planning of selected patients.
6. Demonstrate fiscal accountability in providing patient care.
7. Demonstrate basic knowledge of disease prevention and health promotion in delivery of care to patients and their families.
D. Provide safe, compassionate, basic nursing care to assigned patients with predictable health care needs through a supervised, directed scope of practice.
1. Assume accountability and responsibility for nursing care through a directed scope of practice under the supervision of a registered nurse, advanced practice registered nurse, physician assistant, physician, podiatrist, or dentist using standards of care and aspects of professional character. professional values.
2.a. Identify priorities and make judgments concerning basic needs of multiple patients with predictable health care needs in order to organize care.
b. Manage multiple responsibilities.
c. Recognize changes in patient status.
d. Communicate changes in patient status to other providers.
3.a. Implement plans of care for multiple patients.
b. Collaborate with others to ensure that healthcare needs are met.
4. Participate in management activities.
E. Implement aspects of the plan of care within legal, ethical, and regulatory parameters and in consideration of patient factors.
1. Implement individualized plan of care to assist patients to meet basic physical and psychosocial needs.
2. Implement nursing interventions to promote health, rehabilitation, and implement nursing care for clients with chronic physical and mental health problems and disabilities.
3. Initiate interventions in rapidly changing and emergency patient situations.
4. Communicate accurately and completely and document responses of patients to prescription and nonprescription medications, treatments, and procedures to other health care professionals clearly and in a timely manner.
5. Foster coping mechanisms of patients and their families during alterations in health status and end of life.
6.a. Assist interdisciplinary health care team members with examinations and procedures.
b. Seek clarification as needed.

c. Provide accurate and pertinent communication when transferring patient care to another provider
7.a. Inform patient of Patient Bill of Rights.
b. Encourage active engagement of patients and their families in care.
8. Communicate ethical and legal concerns through established channels of communication.
9. Use basic therapeutic communication skills when interacting with patients, their families, and other professionals.
10. Apply current technology and informatics to enhance direct patient care while maintaining patient confidentiality and promoting safety.
11. Facilitate maintenance of patient confidentiality.
12.a. Demonstrate accountability by providing nursing interventions safely and effectively using a directed score of practice
b. Provide nursing interventions safely and effectively using established evidence-based practice guidelines.
13. Provide direct patient care in disease prevention and health promotion and/or restoration.
F. Identify and report alterations in patient responses to therapeutic interventions in comparison to expected outcomes.
1. Report changes in assessment data.
2. Use standard references to compare expected and achieved outcomes of nursing care.
3. Communicate reasons for deviations from plan of care to supervisory health care team member.
4. Assist in modifying plan of care.
5. Report and document patient's responses to nursing interventions.
6. Assist in evaluating patient care delivery based on expected outcomes in plan of care and participate in revision of plan of care.
G. Implement teaching plans for patients and their families with common health problems and well-defined health learning needs.
1. Identify health-related learning needs of patients and their families.
2. Contribute to the development of an individualized teaching plan.
3. Implement aspects of an established teaching plan for patients and their families.
4. Assist in evaluation of learning outcomes using structured evaluation tools
5. Teach health promotion and maintenance and self-care to individuals from a designated teaching plan.
6. Provide the patient with the information needed to make choices regarding health
7. Provide patients and families with basic sources of health information.
H. Assist in the coordination of human, information, and physical materiel resources in providing care for assigned patients and their families.
1. Participate in implementing changes that lead to improvement in the work setting.
2.a. Report on unsafe patient care environment and equipment.
b. Report threatening or violent behavior in the workplace
3. Implement established cost containment measures in direct patient care.
4. Assign patient care activities taking patient safety into consideration according to Texas Board of Nursing rules (217.11).
5. Use management skills to assign to licensed and unlicensed personnel.

6. Assist with maintenance of standards of care.
III. Patient Safety Advocate
The student vocational nurse who promotes safety in the patient and family environment by: following scope and standards of nursing practice; practicing within the parameters of individual knowledge, skills, and abilities; identifying and reporting actual and potential unsafe practices; and implementing measures to prevent harm.
A. Demonstrate knowledge of the Texas Nursing Practice Act and the Texas Board of Nursing Rules that emphasize safety, as well as all federal, state, and local government and accreditation organization safety requirements and standards
1. Attain licensure through completion of these objectives in preparation to pass NCLEX and receive licensure
2. Practice according to Texas Nursing Practice Act and Texas Board of Nursing rules.
3. Seek assistance if practice requires behaviors or judgments outside of individual knowledge and expertise.
4. Use standards of nursing practice to provide and evaluate patient care.
5. Recognize and report unsafe practices and contribute to quality improvement processes.
6. Participate in peer review
B. Implement measures to promote quality and a safe environment for patients, self, and others.
1. Promote a safe, effective caring environment conducive to the optimal health, safety, and dignity of the patients and their families, the health care team, and others consistent with the principles of just culture.
2. Accurately identify patients
3.a. Safely perform preventive and therapeutic procedures and nursing measures including safe patient handling.
b. Safely administer medications and treatments.
4. Clarify any order or treatment regimen believed to be inaccurate, non-efficacious, contraindicated, or otherwise harmful to the patient.
5. Document and report reactions and untoward effects to medications, treatments, and procedures and clearly and accurately communicate the same to other health care professionals.
6. Report environmental and systems incidents and issues that affect quality and safety and promote a culture of safety.
7. Use evidence-based information to contribute to development of interdisciplinary policies and procedures related to a safe environment including safe disposal of medications and hazardous materials.
8. Implement measures to prevent the risk of patient harm resulting from errors and preventable occurrences.
9. Inform patients regarding their plans of care and encourage participation to ensure consistency and accuracy in their care.
C. Assist in the formulation of goals and outcomes to reduce patient risks.
1. Assist in the formulation of goals and outcomes to reduce patient risk of health care-associated infections
2.a. Implement measures to prevent exposure to infectious pathogens and communicable conditions.
b. Anticipate risk for the patient.
3. Implement established policies related to disease prevention and control.
D. Obtain instruction, supervision, or training as needed when implementing nursing procedures or practices.
1. Evaluate individual scope of practice and competency related to assigned task.
2. Seek orientation/ training for competency when encountering unfamiliar patient care situations.
3. Seek orientation/ training for competency when encountering new equipment and technology.

E. Comply with mandatory reporting requirements of the Texas Nursing Practice Act, SPC policies and agency policies.
1. Report unsafe practices of healthcare providers using appropriate channels of communication.
2. Understand nursing peer review rules Safe Harbor rules and implement when appropriate.
3. Report safety incidents and issues through the appropriate channels.
4. Implement established safety and risk management measures
*** F. Accept and make assignments that take into consideration patient safety and organizational policy.**
1. Accept only those assignments that fall within individual scope of practice based on experience and educational preparation.
** 2. When making assignments, ensure clear communication regarding other caregivers' levels of knowledge, skills, and abilities.*
** 3. When assigning nursing care, retain accountability and supervise personnel based on Texas Board of Nursing rules according to the setting to ensure patient safety.*
IV. Member of the Health Care Team:
The student vocational nurse who provides patient-centered care by collaborating, coordinating, and/ or facilitating comprehensive care with an interdisciplinary/multidisciplinary health care team to determine and implement best practices for the patients and their families.
A. Communicate and collaborate with patients, their families, and the interdisciplinary health care team to assist in the planning, delivery, and coordination of patient-centered care to assigned patients.
1. Involve patients and their families with other interdisciplinary health care team members in decisions about patient care across the lifespan.
2. Cooperate and communicate to assist in planning and delivering interdisciplinary health care.
3. Participate in evidence-based practice in development of patient care policy with the interdisciplinary team to promote care of patients and their families.
B. Participate as an advocate in activities that focus on improving the health care of patients and their families
1. Respect the privacy and dignity of the patient.
2. Identify unmet health needs of patients.
3. Act as an advocate for a patient's basic needs, including following established procedures for reporting and solving institutional care problems and chain of command.
4. Participate in quality improvement activities.
5. Refer patients and their families to community resources.
C. Participate in the identification of patient needs for referral to resources that facilitate continuity of care and ensure confidentiality.
1.a. Identify support systems of patients and their families.
b. Identify major community resources that can assist in meeting needs.
2.a. Communicate patient needs to the family and members of the health care team.
b. Maintain confidentiality according to HIPAA guidelines.
c. Promote system-wide verbal, written, and electronic confidentiality.
3.a. Advocate with other members of the interdisciplinary health care team on behalf of patients and families to procure resources for care.

b. Assist patient to communicate needs to their support systems and to other health care professionals.
4. Identify treatment modalities and cost of health care services for patients and their families.
D. Communicate patient data using technology to support decision making to improve patient care.
1.a. Identify, collect, process, and manage data in the delivery of patient care and in support of nursing practice and education.
b. Use recognized, credible sources of information, including internet sites.
c. Access, review, and use electronic data to support decision-making
2.a. Apply knowledge of facility regulations when accessing client records.
b. Protect confidentiality when using technology.
c. Intervene to protect patient confidentiality when violations occur.
3.a. Use current technology and informatics to enhance communication, support decision making, and promote improvement of patient care.
b. Advocate for availability of current technology.
4. Document electronic information accurately, completely, and in a timely manner.
E. Assign nursing care to other SVNs or unlicensed personnel based upon an analysis of patient or workplace unit need.
**1. Compare the needs of patients with knowledge, skills, and abilities of assistive and licensed personnel prior to making assignments.*
**2. a. Assign and monitor tasks of unlicensed and licensed personnel in compliance with Texas Board of Nursing rules.*
b. Reassess adequacy of care provided.
**3. a. Document and/ or report responses to care or untoward effects.*
b. Provide feedback on competency levels of team members.
F. G. **Supervise nursing care provided by others for whom the nurse is responsible.*
**1. Provide instruction where needed to members of the health care team to promote safe care.*
**2. Seek direction and clarification from supervisors when questions arise to promote safe care by health care team.*
**3. a. Oversee and monitor patient care provided by unlicensed assistive personnel and vocational licensed personnel as assigned.*
b. Base assignments on individual team member competencies.
**4. Ensure timely documentation by assigned health team members*
G. Assist health care teams during local or global health emergencies or pandemics to promote health and safety, and prevent disease.
1. Recognize the impact and prepare to respond to an emergent global or local health issue in an assistant role
2. Guide patients, staff, and others in understanding the extent of the emergency and their response
3. Participate with the health care team to promote safety and maintain health during an emergency or pandemic
4. Include public health strategies in the care of individuals and communities that address resolution of a global or local crisis and promotion of health among the population.

Policies for Clinical Assignments:

- Failure to call the assigned clinical area when absence is unavoidable is considered an infraction of program policies.
- Tardies in the clinical area are not tolerated. A student is considered absent if he/she does not report for duty at the scheduled time for that clinical area.
- A student who is absent any portion of a clinical shift will be given an absence for that day.
- Students may not leave the assigned clinical area without permission of the clinical instructor or charge nurse of the unit. Student is to notify the clinical instructor prior to leaving the assigned area.
- The clinical instructor should be notified if learning opportunities at the assigned location are not available.
- Attendance at scheduled clinical rotations is considered a critical ethical responsibility of the health care professional, and will be seen as reflective of the integrity of the student.

CLINICAL AFFILIATE PHONE NUMBERS:

Cogdell Clinic (320 N. Main, Lockney) 652-3130
Covenant Children's Hospital (4015 22nd Pl.)..... 725-0000
Covenant Health Plainview (2601 Dimmitt Road) 296-5531
FMC Dialysis Medical Facility (3304 Olton Rd) 296-6661
Mangold Memorial Hospital (320 N. Main, Lockney)..... 652-3373
Regence Health Network, Inc. (2801 W. 8th St.).....291-0297

Clinical Times: (must be signed in BEFORE the "Absent at" time; students are absent on the given time.

Facility	Clinical Time	Lunch	Absent at:	Call In Time	May leave floor at
Covenant: ED,Med,Surg,ICU, SURGERY/PACU	0630-1600	30 minutes	0630	0530	1530
Simulation	0755-1600	Approx. 60 minutes	0800	0700	1600
Cogdell Clinic/ Regence Health Network	0800-1700	1-hour	0800	0700	1700
FMC Dialysis Medical Facility	0630-1600	30 minutes	0630	0530	1600
WJ Mangold Memorial Hospital	0630-1600	30 minutes	0630	0530	1530

Clinical time is "on the job" learning. Students are expected to be up and working throughout the entire shift. Students MAY NOT leave the assigned unit at the hospitals until 3:30 unless specified by Instructor. This means that the student gives report, checks on the patients and participates in patient care until 3:30 and then gathers belongings, leaves the floor and clocks out. Students who leave the floor before 3:30 or students who signs out right at 3:30 (which means they had to leave early in order to get downstairs) are given an absence for the entire day.

Simulation is considered a clinical experience. An absence in simulation is the same as for all other clinical experiences. A student that arrives late or unprepared for simulation will be given the option to stay and observe for the learning experience but will still be given a zero for the day and an absence.

LUNCH—the lunch break in the hospital setting is 30 minutes; this begins when the student reports off care of the patient until the time the student returns and resumes care. If the student spends 10 minutes waiting on the elevator, the student has 20 minutes remaining on the lunch break. In some outpatient settings, the student may be given an hour for lunch IF there were no meetings during the noon hour which would give the student an additional learning experience (see each clinic objective). A student who takes excessive lunches or who leaves the site when there is a meeting during the noon hour will receive full disciplinary action and possible dismissal for unprofessional conduct.

NOTE ABOUT CLINIC TIMES—some clinics may finish their work early and staff may tell the student that they can leave early. THIS DOES NOT MEAN you can leave. Please contact your instructor and request instructions for the rest of the scheduled time; many times, the student may be moved to another clinical for additional experience. To "assume" it is okay to leave the clinical setting results in an absence assigned for that day. If this absence causes the student to fail, the student will fail the clinical course, regardless of other clinical grades.

SIGNING IN/OUT: SIGNING in/out for another student is PROHIBITED and is considered unprofessional conduct as dishonest behavior. All students involved are dismissed from the Vocational Nursing Program (please refer to the Student Handbook).

Time sheets are required at off-hospital rotations. Students who misrepresent themselves on the time sheet or forge a time sheet are deemed "unprofessional" and are dismissed from the program for unprofessional conduct (please refer to the Student Handbook).

Students who show up at the wrong facility will be counted as absent for the day. Students should verify their schedule on Tuesday and make sure they understand the clinical assignment.

Students MAY NOT bring course work to "study" during clinical rotations, complete clinical assignment paperwork (like care plans, case studies), research clinical information or other activities that distract from the clinical experience while on the units. Students should refrain from asking class questions of instructors during clinical time; instead, the student who has questions about class work should make an appointment with the appropriate class instructor for that discussion.

General Guidelines for ALL Medical Surgical Rotations in Level 3

Criteria	**Level 3**
Number of patients	3-5
Medication administration with instructor supervision	Yes
EMR documentation (MAR only during medication admin)	Yes
SPC Chart Pack	Yes
VS and brief assessment by 0730	Yes
Full assessment documented by 0930	Yes
Staple removal with instructor supervision	Yes
Foley Catheter insertion (initially with instructor) TPCN	Yes
Sterile Dressing change (initially with instructor) TPCN	Yes
Follow Do and Don't List	Yes

Guidelines for Medication Administration during Clinical Medication Administration

THE STUDENT WILL:

1. Be assigned a floor and be assigned medication administration by the faculty.
2. Obtain all information on the patient regarding diagnosis and medications for the first clinical day and prepare all diagnosis and medication cards on the patient and have everything prepared for the instructor on the second day.
3. Prepare drug sheet for the patient(s) that must include all active medications the patient is prescribed by the physician – scheduled meds, prn meds that the patient has had within the last three days, and IVPB medications.

Please Note: Information obtained from the Omnicell systems is incomplete and does not give the student enough information for safe drug administration; therefore, the student must have a completed drug sheet.

4. Be able to verbally tell the instructor and/or TPCN from memory or by reading drug sheet the following:
   a. medication name (trade and generic)
   b. classification
   c. effect (action)--reason patient is on medication (diagnosis)
   d. route ordered
   e. normal dose range for route ordered
   f. major common side effects (expect/report)
   g. nursing implications (V/S, lab, safety, etc.)
   h. patient teaching.

During Med Rotation; THE FIRST TIME THE STUDENT IS UNABLE TO GIVE THIS INFORMATION ON EACH MEDICATION FOR EACH ASSIGNED PATIENT, THE STUDENT WILL have points deducted from the clinical grade (This applies to incomplete/missing RX information as well) AND will be placed on PROBATION. A second infraction will result in dismissal from the program. This policy will carry over from medication rotation all the way through to graduation.

5. Find all orders for all medications to be administered and know where orders are in the patient(s) chart or on the computer.
6. Review medications with instructor and then administer medications only under their supervision.
7. Follow hospital policies which state that SVNs may give medications by all routes **EXCEPT IV** with supervision by the instructor.
8. Complete all other aspects of patient care.
9. Students may NOT print drug card information from the clinical facilities; this is theft of hospital property.
10. Should the student not have four (4) days of medication administration during the Level II semester, the student will be put on probation in Level III and placed on Medical Surgical rotations until successfully completed.

MEDICATION ADMINISTRATION AFTER MED ROTATION

Medication Administration by Student Vocational Nurses after successful medication rotation

DECs: Member of a Profession, Provider of Patient-Centered Care, Patient Safety Advocate

POLICY: Student Vocational Nurses will administer medications following all guidelines and policies for safe, effective administration of medications.

Definition of Supervision: Instructor reviews medications and escorts student to the patient room, at all times. This includes scheduled and prn medication administration. [Please note: the OB floors are an exception to this policy and will be discussed thoroughly by the OB instructor.]

1. The student will follow the SPC/VNP and facility's policy and procedures on medication administration by the student vocational nurse.
2. The student will not pass medications without direct instructor or Instructor approved TPCN supervision following hospital policy which states that the student vocational nurse may give medications by all routes EXCEPT IV (except on pediatrics where only oral and topical medications can be administered) with supervision by the instructor.
3. If the student has not administered a particular route and seeks the experience, the student must have complete medication information for that medication and call the instructor. The route will be documented on the Med/Surg checklist.
4. The student **must** have complete medication information prior to administering any medication. Failure to do so will result in disciplinary action. Students may administer herbal medicines and supplements with required information for which a written physician's order is on the chart and the pharmacy has supplied for the patient. Supplements from home are not to be given by SVNs.
5. The student will be able to administer medication in the following areas:
    - Med Surg-Students may give meds to two or more patients.
    - ICU/Step Down
    - ED
    - Telemetry Floors **except Renal patients on Dialysis**
    - Cogdell Clinic
6. Students should prepare to administer 0900 to 1500 medications (except IV) on the day shift.
7. Students should communicate with the TPCN and notify them that they will be administering medications with their instructor for that patient. Please ask the TPCN to pull the medications from the PYXIS/Omnicell.
8. The student will be responsible for all patient care for assigned patients.
9. If a medication error is made, after assuring patient safety, the student will immediately notify the TPC nurse and instructor. The TPC nurse or instructor will notify the physician of the error, and an investigative report will be completed.
   The Medication Administration Error Quotient will be completed by the instructor and appropriate student action taken. See the example of the Quotient Form IN THE STUDENT HANDBOOK.
10. The student must have a completed med sheet on **all** medications (Except PRN that have not been given in the last 3 days).
11. For new medication orders (orders written between nursing report and 0900):
    a. Look up the new medication in the drug book, review the information and mark the book.
    b. Give the medication per SPC policy following all nursing implications.
    c. Be prepared to show the instructor the new order and to discuss the new medication, including why it was ordered.

d. Complete the medication sheet and turn it in to the instructor the next classroom day.
e. Should the student fail to turn in the sheet on the following class day, the student will be subject to disciplinary action.
f. This process should be the **EXCEPTION**, rather than the rule, meaning that this should only happen on occasion and not daily or weekly! This will be monitored and the student who consistently has to "look up" drugs will be subject to disciplinary action.

SHOULD A STUDENT ADMINISTER MEDICATIONS WITHOUT *INSTRUCTOR* SUPERVISION or INSTRUCTOR APPROVAL with TPCN, THE STUDENT WILL BE PLACED ON PROBATION. A SECOND INFRACTION WILL RESULT IN THE STUDENT BEING WITHDRAWN FROM THE VOCATIONAL NURSING PROGRAM FOR UNSAFE PRACTICE. This policy is followed all the way through graduation!

Clinical Preparation

Each student is expected to prepare for clinical practice in such a way that makes the student a safe, effective care giver. Not understanding the disease process and the expected care is equal to unsafe nursing practice. Preparing for clinical practice is a DUTY of the student vocational nurse and leads to SAFE NURSING PRACTICE. The student must prepare for clinical to understand the medical diagnoses and medications, the implications of labs and diagnostics, the potential complications and how to prevent them, and the required nursing care. **Adequate preparation is necessary**. The student should plan on a *minimum* of two hours of prep time per day for each clinical experience

Prepare" is the **intentional** effort on our part—to fix, establish and set. This means that the student must intentionally spend time and effort to fix, establish and "set" in the student mind the disease processes of the patient and the care required. The student will be expected to demonstrate this understanding through the patient's care and discuss it with the instructor.

CLINICAL EXPECTATIONS OF PREPARATION:

The student is expected to be prepared for clinical experience on a daily basis. The student will :
1. Attend report & get information from report
2. Check patient, obtain VS, perform comfort measures
3. Assess patient
4. Complete chart review: physician's orders, progress notes, history & physical, lab, diagnostics, MAR, nurse's notes (ISBAR and morning paperwork should be complete prior to accessing the computer)
5. Meet with instructor to discuss patient care
6. Answer call lights
7. Assist TPC nurses
8. Perform procedures when successfully checked-off
9. Report off any time leaving the unit, including lunch and end of shift
10. Maintain documentation

Medical Surgical Unit Requirements:

Utilize Computer Checklist.

1. Upon arriving to the Unit, allow charge nurse to assign TPCN. Provide note to TPCN, choose patients (2-3} patients)
2. First day of clinicals: **After *assessment and AM care is completed and documented***, the student may access the patient's medical record for approximately **30 minutes** to gather information. This information should include
    a. Patient's medical and surgical history
    b. Current diagnoses

c. Medications
d. Labs and Diagnostics

3. Prior to leaving for the day, the student may verify with the instructor what information is important for research. **NO RESEARCH IS TO BE DONE ON THE UNIT!**
4. After clinical clock-out, the student should begin the preparation process so that there is enough time to research and organize the student's prepared work.
5. The student should organize the information and be ready to present the information to the instructor. If this patient(s) has been dismissed, the student may still discuss the current information.

Research Requirements:

1. For each patient, the student must complete the ISBAR, page 1 & 2 (assessment and narrative), and flowsheet.
2. On the primary patient, the student must complete the medication sheet and lab list as well and gather information to complete the clinical care map for research.
3. The student will demonstrate understanding of the patient's diagnosis(es) through knowledgeable discussion of the diagnosis, risk factors, s/s, treatments, nursing interventions and rationales, and patient teaching.
    a. In addition to the clinical concept map, the student may add written information in any form the student chooses, i.e., diagnosis sheets or diagnosis cards
    b. Students are encouraged to have this information written so that when the student becomes nervous, there is a reference for the student to use during discussion; however, a written pathophysiology form is not required *if* the student can discuss the information in a logical, organized, reasonable manner.
    c. Students unable to discuss this information will receive a clinical deduction and may be instructed to have written information on subsequent clinical experiences.
4. The student will demonstrate understanding of the patient's medications through knowledgeable discussion of the medication, its action, its indication, the dosage and times of administration, possible side effects/adverse reactions, and applicable nursing indicators and patient teaching.
    a. The Medication List is to be thoroughly completed for the primary patient. There is a deduction for any incomplete Med List
    b. Students unable to discuss the medications will receive a clinical deduction and may be instructed to write additional information on medications.
    c. For students with poor discussion of medications or for incomplete med list, med administration may be forfeited, with additional point deductions.
5. The student will demonstrate an understanding of the patient's laboratory status through discussion of the lab, the normal values, the abnormal values, and the indicators of the lab values.
    a. The Lab Sheet is to be completed for the primary patient.
    b. Students who are unable to discuss the laboratory values will receive a clinical deduction and may be instructed to do additional written work on labs.
    c. There is a deduction for incomplete lab data.
6. Think Thinking Worksheet:

The Think Thinking worksheet must be turned in on the Friday after the clinical experience, by 0900.
The student will need to have all corrections and any additional requirements from the clinical instructor completed on the worksheet. Please follow the instructions for the Thin Thinking Worksheet posted on Blackboard.

    a. Thin Thinking worksheets grades will be included in the weekly clinical evaluation. Please see grading rubric uploaded in blackboard.

THIN Thinking:

Utilize the Thin Thinking Template to demonstrate appropriate clinical judgment. Fill in each area as it applies to your patient. Your clinical instructor will determine which patient you use to complete the Thin Thinking template. It is possible that it will not be the same patient that you are administering medications to.

Thin Thinking is a "compass" used to assist the student in developing clinical judgement. Clinical Judgement is the "doing that happens with critical thinking—the decision-making, problem-solving aspect of nursing."

T—top three priority needs: what are the top 3 needs of this patient? What are the top 3 concepts of this patient, diagnosis, etc. What are the top 3 questions we should ask (about this patient, about this disease, about this med, about this lab?) Are these problems chronic? Stable? Or are they acute? Unstable?

This step helps identify what information is relevant/irrelevant? What information is most important? What information is of immediate concern?

Choosing the top 3 is helping to analyze cues. What conditions are consistent with the cues? Are there inconsistencies? Why are these a concern?

H--Help quick! What can the nurse do RIGHT NOW? What is best for the patient right now? What do I as the nurse need to do immediately? Later? Eventually? This is the greatest area of "failure to rescue" and usually relates back to fundamentals of nursing.

This step addresses the highest priorities with appropriate nursing actions. How should the intervention be accomplished (performed, requested, administered, communicated, taught, documented, etc). Who should be involved in the action?

I--Identify greatest risk of safety for the patient—are there s/s showing that could indicate an increasing problem? Is there a medication that is indicating a problem or could be a problem? Are there family dynamics that could be a problem?

This step helps identify risks to the patient based on s/s, on age, location, medication, disease process—not just "fall risk".

N--Nursing Process/clinical judgement-do I have enough information to act? What do I need to assess? What do I need to implement—do? Who do I need to inform?

This step compares the actual outcome to the desired outcome. What signs point to improving/declining/unchanged status? Were the interventions effective? What needs to be changed or continued? Is there something more effective that could be done?

See Blackboard for the Thin Thinking Rubric

- IF PATIENTS are dismissed prior to 2pm on Day 1, the student is expected to pick a new patient and begin the research process again.
- IF PATIENTS are dismissed after 3:15pm on Day 1, the student is expected to pick new patients upon arrival to the unit on Day 2 and complete an ISBAR, assessment, and flowsheet for the new patients on Day 2. The student must provide care during the clinical day but is not required to complete clinical research on the new patients that evening.
- IF PATIENTS are dismissed after 10am on Day 2, the student is expected to assist the TPCN and fellow classmates with patient care.

CHART PACK:

In all medical-surgical rotations, the student must complete individual research and the chart pack. The Chart Pack is the student's practice documentation and is considered a legal document (it may be subpoenaed for evidence); therefore, the Chart Pack should be treated with respect and completed up to the point the student relinquishes care of the patient. The student must complete the Chart Pack daily.

Instructions for Completing the Chart Pack

Documentation of patient care is an integral part of care and is a necessary skill for the student to develop. ***Student Nurse Documentation is one way that the student demonstrates clinical judgment/critical thinking***! It also has legal implications. The student must make every effort to provide thorough and effective documentation throughout the shift and must complete the documentation on the student work sheets.

Remember: Your chart pack is your form of patient documentation and is considered a LEGAL document; therefore, you should treat your Chart Pack as a legal document. ONLY black ink should be used to document, and you must complete all documentation. All writing must be legible. You should store your papers in a secure place at home.

1. Each patient should have the ISBAR completed because this is your communication tool. You use one (1) ISBAR for each patient for all dates of care. There is room in the "assessment" area to write in your report information or you may use the back of the page. [If you must get a new patient, you need a new ISBAR]. THE ISBAR MUST BE VALIDATED BY THE INSTRUCTOR.
    a. Write your name in the Introduction area.
    b. In the R area, you should identify immediate nursing concerns for this patient and you identify/start discharge planning. Both should have more documentation in your nursing narrative.
2. From Blackboard, print the "chart pack;" you will need a new chart pack each day for each patient.
3. **ASSESSMENT PAGE 1:** print your name, patient initials, room number and date of the assessment across the top. At the bottom of the page is a place to document the time of the assessment. This format is a CHECKLIST of important assessment areas. It is to help you remember what to assess and then to document the assessment. You should complete it at the bedside. KEEP IT NEAT!
    a. Go through each assessment area, placing a check mark (√) in all areas that apply to this patient and completing all blanks as necessary as you complete your patient assessment—**BE WARY OF THE TEMPTATION TO COPY FROM DAY-TO-DAY! This is unprofessional, illegal, and unethical.**
    b. If your patient has diabetic checks (accudatas), be sure to get that information for breakfast) on your assessment page. If that check is covered by insulin, be sure and document that. YOU SHOULD ALWAYS KNOW YOUR PATIENT'S LATEST BLOOD SUGAR (diabetic patients). Also, be sure to inspect the diabetic patient's feet
    c. Be sure that you document your initial safety check on the checklist. You will also document this in your FLOW SHEET, but this is your FIRST check.
    d. Under skin, describe the color—using descriptive terms but not "NORMAL FOR RACE" or a similar statement. Actually, describe the color.

e. Be sure under "musculoskeletal" that you appropriately mark the pulses on the stick figure.
f. If something does not apply to your patient, leave it blank
g. Some areas indicate that they must be described in the narrative.
h. ANY unusual finding should be marked with an asterisk* and then detailed in the narrative. This is a patient problem.
i. The Braden scale should be done on each patient, using your scale to make that determination. (You will no longer complete a Braden scale worksheet on each patient). Write in the Braden Score.

4. **ASSESSMENT PAGE 2:** Print your name, patient initials, room number and date across the top. There is a Narrative charting checklist provided for you at the top of the page to remind you of what you should include. This is the NARRATIVE NOTE. "Narrative" means story—this is the story of the patient that you will write for the day. You must write in BLACK ink and your writing MUST BE LEGIBLE! Please note the following basic rules:
    a. This is considered "legal"—your records could be subpoenaed, so remember that when you document! ONLY factual information should be put in the patient's record.
    b. Writing must be clear. Correct spelling and punctuation are essential! Misspelled words could be used to indicate poor nursing care!
    c. This story is about THE PATIENT. Therefore, the *subject understood* of each sentence is "the patient" unless you change the subject. You do not need to write "the patient" every time—it is acceptable to start the sentence with the verb, realizing that "the patient" could be placed in front of the verb.
        i. You must be cautious with this—if you fail to change the subject of the sentence, it could be read and interpreted as if the patient were doing his/her own care. For example, if you write "gave bed bath," it legally reads "the patient gave bed bath"—as if the patient gave his own bed bath. To write this, you would change the subject to "bed bath" and then you would write "bed bath given." Now, it clearly reads that you were the one giving the bed bath.
        ii. Because this story is about the patient, you NEVER use personal pronouns in your narrative "I" "me" "we" . . . it is NOT about you. It is about the patient, the care given to the patient, and the patient's response to that care!
        iii. If you document care that is given by others, use their name and credential as much as possible so that it is clear who the care giver was. "TPCN" may be easy for you to write but is unclear in the documentation.
    d. NEVER cross out, white out, erase or use any other method to remove an error. If there is an error made in the charting, use ONE line to cross through the error, and place your initials above that line [follow this same rule for all papers written in the VNP]. Any attempt to obliterate documentation indicates that something is being hidden. Do not write the word "error" anywhere on the chart—this could be used against you in a court of law, indicating nursing errors.
    e. If you forget to document something that you did at an earlier time, write in the current time that you remembered, and then in the narrative write "Late entry for ___(the time you took action), then complete the documentation. *Eventually as a licensed nurse, you will document on a computer which automatically times each entry—therefore, it is important that you correctly learn to write a late entry.*
    f. Your student paperwork is CONFIDENTIAL. Always be aware of where you leave your papers. For all your student paperwork, please identify your patient by initials. Do not leave your papers out where anyone can read them.
    g. Be FACTUAL—only document what you observe or do or what the patient tells you,

using direct quotes if necessary. Do not make a judgmental statement, but instead describe the behavior. For example, do

not write "patient is angry." Instead describing the behavior "yelling, cursing, and throwing urinal at staff" is more specific and allows the reader to determine the patient's state of mind. You could even quote the patient's yells or curses to give a more accurate picture of the patient.

h. Use only APPROVED abbreviations. The national trend is to use fewer and fewer abbreviations so that there is clarity in the documentation.
i. The left column is the Time column. Please write—in military time—each time you are noting the care given. In the right column, is where you write your notes.
j. NEVER leave blank spaces in the narrative chart. Always draw a single line through any empty space to prevent subsequent entries from being made in your documentation by another person.
k. To begin your documentation, "open" your chart.
    i. The OPENING statement should include the following:
        1. report was received
        2. care was assumed
        3. of the patient by sex and age
        4. the diagnosis and the physician—this shows that you are taking care of the patient and that you know who the patient is and why they are there.
    ii. The next statement should be how you found the patient when you first went into the patient room. Is the patient (in bed? What position was the patient in? Was the patient breathing? Is the patient safe?)
        1. *Position:* chickens "lay", and people "lie" [lying]—patients in bed are in a position: supine, prone, left lateral, right lateral, high-fowler etc. Do not say "the patient was laying in bed" or "lying in bed"!
        2. *Breathing:* the patient should be breathing! You need to note that you saw that their respirations were present, regular, etc.
            i. *You cannot say the patient is "sleeping"—how do you know they are sleeping? The only way to know for sure is if you wake the patient up.*
            ii. *Their eyes may be closed. This is what you observe. This is why you document their breathing.*
            iii. Other items that must be described
        3. Describe what safety features are present.
        4. Pain—rating on a scale, location, intensity, duration
            a. What is done about the pain
            b. Follow-up—did whatever was done about the pain, change the pain?
        5. Wounds—must be described, including location, dressings, care, etc.
        6. IV/INT: the IV/INT site, dressing, condition should be described. If it is an IV, the solution, rate, amount should also be described—this is for primary solutions, not IVPBs. You must know the difference.
    iii. Asterisk items from assessment page must also be described in narrative and what was done about those items.
    iv. Any unusual assessments or specific nursing actions should be addressed in the narrative. The narrative should show that care was given to the patient and that the patient needs were addressed. If the patient doesn't need nursing care, why

are they still here?

v. IF A PATIENT ***REFUSES*** any care, it must be documented
The REFUSAL must also be reported to the TPCN and the instructor WHO WILL VERIFY THE REFUSAL. Document your reporting the refusal in the chart: *"Refused bath; refusal reported to TPCN Cindy and Instructor Blair."*

vi. If the patient leaves the unit for any reason, the reason should be documented, how they left and with whom they left with. Their time of returning to the unit should also be documented, along with a quick assessment to make sure the patient is okay. *"To x-ray via w/c accompanied by transportation assistant. Returned to room, assist to bed; resp even and reg. denies needs at this time."*

vii. Who is with the patient? Do they have needs? Questions?

viii. Discharge Planning: discharge planning begins on admission; what needs are identified? How can those needs be met? What resources might the patient need?

ix. Ambulation: how far did they walk? Did they use equipment? How many nurses had to assist? What type of assistance? What therapy? "*Ambulate 20 feet to nurses station and back. Up to chair, call light within reach, overbed table at chairside."*

x. "Close" the chart at the end of the shift. The closing statement should indicate that the report about the patient was given to another nurse and that care for that patient was relinquished to the nurse. The narrative must be signed by your LEGAL signature, your first initial, last name, nursing credential "SVN SPC." The signature must be legible.

5. **Page 3: FLOW SHEET**—This is your every 2-hour documentation!

a. ALL **bold face** items must be documented every 2 hours throughout the shift:

i. Pt position: what position is the patient in: B (back), R (right side) L (left side) P (prone), is the patient independent in turning = I. If the patient gets up to the chair = U; if the patient dangles on the bedside, "D." Write in the appropriate letter every 2 hours. If something happens not listed here, write this in the narrative.

ii. Check armband and allergy band every 2 hours and initial. If there is a change or a loss, write this in the narrative.

iii. What position is the bed in? Use the arrows to indicate this. If something unusual happens with the bed, write this in the narrative.

iv. Where is the call light? ✓ that you have checked its availability every two hours. If something happens unusual, write it in the narrative.

v. Are the bed brakes locked? ✓ every two hours that you know the brakes are locked. If something unusual happens, write it in the narrative.

vi. Are the siderails up at the head of the bed? ✓that you have checked every two hours. If there is something unusual happening or if the lower rails are also raised, write this in the narrative, explaining why the lower rails are raised. You would also need to narrate more information about assisting the patient out of bed or other safety measures if the lower rails are up.

vii. The IV/INT site should be inspected at least every 2 hours and you should note if it is Clean (C), Dry (D) and intact (I). You should ✓ each time it is checked. If the IV infiltrates or other problems develop, those should be noted in the

narrative. If the IV is DC'd or restarted, it should be documented in the narrative.

viii. Oxygen therapy should be noted via the device (write in the blank) and the Liters completed. ✓ each time it is checked. If the oxygen is DC'd or changed, it should be noted in the narrative. You should also note how the change in order has affected the patient's respiratory function.

ix. ✓every time the Incentive Spirometer (IS) is used by the patient. If the patient is not using IS, leave this area blank. If the patient is having respiratory issues, you should evaluate the need for IS.

x. ✓ every time you have the patient TCDB. If the patient's care does not require TCDB, leave this blank. If the patient is having respiratory issues or has had any anesthesia, or if the patient is having respiratory issues, nurses should automatically introduce TCDB to the patient.

xi. Is there family present? Indicate with a ✓. Specific family questions, requests, or problems should be documented in the narrative.

xii. Is toileting offered? This is especially important for patients with mobility or voiding problems and should be offered. Note the offer with a ✓. If there are issues with toileting, these should be described in the narrative. If the patient is independent in toileting, leave this area blank.

b Routine AM Care:

i. Write in the type of bath the patient takes. ✓when this occurs. If the patient refuses a bath, this should be (1) reported to TPCN, (2) reported to instructor, and (3) documented in the narrative with the explanation of why the bath is refused.

ii. Initial the time when the following are done: oral care, skin care, peri care, Foley care, linen change, ROM exercises and when TED/AE or PP are on. If the patient is independent in these activities or if the patient does not have a Foley, TED/AE, or PP, leave those blank. If the dependent patient refuses an area of care, this should be documented in the narrative.

c. **INTAKE and OUTPUT**:

i. INTAKE: Record the patient's intake for the day. Be sure that you note the difference between an IV solution and IVPBs! At 2 p.m. (1400), you should total all the day's intake in each category, then add them all together for the grand total intake. You should be concerned if the patient has NO intake all day**! In addition to getting a total and documenting it, you should report the intake to your TPCN when you relinquish care**.

ii. OUTPUT: write in output in each category for the time throughout the day. ***An output that is less than 30 mL an hour MUST BE IMMMEDIATELY reported to the TPCN/CN! This is an emergency***. You should be concerned if there is no output! At the end of the day, total each category, then total all categories for the grand total. **In addition to documenting the output, you should report the output to the TPCN when you relinquish care.**

d. Vital signs—record the vital signs and the time. If frequent VS are required (like a post-op patient), there is space to write them. ***Any abnormal VS should be discussed in the narrative, along with what was done about the abnormality. As a reminder to you, if there are extremes, there are reminders that these need to be reported IMMEDIATELY***. IF the patient has an elevated temperature, you must check the WBCs and document them.

e. Glasgow Score should be completed <u>on all neuro patients</u> or on patients that have an order for neuro checks. *Routine med-surg patients usually do not need this*.
f. Nutrition: Write in the diet ordered, then record the percentage consumed of each meal. If the patient has a snack during the day, this should be documented in the narrative. If the patient is refusing to eat,
(1) report and (2) document this in the narrative. Also write in the narrative what else was offered to the patient in the way of nutrition.
g. For diabetic patients, record the AC lunch accudatas and amount of insulin given is appropriate. You should always be aware of your patient's blood sugar. If there is an unusual occurrence, document this in the narrative.
h. INCISIONS, WOUNDS, Pressure ULCERS: for each wound, please write in the location (i.e., midline Abd), the type of wound (i.e., surgical, pressure) a brief description and the dressing type—can use OTA if the wound is open to air. If there are more than 4 wounds or great drainage or dehiscence, etc., then describe this in the narrative and the care given.

LEVEL 2 AND LEVEL 3:

6. **MEDICATON FORM**: **AFTER** you have completed your a.m. care, go to the patient's medical record, and list your medications on this form. You should include the dose, the route, the frequency, and the times the medication is to be administered. a.WEDNESDAY NIGHT RESEARCH:
    i. Write in both the GENERIC and TRADE name of the medication
    ii. Therapeutic Class and Drug Class: find this in the drug book: *classification* of each medication
    iii. How it works: Look at *Action* in the drug book.
    iv. Why is YOUR pt taking it? Write the *indication* for THIS patient— "My patient is taking this because. . ." Many times, the patient takes a medication for a different reason than that of its classification. An example is Aspirin. Aspirin is classified as an antipyretic or pain reliever. However, for an adult, 81 mg or 325 mg dose will not do either of those things. In this case, the patient is taking this as an antiplatelet/anticoagulant, NOT for fever. KNOW THE REASON!
    v. Why is this med usually given: Look at *indications* in the drug book.
    vi. Pt Dose: Write in the ordered dose (noting if this is a correct dose when you research) and the route; Also complete the Normal Dose Range
    vii. Pt. Route: PO, IM, IV, etc.; Also Possible Routes
    viii. Times: Write in the frequency of the medication AND the time— "daily" is not a time—not all meds ordered daily are at 0900, so you must write in the time the medication is to be administered.
    ix. Side Effects: Identify 3 major *side effects* or adverse reactions (if you write a comprehensive term like *Steven Johnson Syndrome* you better be able to explain what that is [hint: write it on a stickie note])
    x. Nursing considerations: Identify 3 (can include labs, VS needed prior to administering this medication (Look at Nursing Implications and Implementation in Drug Book)
    xi. Patient Teaching: 3 things to teach your patient about this med.
    xii. Citation: Correctly site the drug book with page number.
    xiii. Write therapeutic level, antidote, max dose in 24hrs as applicable. Onset and Peak for all insulin

b. Review your medications and think about the relationship to the diagnosis, the expected effect of the medication and how each works in the body so that you can effectively discuss these on Tuesday with your instructor.

7. **LAB DATA**: **AFTER** you have completed your a.m. care, go to the patient's medical record, and pull up lab and diagnostic information. You should write in all labs from the date of admission, then current labs for dates of care. **PLEASE NOTE:**agency values may be slightly different based on each agency's equipment. If the agency calls something "abnormal" and its value is a little different, please go with the agency determination
    a. ROUTINE LABS: There are some labs that all patients have, and these are listed on the lab sheet, along with "normal" adult values as found in Van Leeuwen & Bladh, 2019. Highlight in YELLOW all abnormal labs for this patient.
    b. RESEARCH: WEDNESDAY night (and then note any changes on Thursday night), research why the patient's values are abnormal—you are looking for REASONS, not diagnoses.
    c. PATIENT SPECIFIC LABS: there are blank spaces in the lab form for you to use to write labs that are specific to this patient. There is a suggestion box to use to help you think about what to look for. There is also a table in the back of your lab manual that has labs listed by diagnoses that you can use to help you. THIS AREA SHOWS YOUR CRITICAL THINKING when you determine that the lab is important to your patient and write it down or when you determine a lab is needed and request it to be ordered! Students who either cannot recognize important labs and have them written or who want to skip this will find deductions taken from the clinical evaluation!
    d. Students are expected to discuss all labs as part of the student discussion with instructors.
8. **LAB AND DIAGNOSTIC STUDIES** (x-rays, etc.). Write in the dates they were ordered, and the "impression" from the radiologist under patient results. Determine why you think these were ordered; also place in appropriate place on CCM (clinical care map)
9. **Turn in your completed stamped chart pack(s) in a folder to the assigned box in the Vocational Nursing Office NO LATER THAN 0900 each Friday**. The instructor will evaluate your completed documentation—it should all be complete. Incomplete chart packs will result in additional points deducted from the paperwork/documentation evaluation. Once the chart packs have been reviewed, they will be placed in your box for you to retrieve and to keep for your personal records.

The **completed Chart Packs** should be turned in for REVIEW on Friday by 0900 to the assigned box in the Vocational Nursing Office.

Additional points may be taken from the clinical grade if work is incomplete.

A student who is going to be absent on Friday MUST email the clinical instructor prior to 0800 to report that the chart pack/clinic note is not going to be turned in Friday by 0900 due to illness. On the first day back in class, the Chart Pack/clinic note must be turned in; failure to notify the instructor OR failure to turn in the chart pack/clinic note upon the return to school will result in a deduction on the paperwork/documentation evaluation.

A delay in a didactic course for the day DOES NOT PROHIBIT meeting the 0900 Friday deadline (in other words, if a theory class is delayed by an instructor for some reason, the expectation will still be that the Chart Pack is turned in by 0900 Friday)

Guidelines for Writing a Narrative Note in the Vocational Nursing Program

Although modern technology has done away with much of the written head-to-toe assessment in actual patient documentation, the ability to put such an assessment together with clarity and detail enhances a student vocational nurse's critical thinking about the patient assessment process.

The following guidelines are to be used in writing the narrative note.

General Writing Rules:

1. Write on one side of the Narrative Note only. If you need more than one sheet of paper, continue writing on a second sheet, not on the back.
2. Handwriting must be legible—if it cannot be read, it has no value.
3. Treat this work as a LEGAL document—this means that it could be used in a court of law. Your Chart Pack could be subpoenaed.
4. This writing is about the patient—the focus is the patient and how the patient is, what the patient needs, does, wants, etc. The nurse signature indicates that the nurse is the one providing the care unless the nurse indicates in the writing that someone else provided care, so the writing must be clear. If a sentence starts with a verb, then the subject *understood* is the patient.

   Example: Gave bed bath. Reported pain. *These legally read "The patient gave bed bath. The patient reported pain."*

   a. If the subject of the sentence is not the patient, then the subject should be clearly identified.

      Example: Bed bath given. (Bed Bath is the subject). Pain reported to TPCN. (Pain is the subject of that sentence).

   b. Personal pronouns, *I, we, me, you, us*, should not be used in the narrative assessment.
   c. What the student thinks, feels, does, is not important in this writing except to write what happens to the patient because of the care given.
5. The date and time must initiate the writing, flush left of the page.
   a. Each new entry should have the time
   b. Military time should be used; therefore, no colon should be used in between the hour and minutes.

   Example:
   Incorrect: 07:10 Report received; care assumed. . ..
   Correct: 0710 Report received; care assumed. . ..

   c. If a new page is started, re-write the date and time continued with that entry.
6. At the end of an entry, the student's first initial of the student's *legal* name and the full last name, along with the credential "SVN" must accompany the entry.
   a. If the entire note is written as one entry, only the last line must be signed.
   b. If the entry ends at the end of a page, sign off that entry on that page. Sign off the last entry on the new page.
7. If an entry ends midway through a line, <u>line out</u> the rest of the line to prevent someone else from coming after and writing in additional words.
8. If an error is made in writing, place one line through the error and write the student initials above the line, then continue with the writing. If there is not room to write the correction, place a line through the entire sentence and re-write the entire sentence.
   a. DO NOT blacken out the writing—this indicates something to hide
   b. DO NOT use white out—again, indicates something to hide
   c. DO NOT write over—besides being sloppy, this indicates something to hide
9. Punctuation must be used. Periods must end sentences; commas must separate clauses.
10. This is written in narrative style, meaning a story. Therefore, you do not write a section, colon

and then describe. You write the whole section as a story.

Example:

Incorrect: Eyes: PERRLA. Ears: clear. Skin: warm and dry.

Correct: PERRLA. Ears clear. Skin warm and dry.

11. Use only approved abbreviations in this writing. The ampersand "&" is **NOT** an approved abbreviation for "and."
12. Spelling is important. You must be able to spell words, especially common words!
    a. Most common errors include the use of "i" and "e" such as in receive.
    "I" before "e" except when it comes after "c" or when it sounds like "a" as in "neighbor" or "weigh." b.
    The patient has *bowel* sounds, not *bowl* sounds.

Specific Writing Criteria:

1. The documentation needs to be "opened" or started with the initial opening statement that tells (a) how the nurse took over care, (b) identifies who the patient is and why the patient is there, and (c) tells how the nurse first found the patient.
   Example:
   0700 Report received and care assumed of a 74-year-old male with diabetes, (L) BKA, weakness for Dr. Rabbit, supine in bed with eyes closed, respirations even and regular. *N. Nurse, SVN.*

   In this example, "report" and "care" are the subjects that start this sentence. The age is given to identify the patient, the diagnoses, and physician. The patient was apparently sleeping, as indicated by stating that the eyes were closed, and the respirations were even and regular (as opposed to dead with no respirations). The statement would have been incorrect to say "sleeping" because the only way to be sure the patient was asleep would be to wake the patient up.
2. The patient's position should be clear. People "lie", and chickens "lay"—patients are in positions: supine, left or right lateral, Fowler, prone, etc.
3. Complete Vital Signs should be written because they are "vital" to the patient.
4. Orientation should be specific—to say "x 3" is incorrect because there are many questions that could be asked to determine orientation.
   a. The correct word is "oriented." **Orient** as a verb means to "find direction" or "give direction." The noun form of this kind of orienting is **orientation.**
   b. Sometimes people in their speech will form an imagined verb from **orientation** and say **orientate** or make it a verb as **orientated.** At best, **orientate** is a back-formation used humorously to make the speaker sound pompous.
   c. The correct word is the verb **orient.**
   d. **Orientate** is more widely accepted in the U.K. than in the U.S.A., but <u>it should be avoided</u> in any formal or standard writing.
5. Describe what you see. Don't say "natural" or "normal" for skin color—unless you have seen the patient prior to the hospitalization, how do you know what is natural or normal?
6. Avoid using the word "normal"—who determines "normal"? Instead use the descriptive terms
   a. Lung sounds are clear, adventitious, wheezes, rhonchi, rales, congested
   b. Bowel sounds are present, normoactive, hypoactive, hyperactive, absent
   c. Skin is pink, brown, tan, pale, ruddy.
7. If the patient says something that is important to document, use quotation marks to show that that information came directly from the patient.

8. Don't assume—if you find the patient on the floor, describe it but don't assume the patient fell (they have been known to deliberately get on the floor). Don't assume there is a bruise because of an injection.
9. Intravenous (IV) access can be through a peripheral vein such as those found in the arms or legs, a subclavian vein, or a jugular vein. In most instances on a med-surg floor, the access is peripherally, usually in the lower arms. IVs can be continuous, meaning that they usually have 500-1000 mL bag of solution running continuously throughout care, OR IV access can be *intermittent,* meaning that the vein has an IV port, but solutions do not run all the time—usually for about 30 minutes several times a day for medications, only. Documentation of the IV access must be clear. For a CONTINUOUS IV, termed as "IV," there should be documentation of the solution, the amount, the rate, the pump being used (or if it is by gravity), and the site of the IV access with the access site described as to location, condition, and dressing. Intermittent access is termed "INT." For the INT, the site should be described as to location, condition, and dressing. When either is DC'd, the description of the removal and of the site should be included, as well as the dressing applied, and instructions given to the patient about the DC.
10. If there is an *abnormal* condition or assessment, describe it and include what nursing actions were taken, including who was notified about the abnormality. If the patient reports pain, do not just document the pain. You must also document who you reported the pain to and what was done about it. The documentation should also indicate that you verified pain relief. If there is abnormal skin turgor, you must also include who was informed about it. If the IV infiltrates or develops phlebitis, you should document that it was DC'd (and by whom if it was not you), if it was restarted, and what was done about the injured vessel.
11. Describe wounds and/or dressings. Do not just say there is a wound present.
12. Decubitus prone areas—the back, the buttocks, the heels—should be specifically addressed.
13. If a Foley catheter is present, the size and type of catheter, as well as the amount and color of urine should be clearly indicated. If the Foley is connected to a Continuous Drainage Unit (CDU), that must be stated. The location of the CDU should be stated as well to show that the safety of the catheter was maintained.
14. Safety is a major issue in the hospital. All safety care should be noted in the documentation: ID bands, safety bands, allergy bands, restraint devices, side rails, call light, bed position, brakes, and any alarms. Sitters should be noted if they are part of the safety device. If family have been instructed to not leave the patient alone, family must be noted as part of the safety information.

Remember: the information that is documented must be RELEVANT to patient care. Social conversations, TV shows, political/social views & opinions are ONLY relevant if they impact patient care! What YOU think, feel, believe, etc. is NOT relevant to this documentation. Your documentation should reflect the focus of nursing care—what patient problems you are doing something about!

COMPUTER USAGE

Clinical Computer Usage: Computer systems at the clinical sites are for the purposes of clinical work. Students may only use the agency computer systems for accessing important patient data the student needs for safe and effective patient care. Students MAY NOT use the agency computer for personal usages such as checking emails (even SPC or instructor-sent emails are prohibited on agency computers), Black Board, websites (including drug or diagnoses websites) or other personal usage. **No "research" is to be done during the clinical period**. Students who engage in inappropriate computer usage will be placed on probation for the first offense and dismissed from the VNP for a subsequent offense. Refer to the Student Vocational Nurse Handbook.

The student should not be on the computer if:

(1) each assessment is not completed,
(2) each assessment is not documented
(3) a.m. care is completed for each patient.
Students found on the facility computer will be asked for these records and deductions will be taken if they are not complete.

As computer technology in the field of health occupations continues to become more popular, computers may be used in this course for Case Studies and Care Plans if the student chooses to use them. All students have access to computers and printers on the South Plains College campus. All registered students are supplied with a working email account from South Plains College.

ALL STUDENTS ARE EXPECTED TO KNOW THEIR SPC STUDENT USER NAME AND PASSWORD.

COMPUTER LAB USAGE

The computer lab(s) on any campus may be used by students during scheduled open hours or as assigned by an instructor. The computer lab is open to students. Printer paper will not be provided for students to print materials but students may seek assistance from faculty or staff to request lab paper from the college if needed. Lack of computer lab paper is not an excuse for not completing assignments. Waiting to print at the last minute and then not being able to do so is no excuse either. *Please remember that NO FOOD or DRINK is allowed in the computer lab.*

Use of TikTok on any SPC device or while using SPC Wi-Fi is prohibited. TikTok may not be used for any assignment.

Covenant Computer Checklist

History and Physical

Go to Notes Tab located at top of screen -> Select Note Type or Service Type -> Look for (H&H) History and Physical

If you are still unable to find the history and physical, you need to call your instructor!

- Utilize the H&P to fill in your ISBAR with information you did not receive from your nurse or patient.
- Be sure to READ all the way to the bottom. You can skip over any lab and radiology results as you will be looking at that later under the Lab section.
- At the bottom of the H&P is the Impression and Plan. This is where Physicians write what they believe is going on and will write the plan for treatment.

The H&P is documented within 24hrs of admission so be aware that these diagnoses can change and more may be added. This is why you will be looking next at your Progress notes for changes that have occurred since admission.

Progress Notes

Go to Notes tab located at top of screen -> Select Note Type or Service type -> Look for Physician Progress Notes

- There is typically a progress note for every day of their stay during this admission. You should read at least the first and last progress note. If, when reading the progress note, you do not know how all of the sudden several diagnoses have changed or been added, you can skip back and read more of the progress notes.
- Again, you must read all the way to the bottom. At the bottom, you will find the Impression and Plan. Use this information to fill in your ISBAR with current and past medical diagnoses. Also, fill in what is happening now. You can also see if they are planning discharge.

MAR

1. Get your White Medication Sheet from the chart pack.
2. Fill in the medication name, route, dose, frequency and times.

   This is not the time to fill in classification, indication, side effects, V/S needed etc.- that is for research.
3. For Scheduled medications you will need to right click on the MAR tab located at the top of screen -> Select Scheduled medications -> right click on medication-> look at Order detail. This should show you the times that the medication is scheduled. Be aware that if the med is BID- you are looking for 2 times, TID- 3 times, etc…
4. To look at continuous medication repeat steps located above and instead of selecting scheduled you will select continuous. Repeat for PRN medications.
5. You only need to fill in frequency for PRN medications, not times because they are not scheduled at set times.

Example of Scheduled vs. PRN:

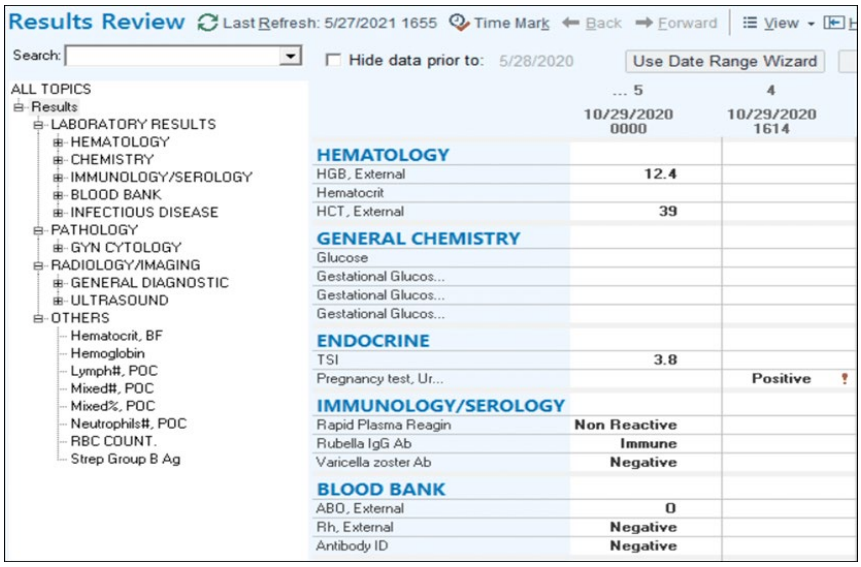
Medication	Classification	Indication	Dose/route	Frequency/time	Side effects	v/s
Furosemide (Lasix)			20 mg PO	Daily 0900		
Acetaminophen (Tylenol)			500mg PO	Q4h PRN		

Orders

- Click on orders tab located at top of the screen.
- Be sure to note any wound care, Ted Hose, SCDs, Oxygen, IV fluids, Accu-checks, Diet, Fluid Restriction, Weight bearing restrictions, etc…

Flowsheets (Labs, Radiology, ect.)

Click on Results Review tab on top left hand side of the screen. This will bring up a chart that looks similar to:



- You will need to look at your patient's admission date and get your lab sheet from your chart

pack. Fill in the labs from the date of admission.

- Then look at the most current labs and fill those labs in on the next column. You need to write this information in black ink.
- DO NOT write in the normal values or draw your high or low arrows in blue or red at this time. This is for you to do at home as research.
- Be sure to look at the left-hand column (Hematology, Chemistry, etc.) You can toggle through the labs using this column.
- Make sure to note any Microbiology. This is where you will find cultures such as blood cultures, urine cultures, wound cultures.
- If your patient has Accu-checks, you will find them in the MAR.
- Next Click the Radiology/Imaging Tab.
    - Get your Diagnostics paper from your chart pack and fill in any x-rays, MRI, US, results from the current admission

Clinic Required Research

To prepare for the Outpatient Clinics: Clinic rotations are senior-level rotations in which the student functions in a more independent role under the supervision of the clinical instructor and clinic nursing staff. Students on probation do not participate in off-campus rotations.

General rules:

1. Students may be assigned to a clinic more than one time during the semester; some clinics may not be available to every student
2. Each clinic has specific requirements of preparation that the student MUST do PRIOR to the rotation.
3. Each clinic will require the following daily, both of which should be turned in to the clinical instructor by 0900 Friday.
    a. Clinic Objectives
    b. Med Sheet from chart pack completely filled out for that clinic (if no meds are administered and or prescribed, please write "No meds administered and or prescribed" and submit)
    c. Completed time sheet
4. Each student will submit a signed time sheet for the clinic rotation turned to the clinical instructor.
5. Additional clinical deductions will be taken for failure to turn the above documents in completed and on time.
6. Students who get placed on probation will forfeit all further clinic rotations so that greater instructor supervision is available to assist the probated student
7. Students at the clinics must follow all SPC guidelines.
8. The Clinic objectives and paperwork are posted on Blackboard

Students in the clinics work with all staff including nurses and physicians in providing outpatient care. Students should anticipate that they will assist staff with calling patients back, taking vital signs, completing focused assessments, assisting with procedures, removing sutures (Instructor/ Instructor approved nurse supervision), administering medications (Instructor/ Instructor approved nurse supervision, completing fingerstick blood sugars and Coumadin checks (Instructor/ Instructor approved nurse supervision), as well as assisting with all phases of nursing care. Students must always have complete medication information while administering any medication and follow all SPC policies and guidelines.

Assignment for each clinic: Complete prework and the Clinic objectives posted on Black Board and follow those instructions. Submit to your clinical instructor by 9 a.m. Friday.

Clinical Research and Expectations

DECs: Member of a Profession, Provider of Patient-Centered Care, Patient Safety Advocate, Member of the Health Care Team

POSITION STATEMENT: Student Vocational Nurses can only provide safe, effective nursing care if they understand the patient diagnosis(es) and/or medications. Therefore, **students must research on a weekly basis** the patient diagnosis and/or medications for each patient for which care is provided. Student research and the ability to discuss this research are one way instructors evaluate the student's clinical judgement.

VIOLATION: Unsafe Nursing Practice—a student who does not understand the patient's diagnosis, lab and diagnostic studies, and medications is UNSAFE and can potentially harm a patient!

Each clinical course has specific research requirements. Please refer to each clinical syllabus for the specific research requirements: VNSG 1160 (Level 1), VNSG 1460(Level 2) and VNSG 2461 (Level 3).

Medication Administration by Student Vocational Nurses after successful medication rotation

DECs: Member of a Profession, Provider of Patient-Centered Care, Patient Safety Advocate

POLICY: Student Vocational Nurses will administer medications following all guidelines and policies for safe, effective administration of medications with supervision of instructor. After successful completion of medication rotation and with written instructor approval, may be supervised by TPCN.

Student Vocational Nurses do not administer any medications until they have successfully completed Medication Administration Check-off in Level 2.

Instructor or TPCN reviews medications and escorts student to the patient room and remains with the student at all times while administering medications. This includes scheduled and prn medication administration.

VIOLATION: Unsafe Nursing Practice, Unprofessional Conduct

If a medication error is made, after assuring patient safety, the student and instructor will immediately notify the TPCN. The TPC nurse or instructor will notify the physician of the error, and an investigative report will be completed. An evaluation of the medication error will be performed and thoroughly reviewed for potential corrective action.

THE SIMULATION EXPERIENCE

PURPOSE: Simulation is a "strategy—not a technology— to mirror, anticipate, or amplify real situations with guided experiences in a fully interactive way." (http://www.ahrq.gov/)

When assigned, students will participate in simulated nursing care scenarios at the Center for Clinical Excellence located in Building 1 at the Reese Center. Refer to the Student Handbook for specific guidelines for this facility.

Students can expect the following from simulation:

- The opportunity for independent critical-thinking, decision-making and delegation
- The opportunity to make and learn from mistakes
- The opportunity for deliberate nursing practice
- The opportunity for immediate feedback
- The opportunity to participate in experiential learning

During Simulation, students fulfill all roles of the nurse and are not restricted to student limitations. Students must treat the simulation experience as a REAL patient situation; if appropriate action is not taken by the student, the patient will experience a negative outcome, including "death. On a rotating basis, students will be assigned roles for each scenario. All roles are important, and all students have learning opportunities in any role.

RESEARCH: Students must be prepared for the simulation. Student prep materials are found on Black Board and should be reviewed the Sunday before the Simulation experience begins. Students are required to prepare for the clinical experience through review of materials, preparation of Dx, RX, procedure cards and other information that will be used during the experience. **Students who are unprepared for the simulation experience due to lack of preparation may be sent home, accruing an absence.**

DEBRIEFING: occurs after the simulation concludes. During debriefing, the scenario is discussed, and the student's nursing actions/decisions are examined. This is a great time for self-reflection. All students should participate in the debriefing process. Confidentiality is a must and students cannot share information with other classmates. **A Breach of Confidentiality in simulation is grounds for dismissal from the VNP.** While observing the scenario, students maintain a plus/delta sheet which allows the student to experientially learn and provide valuable feedback.

SIMULATION EVALUATION: Students will be evaluated during the experience. Adherence to SPC and CCE policies (including dress code), participating in the experience, adhering to safe nursing practice principles and competency of previously learned skills are part of the evaluation. Additionally, students reflect on their own learning through the reflection tool found on Blackboard.

SIMULATION ATTIRE: Students must be in full clinical uniform, including have stethoscope, penlight, scissors, SBAR, Chart Pack, Dx and Rx cards. **If you do not have these items, you are considered out of dress code**. ONLY Pencils may be used in the simulation rooms.

SIMULATION ATTENDANCE: This is a clinical experience. Full attendance is expected. Students who must be absent for any reason must follow call in guidelines by emailing **ALL** instructors by 0700; after 0700, the student is classified as a "No Show." Students are absent at 0800—**THERE ARE NO TARDIES**—this experience is already later than hospital experiences, so there is no reason to be late. Students must clock in with their student ID upon entrance to CCE.

LUNCH: The instructor will assign a lunch break during the day. You may bring your lunch or may leave the campus for lunch depending on the assigned time. You must be on time after lunch, or you will be counted as absent**. If you return late from lunch, you are sent home absent for the day.**

DO NOT BRING CELL PHONE INTO THE BUILDING!! Leave it in your car!

TEXT AND MATERIALS

Students should use current resources from theory textbooks such as the Williams & Hopper, Davis Drug Guide, etc. as tools to equip them for patient care. Websites that the student may use should end in ".org" ".gov" or ".edu." Wiki websites are not acceptable; neither are WebMD or Mayo Clinic [these websites are designed for laypeople—not professionals!]

Students are required to have the following items with them for the clinical experience:

- This syllabus
- Student and Clinical Handbook
- Specific Unit Objectives that are not included in this syllabus
- Davis Drug Guide

ADDITIONAL CLINICAL ITEMS

Students should come to clinicals with all required research, chart pack or clinic notes. The student must be in full clinical uniform which includes the student badge, stethoscope, blood pressure cuff, penlight, bandage scissors, black ink pen and analog watch Refer to the Student Handbook for the full-dress code

Attendance in the Clinical Setting

DECs: Member of a Profession

VIOLATION: Unprofessional Conduct

POLICY: Because the clinical component is the course where the student internalizes the theoretical concepts taught in the class and applies the learning to actual nursing practice, attendance in the clinical setting is mandatory. Additionally, one way a student demonstrates CARING is through timeliness, attendance, and respect.

Clinical Times:
South Plains College requires students to be in the facility and ready to begin the clinical experience as scheduled. Specific times are located on the course syllabus or clinical schedule. The student is responsible for noting the time allotment. There is always the possibility, due to clinical space availability, that the student may be scheduled for some alternate time shifts, including evening hours.

Clinical time is "on the job" learning. Students are expected to be working throughout the entire shift. Students MAY NOT leave the assigned unit until dismissed by instructor. Students who leave the floor early are given an absence for the entire day.

Clinical Absence:
Clinical experiences offer students the opportunity to apply theory to actual nursing practice. Students MAY NOT attend clinical when running a fever, experiencing vomiting or diarrhea, having pink eye or any other

infectious process. ***The student should anticipate that such illnesses or other emergencies may occur and should judiciously take an absence only when truly needed!***

For specific attendance requirements refer to the clinical course syllabus. <u>Exceeding the allowable clinical absences may result in failure in the clinical course.</u>

ATTENDANCE POLICY (*READ CAREFULLY)

Clinical experiences allow the student to apply the theory of nursing to practice. Students are expected to attend all assigned clinical experiences, including Simulation, Clinical Judgment Experiences, and any assigned Friday Lab. The student may be administratively withdrawn from the course when absences become excessive as defined in the course syllabus.

Recognizing that sometimes students are ill or have ill children or have some other real reason to be absent, students may have **2** absences this semester—<u>this includes any day the student is sent home for clinicals for a rule's violation</u> <u>(see Student Handbook) and or Clinical Post Conference Friday lab activity.</u> **Any absence** will require a make-up in order to complete the required clinical hours; Students will be assigned a virtual simulation that must be completed outside of regular class and clinical hours and submitted by the assigned due date. Because students cannot be evaluated if they are absent, points are deducted from the weekly clinical grade and replaced after make-up clinical. Student would be required to meet with the Lead Instructor and VN Coordinator and may be administratively withdrawn from the program.

*If the student has a documented emergency that leads to exceeding 2 absences, the student will be responsible for notifying the instructor. The student must present evidence to the Lead Instructor and VN Coordinator regarding the reasons for all absences. They will review and determine if a true emergency existed for each of the absences. Failure to plan (childcare, transportation, traffic, tardiness) is not an eligible emergency. There are absences available in each course in case one of these needs arises. However, exceeding absences is grounds for dismissal. Should you use an absence, please be aware that if you encounter a true emergency later in the semester and you have already used your absence for a non-emergency, the attendance policy will be upheld, and you may be dismissed from the VNP. The decision of the committee is final.

<u>Clinical Tardiness: Tardiness is not acceptable in the Vocational Nursing Program. Students are either present on time or absent. For more specific information on timeliness, refer to the clinical course syllabus and clinical schedule.</u>

<u>How to Decide if you are Too Sick to Attend Clinical (verify with HCP note):</u>

Students should not come to the clinical setting for the following reasons:

* Fever > 100.4º F
* Conjunctivitis (Pink Eye)
* Diarrhea lasting more than 12 hours
* Group A Strep—culture confirmed or physician diagnoses
* Jaundice—yellowing of the skin which might suggest viral hepatitis
* Cold Sores (herpes) that are weeping, open (not crusted over)
* Active measles, mumps, pertussis, rubella, chicken pox or shingles
* Upper respiratory infection (cold) with productive cough (green or yellow sputum) * Tuberculosis and/or positive TB skin test
* Head lice
* Scabies (mites that burrow under the skin causing a rash)
* Any draining wound such as an abscess or boil
* Impetigo

* Mononucleosis

*** Students who come to clinical contagious are sent home with an absence.**

COVID policy:

COVID-19

If you are experiencing any of the following symptoms, please do not attend class and either seek medical attention or get tested for COVID-19.

· Nasal congestion
· Cough, shortness of breath, difficulty breathing
· Fever or chills
· Muscles or body aches
· Vomiting or diarrhea

Please also notify DeEtte Edens, BSN, RN, Associate Director of Health & Wellness, at dedens@southplainscollege.edu or 806-716-2376

1. SPC policy will recommended a 3-day isolation period for individuals that test positive.
a. Please note that day 0 is the date of positive test. Day 1 begins the first full day after the date of positive result.

2. COVID reporting
a. Please have students and employees notify DeEtte Edens if they have tested positive to verify dates before returning to class or work.
b. The home tests are sufficient but students need to submit a photo of the positive result. The date of test must be written on the test result and an ID included in the photo. If tested elsewhere (clinic, pharmacy, etc.), please submit a copy of the doctor's note or email notification. Results may be emailed to DeEtte Edens, BSN, RN at dedens@southplainscollege.edu.
c. A student is clear to return to class without further assessment if they have completed:
The 3-day isolation period, symptoms have improved and they are afebrile for 24 hours without the use of fever-reducing medication.

3. Please instruct students and employees to communicate with DeEtte Edens prior to their return date if still symptomatic at the end of the 3-day isolation.

4. Exposed individuals will not be required to quarantine. If exposed, SPC does request individuals closely monitor themselves. If an individual does become symptomatic, please do not attend class or work and be tested.

Please immediately notify your instructor and program director, and DeEtte Edens (Associate Director of Health and Wellness) any time you test positive for COVID-19.

Students are officially enrolled in all courses for which they pay tuition and fees at the time of registration. Should a student, for any reason, delay in reporting to a class after official enrollment, absences will be attributed to the student from the first-class meeting.

Students who enroll in a course but have "Never Attended" by the official census date, as reported by the faculty member, will be administratively dropped by the Office of Admissions and Records. A student who does not meet the attendance requirements of a class as stated in the course syllabus and does not officially withdraw from that course by the official census date of the semester, may be administratively withdrawn from that course and receive a grade of "X" or "F" as determined by the instructor. Instructors are responsible

for clearly stating their administrative drop policy in the course syllabus, and it is the student's responsibility to be aware of that policy.

It is the student's responsibility to verify administrative drops for excessive absences through MySPC using his or her student online account. If it is determined that a student is awarded financial aid for a class or classes in which the student never attended or participated, the financial aid award will be adjusted in accordance with the classes in which the student did attend/participate, and the student will owe any balance resulting from the adjustment.

(http://catalog.southplainscollege.edu/content.php?catoid=47&navoid=1229#Class_Attendance)

Student MAY NOT attend clinical when running a fever, experiencing vomiting or diarrhea, having pink eye or any other infectious process.

Call In/No Show Policy and Procedure:

The student who is going to be absent MUST notify the instructor prior to the absence. ***This is a professional habit and will be expected of an employed nurse!*** The notification should be at least an hour prior to the shift start. However, should the student wake up late or experience car trouble (or some other last-minute unseen event), the student should still email the clinical instructor to avoid being classified as NO SHOW.

Violation: Unprofessional Conduct

CONSEQUENCES FOR "NO SHOW": Please refer to the clinical course syllabus.

Procedure: If you must be absent, please follow the clinical course syllabus guidelines to alert the clinical instructor and facility at least one hour prior to the shift start:

- Follow this procedure for each day absent.
- **Failure to email appropriately by the specified deadline results in the student being classified as a "NO SHOW!"** (See NO SHOW policy in the clinical course syllabus.)

As a matter of courtesy and professional behavior, a student who is going to be absent must email the course instructor and inform the instructor of the pending absence.

During clinical rotations, the student will be responsible for notifying the **assigned nursing unit** at the hospital or facility where she/he is scheduled to work, **and the assigned clinical instructor.** The notification should be at least an hour prior to the shift start. **If a student does not call prior to 0530**, patient assignments will be relinquished, and the student will be counted absent. In the case of an extenuating circumstance, if the student has notified the clinical instructor before 0615, they will be late, patient assignments will be held until **0700** after which time the assignment is relinquished and the student will be sent home absent. The student will only be allowed one extenuating circumstance per semester.

Each student will be required to provide their initials along with the time they report and leave duty in a provided attendance record at "in-house" clinical affiliate sites. Attendance verification will be provided by the student in all clinical rotations identified as "external" sites. Attendance verification forms should be obtained through blackboard and returned completed by clinical assignment due date. Failure to do so may result in a clinical absence for those days without verification.

CELL PHONES IN THE CLINICAL SETTING

Cellular phones are **NOT** permitted in the clinical setting because they may interfere with electrical equipment within the facility. Additionally, cell phones are a distraction to patient care.

Cell phones are **prohibited at any time during the clinical experience** and may not be used in any location of the clinical setting during clinical hours. Students should not have cell phones on their person, in their back packs, pockets or other personal areas during clinicals. Cell phones should be left in the student vehicle or left at home.

Students who violate this policy and have their cell phone out during the clinical day or on their person *for any reason* will receive a zero for the day, no matter when the incident occurs.

Clinical Affiliate Approval

Clinical affiliates have a right to deny clinical experiences to students based on that facility's policies and procedures.

1. If a student is a former employee of a facility and ineligible for rehire, that student may not be able to perform clinical rotations at that facility.
2. Should alternative experiences not be available, the student must withdraw from the VNP.
3. Clinical facilities may also request, in writing, a denial. Should a student be denied clinical experiences at a particular-affiliate, the faculty will look for alternative experiences within the program's current affiliations. However, should a student be prohibited from a major facility in which BON required experiences occur, the student cannot meet the program objectives and must withdraw.
4. Clinical facilities may request student information prior to allowing students to participate in clinical experiences. At a minimum, the student name and SPC student ID is shared with facilities for clearance with their IT systems. Other information may be requested.

Clinical Probation

"Probation" is defined by Webster's New Collegiate Dictionary as "the subjection of an individual to a period of testing and trial to ascertain fitness…."

POLICY: During each clinical rotation, an instructor will evaluate the student.

PROCESS: The instructor will complete a weekly clinical evaluation so that the student has many opportunities to improve performance.

1. Should a student have difficulty improving, that student may be placed on clinical probation.
2. A student who has not completed clinical paperwork may be placed on probation.
3. A student who has not completed the skills checklist may be placed on probation.
4. At the end of each clinical level, the summative evaluation tool will be completed by the Nursing Instructors.
5. The student on clinical probation who does not meet the clinical objectives will be withdrawn from the nursing program.
6. Students on probation at the beginning of Level III do not have off campus rotations.
7. *The student who does not meet Level III objectives will not graduate from the VNP.*

NURSING PROGRAM - TARDIES:

- Tardiness is not accepted in the Vocational Nursing Program. Students are either present on time or they are absent. A student is not allowed to disrupt the class for tardiness. A student who is late may come into the classroom after a break to hear the lecture, BUT the student will still be marked as "absent."

- **Level I Clinical – 2 absence (16 hours)**
  Student will be counseled after the first absence
  Student will be dismissed from the course if 3rd absence occurs.
- **Level II Clinical – 2 absences (16 hours)**
  Student will be counseled after the first absence
  Student will be dismissed from the course if third 3rd absence occurs.
- **Level III Clinical – 2 absences (16 hours)**
  Student will be counseled after the first absence
  Student will be dismissed from the course if third 3rd absence occurs.

4.1-C. ATTENDANCE RECORDS**:** Because the student is an adult learner, each student should keep his/her own record of absence. Faculty is under NO obligation to inform a student of absences; the student will be notified when he/she no longer meets program objectives because of excessive absences. *Should the student believe a discrepancy exists, the student should submit the notice in writing to the Program Director within 24 hours of notification*.

4.1-D. RELIGIOUS HOLY DAYS ABSENCES: In accordance with Section 51.911, Texas Education Code, SPC will allow a student who is absent from class for the observance of a religious holy day to take an examination or complete an assignment scheduled for that day within seven calendar days after the absence.

Students are required to file a written notification of absence with each instructor within the first fifteen (15) days of the beginning of the semester in which the absence will occur. Forms for this purpose are available in the office of the Director of Special Services along with instructions and procedures. "Religious holy days" means a holy day observed by a religion whose place of worship is exempt from property taxation under Section 11.20, Tax Code.

ASSIGNMENT POLICY

All assignments must be completed by the assigned due date. Late and/or incomplete work will **not** be accepted and a grade of zero will be recorded. HOWEVER, all assignments must be turned in and turned in complete in order to exit the course. It is the responsibility of the student to be informed of class progress and assignments and to come to clinical prepared to participate in patient care, to turn in any assignments due, and/or take the quiz or test scheduled for that day in Friday lab.
Students should retain a photocopy or computer-accessible file of all assignments turned in. Always have a backup copy.

Assignments are not accepted by email. You must submit via Blackboard or in an approved folder in the Instructor's box located in the Nursing office depending upon the assignment **and it is your responsibility** to make sure that you do not upload blank documents and that your document **can be opened on a PC, because not all Mac files are able to convert.** If you submit a blank document or a file that cannot be opened it could possibly not be accepted. Again, it is your responsibility to make sure it is compatible and not blank. The handbooks that accompany the textbooks offer the students different learning styles or ways of comprehending information. Students struggling to understand the text should refer to these additional books. Students may also access the published website for additional help.

CLINICAL PAPERWORK

Students will be required to turn in written paperwork as assigned on the Expectations and Objectives page. All assignments are due at 0900 on the scheduled date. Late work is not accepted for grading; HOWEVER, all assignments must be turned in and turned in complete in order to exit the course. Students who do not turn in all work will fail the course, regardless of other grades.

GRADING POLICY

The grade for this course will be determined upon completion of the following components:

Weekly Clinical Evaluations	70%
Post Conference Activities/ Written Assignments	30%
	100%

Course grades are based on the following scale:

A = 90-100%
B = 80-89%
C = 76*-79% * Passing
D = 70-75%
F = 69% and below
Grades will not be rounded up or down i.e., 79.4 = 79
The final letter grade will be posted to Blackboard and Campus Connect.

COMMUNICATION POLICY

Electronic communication between instructor and students in this course will utilize the South Plains College "My SPC" and email systems. Students are encouraged to check SPC email on a daily basis. Students will also have access to assignments, web-links, handouts, and other vital material which will be delivered via Blackboard. Any student having difficulty accessing Blackboard or their email should immediately contact their instructor for direction. The instructor will work with any student to ensure the student has access to a computer on campus and can obtain the needed class content that is located on the course website.

Email Policy:

- Students are expected to read and, if needed, respond in a timely manner to college e-mails. It is suggested that students check college e-mail daily to avoid missing time-sensitive or important college messages. Students may forward college e-mails to alternate e-mail addresses; however, SPC will not be held responsible for e-mails forwarded to alternate addresses.

- A student's failure to receive or read official communications sent to the student's assigned e-mail address in a timely manner does not absolve the student from knowing and complying with the content of the official communication.
- The official college e-mail address assigned to students can be revoked if it is determined the student is utilizing it inappropriately. College e-mail must not be used to send offensive or disruptive messages nor to display messages that violate state or federal law
- Instructors make every attempt to respond to student emails *during regular college business hours* when faculty are on campus. Instructors *are not* required to answer emails after hours or on weekends.
- Students who use email inappropriately to faculty, students, staff or others will adhere to the following disciplinary action:

    1. First occurrence - will be counseled by the instructor and a disciplinary warning will be written.
    2. Second occurrence - will be counseled by the lead faculty member, and disciplinary action will be taken. (Initiation of Student Learning Contract.)
    3. Third occurrence - disciplinary action resulting in dismissal from the nursing program.

Mrs. Koelder will answer all emails in a timely manner. If a student emails the instructor prior to 4:00 pm Monday- Friday, the student can expect to receive a response via email the same day. If email is sent after 4:00 pm, the student can expect to receive a response the next business day. Emails will not be checked or answered on the weekend. Any email sent after 4:00 pm on Friday will be answered the following Monday.

Texting Faculty: Students should *not* text faculty via the faculty cell phone. Written communication should be by email or the student may call the office phone. The faculty cell phone is for contact during the clinical hours ONLY and should not be used outside the clinical experience.

Telephone: Hospital or clinical unit - Do not use the telephone for personal calls. Be always courteous when answering the unit telephone. Use the following protocol: "Second floor, Miss Smith, Student Vocational Nurse speaking..." If the student is unable to answer the telephone request, refer the matter to the charge nurse or unit secretary. Be sure to explain any delays to the person calling. **Students <u>are not to accept</u> Physician's orders or laboratory test results verbally or by phone. Refer these situations to the charge nurse.**

Electronics including but not limited to laptops, iPads, ThinkPads, or Chrome books are not allowed to be used or on the desk during class time or skill time unless approved by the instructor and NOT at ALL during clinical time.

Contacting the Clinical Instructor

Instructors often rotate between floors for student instruction. The clinical instructor is the student's BEST clinical resource and should be contacted by the student ANY TIME the student has a clinical question or concern. Should the instructor be on another floor, the student should do the following to contact the instructor:

1.Obtain instructor's contact number from the clinical schedule.
2. Using a phone at the nurse's station (auxiliary stations do not have an outside return number), dial the instructor contact number.
3. The instructor may be with another student or assisting another student with a procedure; please leave a brief but detailed message and your contact number. The instructor will call you back as soon as possible.
4. STAY BY THE PHONE!!! If you must leave, be sure that you have a classmate that can wait for your return call; the staff are not responsible for making sure your message is delivered.
5. If you do not receive a return phone call within 10 minutes, please call again. The instructor may be supervising a procedure and may not be able to call right away.

When Students Should Contact the Clinical Instructor:

The clinical instructor should be contacted:

1. When there is a personnel issue on the clinical unit.
2. When there is a patient care issue on the clinical unit.
3. Any time a patient refuses an essential element of care, such as a bed bath or assessment.
4. When there is any patient or student-related incident.

STUDENT CONDUCT:

Rules and regulations relating to the students at South Plains College are made with the view of protecting the best interests of the individual, the general welfare of the entire student body and the educational objectives of the college. As in any segment of society, a college community must be guided by standards that are stringent enough to prevent disorder, yet moderate enough to provide an atmosphere conducive to intellectual and personal development.

A high standard of conduct is expected of all students. When a student enrolls at South Plains College, it is assumed that the student accepts the obligations of performance and behavior imposed by the college relevant to its lawful missions, processes, and functions. Obedience to the law, respect for properly constituted authority, personal honor, integrity, and common sense guide the actions of each member of the college community both in and out of the classroom.

Students are subject to federal, state, and local laws, as well as South Plains College rules and regulations. A student is not entitled to greater immunities or privileges before the law than those enjoyed by other citizens. Students are subject to such reasonable disciplinary action as the administration of the college may consider appropriate, including suspension and expulsion in appropriate cases for breach of federal, state, or local laws, or college rules and regulations. This principle extends to conduct off-campus which is likely to have adverse effects on the college or on the educational process which identifies the offender as an unfit associate for fellow students.

Any student who fails to perform according to expected standards may be asked to withdraw.

Rules and regulations regarding student conduct appear in the current Student Guide.

CLINICAL POLICIES

Students will be graded daily in clinical (daily grades are averaged into weekly grades, which are averaged into semester course grades). Student daily assignments shall be made in accordance with the clinical objectives and learning needs of the students. The total number of daily assignments shall not exceed five patients. (Texas Board of Nursing).

For Skills Practice, Performance Preps and Required Performances in the practice laboratory, white lab coats must be worn. Lab coats must be laundered and pressed, (must cover buttocks), and fully buttoned. Hair must also be contained, out of face and off the collar. Closed shoes must also be worn. Students may utilize the garment rack located in the skill lab for lab coats. Lab coats should be appropriately labelled and covered. This appropriate attire includes the covering of body tattoos and removal of body piercing jewelry.

ACCIDENT AND/OR INCIDENT REPORTS

- *See Student Handbook*

WITNESSING DOCUMENTS

Students are not permitted to affix their signatures to any permits or other legal documents thereby verifying informed consent and signature of patient or patient's designate.

UNIFORMS AND GROOMING

All students are to wear the South Plains College-Plainview approved scrubs during clinical rotations. Exceptions to this are those areas where street dress code is the norm such as in the child-care centers. The approved dress standards for SPC-Plainview are:

1. Scrubs and undergarments should be clean each day. Scrubs are to be **clean, neat, well-pressed, appropriately fitted, and in good repair**. Approved attire will be announced at the beginning of fall class.

2. During class and CCE, the student will wear royal blue scrub pants and program approved t-shirt that will be assigned. The student is to follow all other clinical rotational guidelines for class time and CCE. The student may wear a royal blue colored crew-neck T-shirt under the scrub top. Only approved long-sleeved apparel may be worn with the scrub uniform. A coordinating (same color as scrubs) solid color scrub jacket or white lab jacket may be worn. Student is expected to wear the white lab jacket while in the skills lab.

    - Scrub tops must have adequate room to hold supplies and not allow exposure of undergarments or inappropriate skin exposure. Pants must be at least ankle length and may not cover the shoes or touch the floor. If scrubs become too tight or loose during the program, the student must obtain appropriate fitting uniform prior to attending clinicals.
    - Maternity scrubs must be made in the basic style and colors of the approved program policies.
    - The SPC nursing ID badge is to be **worn and visible at all times, located on the left upper corner of the shirt or jacket,** when a student is in the classroom, nursing lab, computer lab, CCE, or clinical areas. If a badge is lost, the student will be required to replace it. **A student who reports to a clinical area without an ID badge will be sent home with a absence for the day.**
    - No sweaters or other knit attire, coats or jackets may be worn with the scrub uniform while on duty.
    - White crew socks or white knee-high socks or hosiery are to be worn. NO colored socks or decorative socks are permitted.
    - White leather shoes with composition soles and heels are to be worn with the uniform. (Shoes should be predominantly white – any colored areas must be approved by the lead faculty member).
        - Shoes are to **be polished and clean at all times. Shoestrings should be clean and white**, and replaced as necessary to maintain the clean appearance.
    - Students are to be prepared for the clinical assignment with the appropriate tools necessary for assessment and care of the client. These include resources, Student Handbook/ Syllabi, a watch with second-hand, bandage scissors, pen-light, stethoscope, pens (black ink), approved gait belt, impervious tape measure (retractable), and note pad. Students are encouraged to have available extra pen light batteries and additional pens including a black sharpie.
    - Jewelry other than a solid band and watch is inappropriate in the clinical setting. Rings that contain stone settings or jagged edges are a potential hazard to the safety of the client, both for injury and through the spread of microorganisms. Earrings are to be small studs or rings only. **Tongue rings, nose rings or other body piercings are not permitted during any clinical rotation, CCE, classroom, or during lab**. No decorated or jeweled teeth, "jeweled or gold grill", or tooth jewelry is allowed. A student will be asked to remove any jewelry other than the approved standard.

- Hair must be clean and neatly arranged. Long hair must be worn in a bun, braid, or in a contained manner with no loosely swinging hair. Items such as clamps, combs, barrettes, etc. must be modest and for the containment of hair only. The clamps or barrettes should not be decorative (no flowers, bows, etc.). The student will be asked to remove any item other than the approved standard. **Hair must be modest contained styles and basic natural hair color.**
- No pins or other decorative items may be worn with the student uniform including retractable name badge clips unless approved by the lead faculty member.

3. Fingernails are to be clean and filed to approximately finger-tip length to reduce danger of injury to a client. **NO artificial or acrylic nails, nail polish (clear or colored), gel or shellac are permitted during clinical rotations.**

4. Chewing gum while on duty is not permitted.

5. Strongly scented body powder, cologne, or shaving lotion should not be worn by the student when on clinical duty. Personal and oral hygiene must be a priority for the professional. Deodorant and anti-perspirants should be used daily and must be sufficient to control personal body odors. Students who demonstrate problems with either halitosis or body odor will be counseled by the clinical instructor. Action by the student is expected if a problem exists. Smoking is not allowed on any affiliating property. Please ensure tobacco odors are not present on clothing, hair, or other attire prior to arrival.

6. The student should not wear false lashes/lash extensions, heavy or dark makeup while in class, nursing lab, CCE, or clinical setting.

7. Acceptance of monetary gifts from clients is not permitted. This is an infraction of professional nursing ethics.

8. During day-care rotations, students are permitted to wear jeans, Capri pants, or walking shorts. No halter tops of brief attire are permitted.

9. **Red or bluish colored bruises (hickies) on the neck or other visible area are NOT ALLOWED**. Any student who presents in the **clinical area** with any such visible marks **will be sent home with an absence** (also enforced by most hospitals and physician's clinics).

10. **Tattoos** that are visible must be covered in compliance with policies of SPC-VNP and the clinical agencies. Tattoos on hands do not have to be covered with a bandaid unless they are offensive (if considered offensive by faculty, clinical setting, fellow students, tattoo must remain covered at all times). Student with hand tattoos should apply gloves as hand hygiene is performed upon entering the room.

11. In addition to the General Rules and Regulations, the Vocational Nursing Program reserves the right to request an immediate drug screen for any student. Any suspicion of drug or alcohol use during any portion of the nursing program is in violation of program and institutional policies. The student will incur and is responsible for the costs of any testing related to suspected drug use. SPC will adhere to all affiliate's substance abuse and testing policies during any tenure at their facility.

12. While in the VN Program, the student is required to act in a manner of professionalism and be prudent in decision making both in and out of uniform. Any reports of behavior which identify a breach of the Texas Board of Nursing Rules and Regulations will result in dismissal from the VN program with no readmission.

ENFORCEMENT OF CLINICAL/CLASSROOM POLICIES

Accrued documentation of non-compliance with program policies is included in the student evaluation. A student found guilty of plagiarism may be dismissed from the program. A student who requires disciplinary action will first be counseled by the clinical instructor. A follow-up counseling session will be done by the lead faculty member and the Director of South Plains College Vocational Nursing Programs will be notified. The student will be required to develop a plan of action toward improvement. Progress on the student "LEARNING" contract will be monitored by the Program Instructors and Director. Professionalism is not automatic – it must be a conscious effort and practiced!! Habitual infraction of program policies with no demonstrated progress toward improvement may result in termination from the nursing program.

Policy Violations that will result in disciplinary action include, but not limited to:

- **Unprofessional conduct or character**
- **Reporting to classroom, skills lab, or computer without your Student ID badge- (Policies applies to all courses)**
- **Failure to call assigned clinical area prior to absence**
- **Reporting for duty without ID badge – student will be sent home with a absence for the day**
- **Classroom Dress Code violation (scrubs, shoes, shoelaces, jewelry, hair, nails, makeup, body marks)**
- **Body hygiene**
- **Chewing gum during clinical**
- **Unprepared with necessary equipment for clinical tour of duty including Stethoscope, secondhand watch, penlight, student ID badge, scissors, username and passwords for each facility.**
- **Violation of standard precautions**
- **Inappropriate communication with clients, families, or co-workers**
- **Lack of preparation for clinical assignment (care-mapping, clinical objectives, or requested research)**
- **Safety issue in clinical skill preparation**
- **Medication administration procedural error- First offense Probation, Second will result in termination**
- **Interpreting for the health care provider/providers for non-English speaking patients**
- **Other patient safety issue**

DISMISSAL

A high standard of conduct is expected of all students. Obedience to the law, respect for properly constituted authority, personal honor, integrity, and common sense will guide the actions of each member of the college community both in and out of the classroom. Any student who fails to perform according to expected standards may be asked to withdraw. A student is required to withdraw from the current semester upon receiving a failing course grade.

The student may be requested to leave the classroom or clinical setting whenever, in the instructor's/supervisor's opinion, the circumstances warrants such action. Failure to comply with academic, ethics, or personal integrity will result in disciplinary action.

Disciplinary action for unprofessional conduct includes any single or combination of the following:

- Probation
- Being sent home, accruing absence, from the clinical experience.
- Writing research papers regarding the unprofessional behavior.
- Writing letters of apology.
- Other actions as deemed appropriate by the nursing faculty.

- Dismissal from the program when it is obvious the student does not intend to follow rules of good conduct.
- Turned over to the Dean of Students for a formal hearing. Refer to the SPC Student Guide.

The following student conduct problems may result in immediate dismissal:

- UNSAFE nursing practice
- Falsification of any record, including clocking in/out for another student. All students involved in this situation will be dismissed. Falsifying a hospital record puts the patient at risk.
- Patient Abandonment.
- Misrepresentation of the truth (lying)
- Failure to report – a student who fails to report his/her own or another student's error or potentially dangerous patient care situation.
- Sleeping while in clinical practice.
- Threats of violence/violation of Campus Carry Law
- Alcohol or drug use – any student who is reported to have behaviors indicating alcohol or drug use will:
    - be removed from the clinical setting.
    - have to call a family member or friend to take them for testing. THE TESTING WILL BE PAID FOR BY THE STUDENT. **Students should have money set aside should this be required. Students who cannot be tested because of finances will be considered as "positive" and will be withdrawn.**
    - be dismissed from clinicals pending the results.
    - Once results are known:
        - If results are positive, the student is dismissed from the VNP.
        - If results are negative, the student will return to the clinical setting the next day, unless denied rotation by the clinical facility.
    - The student under suspicion who refuses testing will be dismissed.
- Plagiarism

SOUTH PLAINS COLLEGE HEALTH SCIENCESEXPOSURE POLICY

The following policy is to be followed exactly in the event a person experiences an exposure (needlestick, blood, body fluids or respiratory) while participating in any clinical or lab activity.

1. Report incident to instructor.
2. Treat immediately using the following CDC guidelines
    a. Wash needlesticks and cuts with soap and water
    b. Flush splashes to the nose, mouth, or skin with water
    c. Irrigate eyes with clean water, saline, or sterile irrigates.
3. Notify the appropriate facility representative and complete the appropriate work.
4. Each person is encouraged to initiate testing for blood borne disease within 1 hour of exposure.
    - This may be done with a health care provider of choice. If the individual has no designated health care provider, an appropriate referral will be made.
5. When an event occurs in the lab the source person will be asked to voluntarily and confidentially share blood borne disease status with instructor and exposed person.
6. The exposed person will initiate follow up care with Health Care Provider of choice as soon as possible. Recommended time is within 1 hour of exposure for initiation of prophylactic treatment.
7. Each person is responsible for all costs associated with his/her testing and follow up.

8. Because of each person's right to privacy, one may decide whether to be tested and whether to disclose test results to faculty or other students.
9. If the source person decides not to be tested or does not disclose test results, the Center for Disease Control guidelines recommend
   a. HIV and Hepatitis testing be done on the exposed person immediately post-exposure and three, six, and twelve months post-exposure.
   b. Beginning prophylactic treatment within one hour, or as soon as possible.
10. Each individual is encouraged to follow the advice given by the health care provider.
11. South Plains College reserves the right to deny laboratory or clinical privileges to any individual whose health status poses a risk to others.
12. Complete the Exposure Report.

SOUTH PLAINS COLLEGE HEALTH SCIENCES EXPOSURE REPORT

Each individual should retain a copy of this completed form for his/her personal records and is strongly encouraged to share the information regarding this incident with his/her health care provider.

Faculty member: Please assist the individuals completing this form and deliver the original completed form to the nursing office for the student file, a copy given to facility, and a copy given to the student.

EXPOSED INDIVIDUAL_____
FACILITY REPRESENTATIVE _____
ATTENDING FACULTY MEMBER _____
DATE OF INCIDENT_____
DESCRIBE EXPOSURE INCIDENT_____
_____
_____
_____
_____
_____
_____

_____ _____
FACULTY SIGNATURE DATE

_____ _____
AGENCY SIGNATURE DATE

I have read and been informed of the South Plains College Exposure Policy. I have been strongly advised to seek medical attention. I understand all financial obligations regarding testing and follow-up care is my responsibility. I understand I have a right to privacy. I have been encouraged to share any further information regarding this exposure to the appropriate faculty.

_____ _____
STUDENT SIGNATURE DATE

CONFIDENTIALITY STATEMENTS

In the Florence Nightingale Pledge, we pledge:

I solemnly pledge myself before God and in the presence of this assembly:
To pass my life in purity and to practice my profession faithfully.
I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug.
I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my profession.
With loyalty will I endeavor to aid the physician in his work, and will devote myself to the welfare of those committed to my care.

This statement makes it clear that any information gained by the nurse during examination, treatment, observation, or conversation with the client or his/her family is confidential. Unless the nurse is authorized by the client to disclose this information or is ordered by the court to do so, she/he has a clear moral obligation to keep this information confidential.

The nurse may use the knowledge to improve the quality of client care, but she/he never shares information about the client with anyone not involved with his/her care. Even when sharing with care givers, the nurse must be extremely cautious. The information is not discussed with or around persons not involved in the client's care. This information is not to be shared verbally, in writing, or by any electronic means. Students need to be very aware of confidentiality and be extremely careful with whom and where they discuss their assignments. This includes electronic medical records. When not in use, the student must completely logout of the patient's record. The student is responsible for following affiliate policies regarding all electronic medical record access.

Students will be issued **log-ins** and **passwords** for agencies using electronic medical records. This information must be kept **confidential**. No downloading or printing of any patient information is permitted. There will be **NO** sharing of log-in information or passwords with your peers. Students must document only the information they have assessed and **CANNOT** "copy and paste" documentation from anyone else or from their own previous documentation. Failure to follow these policies will be grounds for disciplinary action, including dismissal from the program.

POLICY FOR SOCIAL NETWORKING

Students in the Vocational Nursing Program at South Plains College Plainview are expected to adhere to the highest standards of the nursing profession with regard to maintaining confidentiality. This not only includes guarding patient confidentiality at a clinical site, SPC simulation lab, but also in the classroom, at home and on-line.

The following are guidelines for behavior involved with cell phone use, FACEBOOK, Twitter, Snapchat, Instagram and any other social networking site. Many of you already have such sites established and are eager to use them to convey what you are learning and doing while in the program. You may continue to use those sites but with these **cautions**:

- It is your responsibility to keep your site appropriate and your profile clean.

- Do not post threats or derogatory remarks about anyone associated with the Vocational Nursing Program. This includes fellow students, faculty, staff, college administrators, clinical affiliates, and, above all, patients. This is a violation of the South Plains College Nursing Policy and you will be reported to the police and disciplinary action, such as dismissal, is likely.

- Any photos of yourself must be made out of uniform, make no reference to South Plains College, the Vocational Nursing Program or our clinical affiliates, and will not include any illegal activity. Posting photos of other students, faculty, and staff without their permission is forbidden.

- Cell phone use in the classroom and at the clinical site is forbidden. If cell phones are discovered they will be confiscated for the remainder of the class or clinical day.

COURSE REQUIREMENTS:

Student must successfully meet all clinical competencies for Level III by the completion of this course with a grade of 76% or above.

Student is to review the Policies and Procedures along with the Confidentiality Agreement for the Center for Clinical Excellence – Reese Center at the following link: www.SIMSPC.org

Confidentiality Agreements should be printed and signed and presented to the nursing office no later than October 1st.

Confidentiality Agreements from each clinical affiliate site will be presented to the student during clinical orientation and the student will provide their signature indicating that they have read and understand the policy set forth by the institution/s. This documentation will also become part of the student file.

2025 SCHEDULE OF CLINICAL EXPERIENCES:

5/21	Campus) Clinical Orientation, Affiliate Presentations
5/22	CCE
5/28	Clinical Site
6/29	Clinical Site
6/4	Clinical Site
6/5	Clinical Site
6/11	Clinical Site
6/12	Clinical Site
6/18	CCE
6/25	CCE
6/26	CCE
7/2	Clinical Site
7/3	Clinical Site
7/9	Clinical Site
7/10	Clinical Site

7/16 Clinical Site
7/17 Clinical Site

7/23 Clinical Site
7/24 Clinical Site

7/31 Final week/ Clinical Affiliate Appreciation
8/1 Boone's Photography: 1000/ Pinning Practice Following
8/4-6 NCLEX Review Course

**** SUBJECT TO CHANGE ****

*****ALL CLINICAL PAPERWORK IS LOCATED ON BLACKBOARD in CLINICAL - LPN/VOC TRAIN (VNSG-2461-501)*****

ACCOMMODATIONS

For college policy statements related to Intellectual Exchange Statements, Disabilities Statements, Non-Discrimination Statements, Title IX Pregnancy Accommodations Statements, CARE, Campus Concealed Carry Statements, COVID-19, or the use of AI-Artificial Intelligence,
visit: https://www.southplainscollege.edu/syllabusstatements/.
Be aware you must still hold a LTC to carry on our campus. Also, there is a NO Carry Policy at all within ANY clinical facility.

Diversity Statement

In this class, the teacher will establish and support an environment that values and nurtures individual and group difference and encourages engagement and interaction. Understanding and respecting multiple experiences and perspectives will serve to challenge and stimulate all of us to learn about others, about the larger world and about ourselves. By promoting diversity and intellectual exchange, we will not only mirror society as it is, but also model society as it should and can be.

Intellectual Exchange Statement

In South Plains College courses, the instructor will establish and support an environment that values and nurtures individual and group difference and encourages engagement and interaction. Understanding and respecting multiple experiences and perspectives will serve to challenge and stimulate all of us to learn about others, about the larger world and about ourselves. By promoting intellectual exchange, we will not only mirror society as it is, but also model society as it should and can be.

Disabilities Statement

Students with disabilities, including but not limited to physical, psychiatric, or learning disabilities, who wish to request accommodations in this class should notify the Disability Services Office early in the semester so that the appropriate arrangements may be made. In accordance with federal law, a student requesting accommodations must provide acceptable documentation of his/her disability to the Disability Services Office. For more information, call or visit the Disability Services Office at Levelland (Student Health & Wellness

Office) 806-716-2577, Lubbock Centers (located at the Lubbock Downtown Center) 806-716-4675, or Plainview Center (Main Office) 806-716-4302.

Non-Discrimination Statement

South Plains College does not discriminate on the basis of race, color, national origin, sex, disability or age in its programs and activities. The following person has been designated to handle inquiries regarding the non-discrimination policies: Vice President for Student Affairs, South Plains College, 1401 College Avenue, Box 5, Levelland, TX 79336. Phone number 806-716-2360.

Title IX Pregnancy Accommodations Statement

If you are pregnant, or have given birth within six months, under Title IX you have a right to reasonable accommodations to help continue your education. To activate accommodations you must submit a Title IX pregnancy accommodations request, along with specific medical documentation, to the Health and Wellness Center. Once approved, notification will be sent to the student and instructors. It is the student's responsibility to work with the instructor to arrange accommodations. Contact the Health and Wellness Center at 806-716-2529 or email dburleson@southplainscollege.edu for assistance.

CARE (Campus Assessment, Response, and Evaluation) Team

South Plains College is committed to ensuring the safety, health, and well-being of its students and community. To support its campus community SPC has a CARE Team. This is a dedicated group of campus professionals responsible for assessing and responding to students who could benefit from academic, emotional, or psychological support, as well as those presenting risk to the health or safety of the community. If you see someone experiencing challenges, appearing distressed, posing a threat to their safety or someone else's safety, or causing a significant disruption to the SPC community, please submit a CARE Team referral. You may also submit a referral for yourself if you would like additional support. NOTE: In cases where a person's behavior poses an imminent threat to you or another, contact 911.

Campus Concealed Carry Statement

Texas Government Code 411.2031, et al. authorizes the carrying of a concealed handgun in South Plains College buildings only by persons who have been issued and are in possession of a Texas License to Carry a Handgun. Qualified law enforcement officers or those who are otherwise authorized to carry a concealed handgun in the State of Texas are also permitted to do so. Pursuant to Penal Code (PC) 46.035 and South Plains College policy, license holders may not carry a concealed handgun in restricted locations. For a list of locations and Frequently Asked Questions, please refer to the Campus Carry page at: http://www.southplainscollege.edu/campuscarry.php

Artificial Intelligence Statement

· **Purpose of Artificial Intelligence (AI) Applications:**

AI applications such as ChatGPT, OpenAI, Bard, Grammarly, WordTune and others are advanced language models designed to aid and engage in meaningful conversations, as well as, generate and revise content. AI is intended to supplement learning, stimulate critical thinking, and enhance academic discourse. However, its use comes with certain responsibilities.

· **Academic Integrity:**

Using AI to generate academic work, including essays, reports, or assignments, without proper attribution is a violation of SPC academic integrity policies. Plagiarism undermines the learning process and is strictly

prohibited. Students must ensure that their work reflects their own ideas, research, synthesis, and analysis and appropriately cites all sources, including AI.

· **Collaboration and Consultation:**

While AI can be a valuable resource, it is essential to strike a balance between seeking assistance and maintaining personal responsibility. Collaboration with peers, consulting instructors, and utilizing other approved learning resources should be prioritized. Overreliance on AI for solutions without actively engaging in the learning process is discouraged and can be grounds for academic integrity violations. Utilizing AI as a tool for brainstorming or research is allowed but the writing should be the student's own work and thoughts.

· **Critical Thinking and Originality:**

AI usage can provide suggestions and information, but it is essential to critically evaluate the responses and exercise independent thought. Relying solely on AI for answers deprives students of the opportunity to develop their analytical and problem-solving skills. In assignments where originality, creativity, and independent thinking are valued, AI would be detrimental to the student learning process. Critical thinking and originality emphasize the importance of independent thinking in all academic endeavors as part of the student's learning experience apart from outside influence and offers the student the opportunity to refine their unique, individual voice through academic discourse with other students and faculty.

· **Ethical Use and Bias Awareness:**

AI is trained on large amounts of data from the internet, which may include biased or inaccurate information. Be mindful of the potential for bias and critically evaluate the responses provided by AI. Therefore, when using AI, just like with using any other database, students must verify that the information is from reliable sources, question any potential biases, and ensure that the information and sources used in the paper are neutral, peer-reviewed sources.

· **Responsible Engagement:**

Students should engage with AI in a respectful and responsible manner and avoid using offensive language, discriminatory remarks, or engaging in any form of harassment or inappropriate behavior. Students should also uphold the standards of respectful communication in addressing both AI and fellow classmates.

· **Compliance with South Plains College Policies:**

Policies regarding the appropriate use of AI in South Plains College courses are set by instructional departments and individual instructors. Appropriate use of AI may range from strict prohibition to assignments they may require the use of AI. Misusing or violating the guidelines outlined in this syllabus warning may result in disciplinary action, including academic penalties. Students are expected to familiarize themselves with the specific course policies regarding the use of AI and adhere to them throughout the semester.

· Remember, AI can be a tool to support your learning in certain courses and assignments, but it cannot replace the critical thinking, creativity, and independent work that are integral to your overall academic growth.

VNSG 2461.501 Clinical Level III Syllabus Contract

Print Name:_____

I have read and understand the Clinical Syllabus and schedule. I have had the opportunity to ask questions. I also understand to exit this course I must meet All Objectives Listed in the course Syllabus as stated below:

COURSE EXIT GOALS:

For the student to exit this course, the student must do ALL of the following:

- Have a 76 average grade AND
- Complete and turn in all required clinical paperwork. Students who fail to turn in work fail the clinical course regardless of other grades.
- Maintain CPR and immunizations AND
- Complete 90% of the skills checklist 4 weeks prior to graduation AND
- Complete at least one sterile procedure (Foley catheter and sterile dressing change) AND
- Have no more than two absences this semester AND
- Pass the Summative Evaluation AND
- Practice within the score of practice for SVNs, demonstrating movement to the graduate level of practice and clinical judgment

Signed:_____ Date:_____

If ALL course exit goals are not met, student will be given an "D" for the course grade and will be withdrawn from the vocational nursing program.

Plagiarism Declaration
Department of Nursing
South Plains College

By signing this plagiarism declaration, I acknowledge that I have received a copy of the honesty policy and been made aware that the penalty for plagiarism is dismissal from the program.

Offering the work of another as one's own, without proper acknowledgment, is plagiarism. Any student who fails to give credit for quotations or essentially identical expression of material taken from books, encyclopedias, magazines, websites such as: blogs, journals, or articles, other referenced works, from themes, reports, and/or other writings of a fellow student, is guilty of plagiarism. If there is any suspicion of work completed by Artificial Intelligence (A.I.), the student and their work may be questioned, and if proven that A.I. was used will be considered guilty of plagiarism.

Examples of student plagiarism:

- Copying material without quotes, in-text citations, and/or referencing
- Paraphrasing content without in-text citation and/or referencing
- Copying ideas, words, answers, exams, or shared work from others when individual work is required
- Using another's paper in whole or in part
- Allowing another student to use one's work
- Claiming someone else's work is one's own
- Resubmitting one's own coursework, when original work is required (self-plagiarism)
- Falsifying references or bibliographies
- Getting help from another person without faculty knowledge or approval
- Purchasing, borrowing, or selling content with the intent of meeting an academic requirement for oneself or others

Printed Name:_____

Signature: _____

Date: _____

VOCATIONAL NURSING CONTRACT

In compliance with the policies of South Plains College and the Vocational Nursing Program of the Plainview Center campus, the Vocational Nursing Student will:

1. Be in attendance and be punctual for lecture and clinical experiences.
2. Satisfactorily pass nursing courses with a 76-grade average in all nursing subjects and meet all other graduation criteria as found in this handbook. **I understand that if I do not earn a 76 "C" in any course, I must repeat that course and cannot progress in the VNP. I understand that if I do not meet all graduation criteria, I will not graduate from the VNP.**
3. Demonstrate satisfactory nursing skills in both lab and clinical experience as evaluated by instructors. **I understand that should I fail in the lab experiences, I must withdraw from the program.**
4. Complete assignments by the designated deadlines. **I understand that penalties occur for any incomplete assignment.**
5. Comply with the dress code. **I understand that to violate the dress code is unprofessional conduct and that continued violations may be grounds for dismissal.**
6. Adhere to the confidentiality statement. **I understand that to violate confidentiality/HIPAA this may be grounds for dismissal.**
7. Satisfactorily meet all clinical objectives. **I understand that if I do not meet clinical objectives, I will fail the VNP.**
8. Understand and will comply with all policies regarding professional conduct and **understand the disciplinary actions that may be taken should I fail to follow these policies.**
9. Understand that should I have a criminal incident, **I must report the incident to the VNP and withdraw from the program until I am cleared by the BON.**
10. **The use of electronic devices (cellphone/PC apps) are to be used for training purposes and may NOT be used in the clinical settings.**

I have read and understand the statements regarding State Board Regulations for Licensure as outlined in the Student Handbook, including the statements with regards to a criminal background. I understand that graduating from this program does not guarantee me a license to practice nursing and that I must meet all Board requirements to be licensed.

I have read and understand fully my individual responsibility to comply with the rules and regulations as outlined in the Student Handbook. I accept responsibility for my learning. I understand that patient safety is the primary focus of my nursing care.

Printed Name:_____

Signature:_____

Date:_____

STUDENT PROFESSIONAL CONDUCT CONTRACT

Part of the nursing education program that we have adopted at the Vocational Nursing Program, SPC Plainview Campus includes a significant emphasis on the issue of professionalism. While this topic has been briefly discussed in orientation, it will be discussed frequently throughout the year and is also discussed in the Student Vocational Nurse Handbook. Additionally, an even greater and more specific focus will be placed on the area of respect. A list of unacceptable behaviors are listed below but are not limited to only these:

1. Students sighing loudly or rolling of the eyes
2. Students talking and interrupting while a faculty member or guest speaker is talking/lecturing.
3. Students arguing or yelling, stomping of the feet

Consequently, this contract has been designed to inform the student that these behaviors will be specifically targeted and will not be acceptable. Students who engage in these behaviors will be classified as exhibiting "unprofessional conduct" with the following disciplinary action(s) to ensue:

1. Immediate removal from the classroom or clinical setting, accruing an absence for that class or clinical day, a verbal conference will occur and documentation will be done with both the student and instructor will sign the documentation
2. Written conference between the lead instructor and/or program director and the student with a learning contract and/or probation initiated
3. Dismissal from the program.

Continued behaviors as outlined above will be reviewed by the Course Instructor and VN Coordinator and appropriate disciplinary action will be determined by the committee which could include dismissal from the VNP.

It is our desire to teach professionalism through acceptable professional behavior so that you, as the student, may be a successful nurse throughout the year.

I have received a copy of the Vocational Nursing Program, SPC Plainview, Student Professional Conduct Contract and understand the consequences that will follow if I display the behaviors addressed in this contract.

Printed Name: _____

Signature: _____

Date: _____