Clinical

N3561 Clinical Expectations of the Student

Patient assessment is focused on assessment and analysis of patient data and planning for delivery of patient care. The **primary** source for subjective patient data is the **patient**, ***not the chart.***

* + - Information sources include the following:

In-depth interview of the patient

Focused physical assessment, with brief head-to-toe physical assessment,

Report from the patient’s primary nurse.

Kardex

Chart data (medical history, doctor’s orders, physician progress notes, laboratory results, radiology reports, surgery report, nursing history, and nurses’ notes)

* + - It is your responsibility to ask the instructor for assistance (if your primary nurse is unable) to access the computer and in understanding the data, identifying equipment for your patient, and planning care for the day.
    - The manner in which you present yourself to the patient is crucial in establishing rapport, gaining patient cooperation and trust, and eliciting data needed for completion of your electronic health record and clinical paperwork.

### Clinical Day

* You will be assigned to a staff nurse [or assigned to patients, site specific]:

Report on time to your assigned floor and meet your assigned nurse. Listen to the entire report he/she is receiving from the previous shift. Afterwards, you and your nurse will decide which patient or patients will be your assignment (only if assigned to a nurse). It is your responsibility to ensure that a variety of medical/surgical patients are selected during the semester.

For all students: immediately after patient selection:

* Review Kardex (if there is one) for name, diagnosis, allergies, activities, diet, etc.
* Review MAR for meds and time due

Because patient assessment, including vital signs, must be done at the beginning of each shift, these two activities should not take longer than 20 minutes. ***At a minimum, you must have obtained your patient’s vital signs, including pulse oximetry, within one hour of receiving your assignment.* *Report any abnormals first to your nurse, and then to your instructor*.** Your instructor will discuss any additional clinical expectations with you.

* Complete a physical assessment on your assigned patients, focusing on the medical and/or surgical problem. **MUST BE DONE, REPORTED ON, AND DOCUMENTED AT TIME DETERMINED BY YOUR CLINICAL INSTRUCTOR.**
* Discuss your plans for the day with the primary nurse after patient assessment. When discussing your plans, be specific. For example, you will:
  + Perform the a.m. assessment and chart (per hospital policy).
  + Take vital signs, (with manual blood pressure cuff whenever possible).
  + Provide a.m. care.
  + Perform interventions based on your knowledge of the patient’s medical and/or surgical condition.
  + **Monitor IV site for edema, redness or tenderness every hour.**
  + **Give medications *only with your instructor present*. (In some facilities students may be allowed to give medications with the RN assigned to their patients, *but only after approval from faculty*.) Faculty in each site will determine the method(s) for administering meds(i.e. only a few students will give meds each day, or only give 3 to 5 meds, etc.)**
  + **J-2 students are not permitted to administer IV push sedatives (e.g. narcotics and benzodiazapines) or vasoactive drugs (e.g. antihypertensives, antiarrhythmics) but are encouraged to observe the primary nurse administer them. Students are required to verbalize the actions, side effects, and how these drugs are administered. J2 students are permitted to administer IV Push medicines such as Furosemide, Pantoprazole, and Steroids after notifying their clinical instructor and under direct supervision by an R.N.**
  + Measure and record I&O.
  + Assess and document PCA therapy.
* Although patient care assistants are sometimes present, ***you are expected to do all patient care, including the bath and vital signs. In some*** ***facilities, AM care is provided by the PCA/PCT. Please assist them and also ensure that the care gets done***. Communicate with the patient care assistants so they will know what you will be doing for the patient that they would normally do.
* The a.m. baseline assessment must be completed by time set my faculty. This includes checking IV fluids and rates against the MAR.
* You are responsible for assisting the patients with ADL’s including: bath, linen change, range of motion, ambulation, feeding, grooming, etc.see above
* Document as directed by your clinical instructor the interventions you did for your patient and evaluate the response(s)Students are required to inform the instructor about all patient procedures (dressing changes, irrigations, catheterizations, etc.). The student will perform the procedure with the instructor present unless the instructor has given the student permission to do it with a staff nurse instead. Please have all necessary equipment for the procedure assembled prior to beginning. Read the policy and procedure manual and/or your nursing procedures text in preparation for conducting the procedure. Please remember that the patient’s safety, comfort and dignity (including privacy needs) are the central concern during these procedures.
* Your instructor will inform you of conference time, and any additional information specific to your clinical assignment and facility. Notify the primary nurse before leaving the nursing unit.

**Communication on the unit**

* Communicate closely with your instructor and the nurse assigned to your patient(s).
* Any abnormal vital signs or other assessment findings must be immediately reported to the patient’s primary nurse. Report all pertinent observations to the patient’s primary nurse **FIRST** (e.g. patient’s complaints of pain, low urine output, patient falls, physician asks for a permit to be signed).
* Clarify with instructor when unsure of any procedures, responsibilities, clinical rules, etc.
* **N**ever take verbal orders from a physician since you are not yet licensed to practice nursing.
* Avoid racking of charts with unsigned orders on them (if applicable)
* Leave a note on the chart rack indicating that you have the chart (or other method per hospital).

### Medication administration

Be prepared to:

* Tell the instructor and/or staff nurse why the patient is receiving a particular medication, major side effects, allergies, and any necessary assessments, including labs, which must be done before giving the medication.
* The student must also check to ensure that the dose is within normal limits
* Check the MAR against the doctor’s orders.
* Use the five right**s** of medication administration

The following are examples of important information for particular medications:

* + Lasix; know serum K and fluid volume status
  + Potassium, know serum K
  + Laxatives: know time of last BM and its consistency
  + Antibiotics: classification of the drug ( i.e. penicillin, cephalosporin, etc.) and know culture & sensitivity report (if available)
  + Antihypertensives/vasodilators: know drug classification, current and baseline BP
  + Drugs with therapeutic range (e.g. Digoxin): know last blood level
  + Lanoxin: check apical pulse and serum K
  + IM/IV drugs: know compatibilities
  + IVPB’s: know rate of administration

**ANY STUDENT WHO HAS NOT COMPLETED ALL OF THE ABOVE STEPS, WILL NOT ADMINISTER MEDICATIONS THAT CLINICAL DAY**

* **DO NOT give any medication unless supervised by an RN WHO MUST BE IN THE ROOM WITH YOU !!!!.**
* **At some hospitals you can only give medications with your instructor. You will be advised as to which hospitals these are**
* **Never record that you have given a medication before you do so.** Have MAR with you when giving medications.
* Be sure you understand the procedure for monitoring blood glucose and giving sliding scale insulin ( site specific).

### Universal Precautions

To protect yourself and your patients, strict adherence to universal precautions is required at all times. Goggles and/or face shields are available on the unit.

### Professional Attire

Adhere strictly to the uniform policy. Long hair must be pulled back in such a way that it does not fall on the patient during patient care. Fingernails must be short. Acrylic nails are forbidden. Students may not chew gum. Earrings are limited to one per ear.

### Professional Behavior

* Be punctual and prepared.
* Maintain patient confidentiality.
* Adhere to the dress code.
* Demonstrate responsibility and integrity.
* **Cell phones for personal communication can only be used during breaks – they must be turned off or on vibrate at all times. Cell phones are allowed to access information related to providing care for your patient (look up a drug, review medical diagnosis, etc.). At NO TIME can the camera function be turned on or in use.**

**Snow or Ice Days:**

Follow school policy. Watch news and listen to the radio for UTA closures. If UTA closes, we do not have clinical. If UTA opes late, we also start late. Do not attempt to drive on dangerous road conditions. Call your clinical instructor if you feel it’s unsafe for you to drive to clnical. The phone number for the university to verify closures is **972-601-2049.**

**Clinical Paperwork and Electronic Documentation**

Your instructor will explain the clinical paperwork that is due and the requirements for entering patient data into Docucare. It is the student’s responsibility to complete the online tutorial for accessing and documenting in Docucare.

**COPIES OF PATIENT’s LABS, ETC. WILL NOT BE MADE DUE TO HIPPA REGULATIONS**. **NO EXCEPTIONS.**

Docucare Submission deadlines are as follows:

Thursday Clinical groups: Noon on Sunday

Friday Clinical groups: Noon on Monday

Monday clinical groups: Noon on Thursday

Clinical paperwork will be submitted to the clinical instructor on the next clinical the following week.