Practical Nursing Student Handbook

Updated July 2013

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Dear Practical Nurse Applicant,

It is a pleasure to inform you that you have been granted *provisional* admission to the Eastern Shore Community College (ESCC) Practical Nursing Program for the fall semester class starting in _________.

Final admission will be granted after you successfully complete/submit the following items:

1. **Notify** the Nursing Office **by letter** no later than if you are or are not accepting the provisional offer of admission. Faxed copies will not be accepted. **All letters must be submitted to:**

   Linda Pruitt, RN, MS
   Director
   ESCC Practical Nursing Program
   29300 Lankford Highway
   Melfa, VA 23410

2. **Schedule** your physical examination upon receipt of this letter. **The physical examination and lab tests must be completed prior to admission into nursing courses.** Report to your doctor and have the enclosed Pre-Admission Medical Form completed. **(Rubella, Mumps, Rubeola and Varicella Titers are required).** Students with negative titers may need immunization. **This completed form must be submitted to program director by**

   ____

3. **Submit** your CPR card for the Healthcare Provider or Professional Rescuer **to program director by_______.** The card must be current for the year____. No other CPR will be accepted. If your CPR is not current, you must enroll in the fall HLT 105 CPR class in August and will need an course enrollment form to do that.

4. **Go to www.nso.com and purchase PN STUDENT liability insurance. When you receive confirmation of coverage print it out and return to program director by__________.**

5. **Enroll in the fall nursing class PNE 161 Nursing in Health Changes I and NUR 135. An enrollment form is enclosed. If you are uncertain about other classes such as general education classes, please come to my office with an unofficial copy of your transcripts for review. Take this form to the Registrar to enroll.**

6. **Complete a criminal background check and order the drug screening kit. Go to http:/www.certifiedbackground.com. Click on students. In the package code box enter the package code: at36bgdt. You will need a charge card and the cost is $68. This is a required criminal background check and drug screening. The drug screening will be an oral swab and will be completed by the practical nursing faculty in the fall. This must be purchased by_________. No exceptions.**

7. **Attend** the orientation session scheduled for _________at ESCC in classroom A45. **Business attire is appropriate dress for the session. Matters relating to the class schedules, uniforms, drug screening, etc. will be discussed at the interview session. ALL STUDENTS MUST ATTEND.** No other date is available.

Failure on your part to comply with any of the items will be interpreted to mean that you are not interested in the program.

Thank you for selecting our nursing program. We look forward to working with you as you begin your nursing career!

Sincerely,

Linda Pruitt, RN, MS

PN Program Director

ESCC PRACTICAL NURSING PROGRAM

Admissions Information Student Checklist

Name ______________________________________ Date____

Student ID No.______________________________ DOB ____

Home Phone No. _____________________________ Cell Phone______________________________________

ESCC School email ____
(Note: We will email only using this email. **You are responsible for checking your school email regularly**

Mailing Address____

____

911 Address ____

____

Person to contact in case of an emergency ____

Relationship _______________________ Phone________________________________

Please check the following if complete:

___________ Physical exam forms completed

___________ 2 Step PPD Current (date _______)

___________ Hepatitis B Immunization Series Complete

___________ Proof of MMR or Immunity

___________ CPR Health Care Provider Level (expiration date ________)

___________ Student Liability Insurance

___________ Signed Student Handbook Form

___________ Signed Confidentiality, Honor Pledge, Substance Abuse Form

___________ Drug Screen

___________ Criminal Background Check

___________ Review of Fall Semester Schedule

___________ Letter of Acceptance

___________ Flu Shot Vaccine

Eastern Shore Community College
Academic Calendar 2013 – 2014

Fall Semester 2013

Event	Date
Registration for Current Students Begins	April 8
Open Registration Begins	April 15
Fall Graduation Application Deadline	Sept 5
Convocation and Advising	Aug 16 -20
Last Day to Register	Aug 20
Classes Begin	Aug 21
Labor Day Holiday	Sep 2-3
Planning Day	Sep 3
Last Day to Withdraw with Refund	Sep 6
Last day to Withdraw without Penalty	Oct 28
Thanksgiving Holiday	Nov 27-30
Last Day of Classes	Dec 10
Final Exams	Dec 11-17

Spring Semester 2014

Event	Date
Registration for Current Students Begins	Nov 11
Open Registration Begins	Nov 18
Spring Graduation Application Deadline	Dec 5
Convocation and Advising	Jan 2-3
Last Day to Register	Jan 5
Classes Begin	Jan 6
Martin Luther King Day	Jan 20
Last Day to Withdraw with Refund	Jan 22
Mid-Semester Break	March 3 - 8
Last day to Withdraw without Penalty	Mar 21
Last Day of Classes	Apr 28
Final Exams	Apr 29 – May 5
Commencement	May 16

Summer Semester 2014

Event	Date
Registration for Current Students Begins	Apr 14
Open Registration Begins	Apr 21
Summer Graduation Application Deadline	June 5
Last day to register	June 1
Classes Begin	June 2
Last Day to Withdraw with Refund	June 10
Holiday Observed	July 4
Last day to Withdraw without Penalty	July 7
Last Day of Classes	July 29
Final Exams	July 30-31

Approved by the Eastern Shore Community College Board on 1/8/2013

MISSION OF THE COLLEGE

We serve the Eastern Shore of Virginia by meeting education and training needs, creating an environment for student success, and preparing our students and ourselves for citizenship in a global society. By providing access to a broad range of academic, workforce development, and personal enrichment opportunities, we empower learners to improve the quality of life for themselves and their communities.

Our Goals Are:

- To meet the educational economic needs of our communities by providing access to responsive and affordable lifelong learning opportunities.
- To promote and support student learning and success through exemplary instruction in a learning-centered environment.
- To provide equitable access to learning resources and student support services for the college communities.
- To offer students leadership opportunities and to prepare them for the challenges of an increasingly global economy and society.
- To be a preeminent workforce development provider and to promote personal enrichment through continuing education.
- To foster and advance significant and productive educational, economic, and cultural partnerships.
- To provide the educational component of local economic and community development initiatives, in partnership with business and government agencies.
- To recruit and develop well-qualified, caring and creative employees.

Our Vision Is:

To be an innovative, learning-centered community college recognized as a leader in education and as a vital link in the economic and cultural enrichment of our communities.

GENERAL INFORMATION

Eastern Shore Community College is a member of the Virginia Community College System and serves the residents of Accomack and Northampton counties as a two-year institution of higher learning. Operating under policies established by the State Board for Community Colleges and the Eastern Shore Community College Board, the college is financed primarily with state funds, supplemented by contributions from the two counties and the Eastern Shore Community College Foundation.

Eastern Shore Community College occupies a 115-acre site on U.S. route 13, south of Melfa, in Accomack County. The facility is accessible to the handicapped and includes classrooms, laboratories, a bookstore, a lecture hall, administrative offices, occupational trade areas, a student lounge, and a Learning Resources Center/Library. The College is open during the entire year on a semester system. Classes are held from early morning through late evening.

Accreditation

Eastern Shore community College is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools (1866 Southern Lane; Decatur, GA; 404.679.4501) to award the associate degree.

The associate degree curricula of the College have also been approved the State Council of Higher Education for Virginia. The Associate Degree in Nursing Program (in cooperation with Tidewater Community College) is fully accredited by the National League of Nursing and approved by the Virginia Board of Nursing. The National League for Nursing Accrediting Commission (350 Hudson Street; New York, NY; 800.669.1656) may be used as a resource for program information. The Long-Term Care Assistant (LTCA) program is approved by the Virginia Board of Nursing. The Practical Nursing Program has full approval by Virginia Board of Nursing. The NCLEX-PN passrate for 2012 was 100%. All degree and certificate programs offered at the college are approved by the State Department of Education for full payment of veterans' educational benefits.

Students with Disabilities

Students with disabilities, who meet the program prerequisites, complete the physical/mental exam and submit the physical form signed by the physician stating that they are able to perform as practical nurses in the clinical setting are admitted. It is the responsibility of the student to meet the physical/mental/legal requirements for state certification.

Illness Change Adaptation Wellness

Conceptual Framework

Equal Opportunity/Affirmative Action Policy
Eastern Shore Community College (or ESCC) 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: Dean of Learning Resources, 29300 Lankford Hwy., Melfa, VA 23410; 757.789.1723.

Disability Statement
Provision of disability services is an integral part of Student Services at ESCC. Our mission is to provide support services to students with disabilities that will allow equal access to college classes, services, and events. Services are free of charge and available to any student with a disability who provides appropriate documentation of their disability and makes a request for services through the Disability Services Coordinator, Jody Baggett. To schedule an appointment for an intake interview, please contact her at (757) 789-1730 or jbaggett@es.vccs.edu.

EASTERN SHORE COMMUNITY COLLEGE PRACTICAL NURSING PROGRAM

The Eastern Shore Community College Practical Nursing Program was originally Northampton-Accomack Memorial Hospital School of Practical Nursing formed in 1956 as a joint effort of Northampton County Schools, Accomack County Schools and the Northampton-Accomack Memorial Hospital. Later, when NAM Hospital was renamed, the school became Shore Memorial Hospital School of Practical Nursing. In 2007, Eastern Shore Community College began a certificate program in Practical Nursing. It is a three semester program leading to a certificate in practical nursing and graduates are eligible to sit for the National Council Licensing Exam for practical nurses (NCLEX-PN). The ESCC Practical Nursing Program has full approval by the Virginia State Board of Nursing. NCLEX pass rates are available on the Department of Health website.

This program is committed to providing each individual an equal opportunity for success and does not discriminate in admissions and/or during matriculation based upon an applicant's or student's race, color, religion, gender, national origin, marital status, non-disqualifying disability or age.

PHILOSOPHY AND OUTCOMES
The mission and outcomes of the Practical Nursing program were developed to reflect the mission of the ESCC. The goal of the program is to prepare admitted students to gain the knowledge, skills and expertise to render direct patient care services as beginning practitioners in various health care facilities.

The current needs of the health care system demand practitioners who are prepared to address the health care needs of individuals, families and communities in a holistic and interdisciplinary manner. The Practical nurse is a member of the health care team whose skills interface with other members of the health care team to provide for the needs of patients in a variety of settings across the lifespan with multiplicity of health needs. The program focuses on preparation of basic, competent, entry level practical nurses who are able to think critically, utilize the nursing process to solve problems, and use available resources.

The faculty recognizes the unique learning needs of individuals, and offers a multiplicity of approaches to learning including didactic content, patient simulation, guided clinical experience and case study approaches. Multiple teaching strategies and diverse network of agencies provide the student with opportunity to experience a broad based education with guided learning.

The graduate practical nurse is prepared to sit for the NCLEX-PN examination, practice within the guidelines of the State Nurse Practice Act, and administer direct patient care to a diverse population of varied ages, cultures and health problems within structured health care settings.

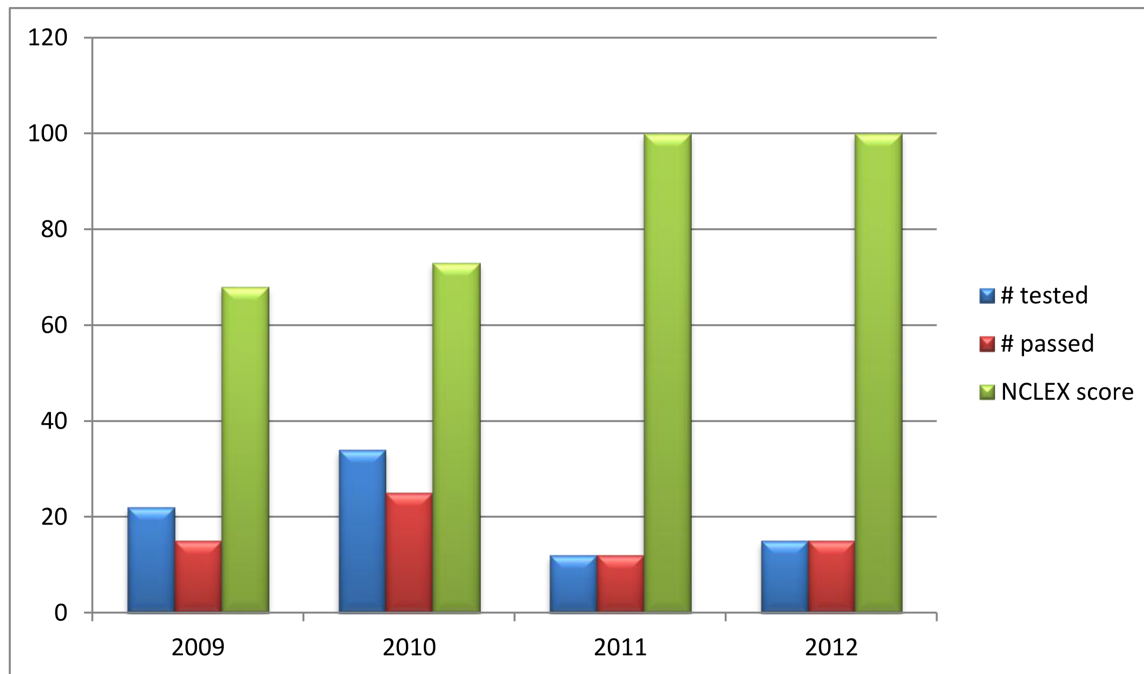
PROGRAM OBJECTIVES
At the conclusion of the program the nursing student will be able to:

1. Apply nursing concepts based on bio-psycho-social cultural and spiritual aspects of individual patients across the life span.
2. Utilize the nursing process in providing safe, prudent nursing care to patients experiencing alterations in basic human needs.
3. Relate cause and effect in disease, injury and disability to the bio-psycho-social cultural, and spiritual health of the individual
4. Demonstrate competency in the performance of basic clinical nursing skills.
5. Interact professionally with peers and members of other health care disciplines.

6. Using the concepts of the nursing process that include conducting a focused nursing assessment of the patient status, be able to make appropriate decisions about who and when to inform, identify patient needs, plan for nursing care, implement appropriate aspects of nursing care, and contribute to the evaluation of patient outcomes.

7. Complete requirements for application for licensure by the Virginia State Board of Nursing.
8. Demonstrate professional growth and development by acquiring knowledge and skills through continuing education.
9. Adhere to the Practical Nurse Code of Ethics.

Eastern Shore Community College
Practical Nursing Program
NCLEX Pass Rates



CONCEPTUAL FRAMEWORK

The conceptual framework of the program flows from the program philosophy. Nursing is an essential part of the health care system and practical nursing is an important component of the discipline of nursing. The client is viewed in a holistic manner that encompasses care throughout the life span. Basic human needs are utilized as a curriculum framework, which also encompasses the core concepts of health promotion/illness prevention, therapeutic communication, cultural diversity, ethical/legal issues, pharmacology, and nutrition. The nursing process is utilized for the assessment, planning, intervention and evaluation of care provided to the client and/or family. Critical thinking skills are utilized in this process and through all aspects of the nurses' involvement in the healthcare arena. Psychomotor skills are developed throughout the program to facilitate safe delivery of care, both to the client and the nurse. These core concepts are integrated throughout the curriculum.

The curriculum is designed to provide a logical sequence of courses and content. Course content increases in the degree of difficulty and complexity. The faculty has agreed on the definitions of the following terms:

- **CLIENTS**
  Clients (human beings) are holistic beings. The faculty view the client as a biological, psychological, developmental, socio-cultural, and spiritual being with the unique capacity to experience emotions. Individuals exist, develop, and interact within the context of their families, communities, and societal environments. Each individual is unique and has intrinsic worth. Clients have the right and responsibility to make decisions for themselves and to develop to their maximum potential. The nurse intervenes at primary, secondary, and tertiary levels. Human beings strive for a sense of balance and well being with a societal context.

- **HEALTH-ILLNESS CONTINUUM**
  The health-illness continuum is a dynamic state of wellness requiring nursing interventions focused on health promotion, restoration and rehabilitation. Clients may be at any point on the continuum at any time during the growth and developmental process. Nurses may assist clients to a maximum state of wellness within the client's potential or assist in providing a dignified death.

- **SYSTEMS**
  Human beings are individuals each comprised of a unique set of characteristics which include physical, psychological, developmental, environmental, socio-cultural and spiritual components. Humans are dynamic systems unto themselves who exist within systems, which are constantly changing.

  The nurse is an individual who is part of the complex group of systems. The role of the nurse with the system is to aid the client to adapt, and to change.

- **COMMUNICATION**
  Communication consists of verbal, nonverbal, written, oral and technological means of communicating with other healthcare professionals and clients to meet client needs and implement change. It is the transferring of information from all domains (affective, cognitive and psychomotor.)

- **CULTURAL DIVERSITY**
  Cultural Diversity refers to the recognition of differences and similarities among individuals and groups related to expectations, behaviors, and ethnicity. Respecting and encouraging diversity enhances one's view of the world and promotes personal and professional growth.

- **CRITICAL THINKING**
  Critical thinking incorporates skills in reasoning, analysis, and decision-making relevant to the discipline of nursing, demonstrated by openness of inquiry, ability to ask questions, generate ideas and offer perspectives.

(Note: Modeled after Utah Basic Applied Technology College PN Program.)

DEFINITION OF PRACTICAL NURSING

"Practical nurse" or "licensed practical nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice practical nursing as defined in this section. Such a licensee shall be empowered to provide nursing services with compensation. The abbreviation "L.P.N." shall stand for such terms.

"Practical nursing or "licensed practical nursing" means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health presses; in the maintenance of health; in the prevention of illness or disease; or subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

Commonwealth of Virginia
Department of Health Professions
Laws Governing Nursing
Virginia Board of Nursing
54.1-2000 Definitions

EXPENDITURES

Miscellaneous Costs (estimated) – responsibility of student

Item	Cost
Watch with second hand	$ 20.00
Stethoscope	20.00
Bandage Scissor	6.00
Student Uniforms (prices subject to change)	60.00 – 65.00
Pant Suit (Additional cost for X-Large)	
White Shoes	50.00
Nursing Cap	19.00
Nursing Grad Pin	25.00 – 100.00
Nurse Pac (depending on type)	50.00
Student Liability Insurance	25.00 – 35.00
Graduation Uniform	65.00
Licensure Examination Fees	370.00
Books (Approximate for Nursing Books Only)	400.00
Physical Exam	100.00
White Lab Coat	50.00
Criminal Background Check/Drug Screen	67.00
HESI Assessment Package	175.00
HOSA Dues	5.00

This list is subject to change and is approximate.

PRACTICAL NURSING COURSE CURRICULUM

PN Courses That Can Be Taken Prior to PN Program Admission

ENG 111	College Composition I
SDV 101	Orientation to Health Careers
PSY 200	Principles of Psychology
PSY 235	Child Psychology
PNE 116	Normal Nutrition
PNE 155	Body Structure and Function
ITE 115	Introduction to Computer Applications and Concepts or evidence of computer literacy

PN Program Course Sequence

Credits	Course	Title
Fall Semester:		
4	PNE 155	Body Structure and Function (A&P)
1	SDV 101	Orientation to Health Careers
3	PSY 235	Developmental Psychology
6	PNE 161	Nursing in Health Changes I
3	PSY 200	Principles of Psychology
1	NUR 135	Drug Calculations
18 (total)		
Spring Semester:		
1	PNE 116	Normal Nutrition
10	PNE 162	Nursing in Health Changes II
2	PNE 173	Pharmacology for Practical Nurses_
4	PNE 136	Care of Maternal Newborn Pediatric Nursing
17 (total)		
Summer Semester:		
8	PNE 163	Nursing in Health Changes III
3	ENG 111	College Composition 1
1	PNE 158	Mental Health Nursing
1	PNE 145	Trends in Practical Nursing I
2	PNE 174	Applied Pharmacology for Practical Nurses
15 (total)		

Total Credit Hours 50
Total Lab/Clinical Hours 536

All students must be CPR certified at Health Care Provider level. HLT 105 CPR is offered at ESCC.
All Students must demonstrate basic computer skills or take ITE 115.

ESCC PN Program Lab Clinical Hours

Semester 1
7 weeks x 8 hours = 56 hours skills lab
7 weeks x 8 hours = 56 hours long term care
8 hours orientation
Safety Simulation
Total – 120 hours (56 hours BON)

Semester 2
14 weeks x 16 hours = 224 hours Acute Care Medical Surgical Pediatrics
16 hours orientation
Cardiac/CHF/MI Simulation
Pharmacology Simulation
Diabetes Simulation
Total 240 hours (224 hour BON)

Semester 3
11 weeks x 16 hours = 176 hours Acute Care Medical Surgical Mental Health
RSV Pediatric Simulation
Newborn OB Simulation
(8 hours OR observation)
Total 176 hours (168 hours BON)
Total 536 hours (448 hours (BON)
All Clinicals with the exception of OR not directly supervised by clinical faculty are supervised by preceptors and signed agreements.

CORE PERFORMANCE STANDARDS

The nursing faculty endorses the recommendations of the Southern Council on Collegiate Education for Nursing and has adopted the "Core Performance Standards for Admission and Progression" for use by the program. Each standard has at least one example of an activity the nursing students are required to perform to successfully complete the program. Each standard is reflected in the course objectives.

Admission to and progression in the program is not based on the core performance standards. Rather, the standards are used to assist each student in determining whether accommodations or modifications are necessary. The standards provide an objective measure upon which students and faculty/advisors base informed decisions regarding whether students are "qualified" to meet requirements. Every applicant and student receives a copy of the standards.

If a student believes that he or she cannot meet one or more of the standards without accommodations or modifications, the nursing program will determine, on an individual basis, whether or not the necessary accommodations or modifications can reasonably be made.

Issue	Standard	Some Examples of Necessary Activities (not all inclusive)
Critical Thinking	Critical thinking ability sufficient for clinical judgment.	Identify cause-effect relationships in clinical situations in a timely manner, use analytical skills to identify and solve problems and make decisions, perform mathematical functions, and contribute to the development of nursing care
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.	Establish rapport with patients/clients and colleagues. This involves: Determining client's ability to understand, responding to client's ability to understand, responding to client's concerns and fears, using language appropriate to the situation, using school guidelines for giving health care information, respecting client's religious and cultural differences.
Communication	Communications abilities sufficient for interaction with others in verbal and written form.	Explain treatment procedures, initiate health teaching, document and interpret nursing actions and patient/client responses. This involves: Assisting others' ability to understand, adapting communication to individual needs, including paraphrasing or translating, asking for clarifications when needed, being sensitive to multicultural and multilingual needs, use program guidelines and methods of sending and receiving information, accessing and using electronically produced information.
Mobility	Physical abilities sufficient to move from room to room and maneuver in small places.	Moves around in patient's rooms, work spaces, and treatment areas, administer cardiopulmonary procedures.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective nursing care.	Calibrate and use equipment; position patients/clients; keyboarding skills; administer medication by injection; maintain proper asepsis when performing various nursing procedures.
Hearing	Auditory ability sufficient to monitor and assess health needs.	Hears monitor alarm, emergency signals, auscultatory sound, cries for help.
Visual	Visual ability sufficient for observation and assessment necessary in nursing care.	Observes patient/client responses.
Tactile	Tactile ability sufficient for physical assessment.	Perform palpations, functions of physical examination and/or those related to therapeutic intervention, e.g., insertion of a catheter.
Endurance	Endurance sufficient to provide safe and effective nursing care.	Prolonged standing, walking, transferring client from bed to stretcher or chair and back, and lifting. Extended empathetic relationships with clients who have prolonged chronic conditions and difficulty with coping.

RESOURCES AND SUPPORT SERVICES

Name	Phone	email
Administration		
Dr. Linda Thomas-Glover, President ESCC	757.789.1775	lglover@es.vccs.edu
Linda Pruitt, Practical Nursing Program Director	757.789.1772	lpruitt@es.vccs.edu
Carol McGarrity, Adm. Asst. to the Dean of Instruction	757.789.1725	cmcgarrity@es.vccs.edu
Nursing Faculty		
Peggy Bennett, RN, M.Ed.	757.789.5925	mpb209@email.vccs.edu
Marissa Blair, RN, BSN		mnb230@email.vccs.edu
Bonnie Nordstrom, RN, M.Ed.	757.789.1780	bnordstrom@es.vccs.edu
Denise Dechene, RN		

Counseling

Personal and career planning is available in the ESCC Counseling Office. Tutoring services may be available.

Jody Baggett, Counselor, Enrollment Services	757.789.1730	jbaggett@es.vccs.edu
Mark Flanders, Career Services Counselor	757.789.1777	mflanders@es.vccs.edu

See the *ESCC Catalog & Student Handbook* for additional information regarding Learning Resource Center, Bookstore, Student Activities, Financial Aid and other services.

Scholarships

Special scholarships are available for nursing students who qualify. See the Financial Aid officer, Carole Read (789.789.1733 or cread@es.vccs.edu) for information and application. Scholarships typically offered include the Craft-Crumb Scholarship.

POLICIES AND PROCEDURES OF THE PRACTICAL NURSING PROGRAM

A. ACADEMIC

Classroom

- Street Clothes are worn in the classroom.
- No smoking, eating, or drinking is permitted in the skills lab, no exceptions.
- Students are expected to be present and on time at all scheduled classes and laboratory sessions.
- Instructors may not admit a student who arrives late to class.
- Students are expected to adhere to the College's policy regarding attendance.
- Argumentative or other disruptive classroom behavior will not be tolerated. Any student exhibiting such behavior will be asked to leave the class.
- Students may tape classroom lecture-discussions **only** with the consent of the faculty member involved.
- Written tests are given periodically according to the instructor's preference.
- Permission for make-up of missed tests or other assignments will be granted only at the discretion of the instructor involved. The instructor reserves the right to give an alternate test in any form deemed appropriate.
- Grading Scale:

  A = 94-100
  B = 93-87
  C = 86-80
  D = 79-74
  F = 73 or below
  Points are designated for each course which equate to the alphabetical grade.
- Any student who receives a final grade lower than 'C' courses may not continue in the PN program. The student must maintain a 2.00 grade point average while enrolled the nursing curriculum.
- Students may be required to purchase course materials, such as books, nurse pacs or other needed items.

Academic Misconduct
When a faculty member has reliable evidence of academic misconduct, the faculty member may refer the matter to the appropriate administrator for possible disciplinary sanction, and/or the faculty member may, for the test, paper or exercise, give no credit, require the work to be accomplished again, assign a grade of zero or another appropriate grade of 'W' or 'F' for the course, after first investigating the matter, and reviewing the facts of the matter and the proposed penalty with the appropriated division chairman. Refer to *ESCC Catalog & Student Handbook*.

Student-Faculty Relations

- Each student will be assigned to a nursing faculty advisor for academic assistance. The instructor will have office hours posted for regular conferences. When necessary, students having special needs or problems should initiate a conference with the assigned faculty advisor at times other than posted office hours. Students are free to make appointments for conferences with the nursing program director.
- Nursing students are **required** to have their enrollment forms checked and signed by the nursing **faculty advisor** for each sequential course in the nursing curriculum.

B. ADVANCED PLACEMENT POLICY

Students seeking advanced placement in the PN Program should:

1. Submit an official copy of transcripts from prior nursing program.
2. Submit course descriptions and course syllabi from prior nursing program.
3. Make an appointment for assessment testing with ESCC PN program director.
4. Make application to the PN program and request advanced placement.
5. Submit letter from prior program director listing the number and type of clinical hours completed and clinical hours completed and clinical checklist.

To achieve advance placement the applicant must:

1. Complete the PSB Aptitude Test for Practical Nurses (this may be waived for second year TCC/ESCC students).
2. Successfully score 80 percent or above on individual course assessment test/final exam.
3. Successfully complete a skills assessment.
4. Successfully gain admission to the PN program by the admissions committee.

No more than 40 hours of clinical hour credits can be transferred into the program. Transfer course substitution must match the credit hours required by the substituted course. Student can request transfer substitution from other practical nursing programs for:

1. PNE 161 Nursing in Health Sciences I – 6 credit hours.
2. PNE 155 Body structure and Function – 4 credit hours.
3. NUR 135 Drug Calculations .- 1 credit hour.
4. PNE 116 Normal Nutrition – 1 credit hour.

Other general education program requirements requests for transfer will be evaluated by the Dean of Instruction.

If seeking re-admission to the Practical Nursing Program:

1. Re-applicant must meet with program director and complete application.
2. Re-admission may be granted by the faculty based on additional data, prior performance and space availability.
3. Students may not apply for re-admission more than one time
4. Re-admission must occur within three years or the student will have to repeat all nursing courses.
5. Students must successfully validate their skills by exam/or practicum for credit
6. Students must complete program requirement current at the time of re-admission.

C. CAMPUS SKILLS LABORATORY

- The campus skills laboratory is located in WDS Rm 139. Students will practice basic nursing skills before caring for patients/clients in health agencies. At least 6 simulations will be required.
- The campus skills laboratory is considered clinical time. Unexcused absences are not permitted.
- Students may wear regular business casual attire, lab coats and name pin in the campus laboratory. No jeans, shorts, or open toe shoes.

- The laboratory will be open at specified hours. Students are required to practice skills, in the lab as assigned. All assigned skills must be demonstrated with instructor supervision in the campus lab to be checked off. Instructors are available when you need help with a skill. The student is requested to arrange an appointment with appropriate faculty for individualized campus instruction.
- Students are responsible for having skills checked off by the instructor on the appropriate form. Audiovisuals are available for individual needs. Models and other occupational equipment are available in the laboratory. Because of the nature and value of the equipment and supplies in the laboratory, they may be in locked cabinets. Check with your clinical instructor to open the cabinets.
- Students must sign up for lab hours and should work in pairs.
- Students will be required to complete 10 independent practice hours in skills lab during fall and spring semesters. Failure to complete the required independent practice hours may result in program dismissal.

D. CLINICAL LABORATORY

- All students must compete a physical examination on the form provided prior to clinical experiences. Immunizations be up to date including Dtap, Tetanus, MMR, Varicella and Hepatitis B OR have titers drawn showing adequate immunity. All students must have a current 2 step PPD. All students must have a current seasonal flu vaccine. Students attending Riverside clinicals must complete an additional criminal background check through the Virginia State Police and complete the Riverside application for clinical placement. All students must complete the orientation prior to beginning of clinicals including Netlearning (if Riverside), Safety, OSHA. All students must have current liability insurance and MUST renew this if it expires prior to completion of the PN program. All students must have current CPR certification at the health Care Provider level. Online CPR is not accepted. Riverside students must carry their CPR cards and proof of flu vaccine on their person at all times while attending a Riverside-clinical experience.
- Instructors make assignments for the students before the clinical experience. Students are responsible for getting their assignments prior to the experience. An assignment sheet and laboratory guidelines are posted at the cooperating agency for the nursing service staff.

MAJOR CONTRACTUAL AGENCIES

1. Riverside Healthcare Association, Inc.
    - Riverside Shore Memorial Hospital
    - Riverside Shore Rehabilitation Center
    - Riverside Behavioral Center
2. Peninsula Regional Medical Center
3. Hartley Hall
4. Accomack/Northampton School Systems
5. Heritage Hall
6. Eastern Shore Rural Health

CLINICAL PERFORMANCE GUIDELINES

There are responsibilities and expectations for students in all areas of the program. This is an explanation of the expectations of the student in the clinical area. These expectations were developed to maintain a safe and secure environment for all in the clinical setting.

The responsibilities of the student include client assessment and evaluation; planning and performing safe and competent nursing care; reviewing the client record, developing individual nursing care plans, implementing physician’s orders, assessing the physical – psychosocial – cognitive – spiritual aspects of the client and family; and ability to utilize written, verbal, and computerized communication with faculty, peers, and other health care professionals. The student must be able and willing to accept professional supervision from the clinical instructor and other supervisors and effectively integrate feedback they receive in practice.

Students are NOT allowed to work the night preceding a clinical experience.

ATTENDANCE POLICY

1. Attendance to **all** classes & clinical is mandatory
2. Do **not** schedule appointments during class or clinical time.
3. Any time missed on a clinical day will be considered a full day.
4. Missing more than 20% of lecture hours in any class will result in failure unless dire extenuating circumstances can be substantiated.

5. If you must miss a class you must call the instructor prior to class.
6. If you must miss a clinical you must call the instructor at least 45 minutes PRIOR to the clinical.
7. If you miss a test it must be made up within two days unless other arrangements are made with the instructor or no credit will be given.
8. The Board of Nursing requires that you complete a minimal number of clinical hours per semester.
9. **<u>All</u>** missed clinical hours must be made up.

The ESCC program contains more than the minimal number of hours. All of these hours must be completed.

Tardiness will not be tolerated during the clinical experience. The student is to make arrangements to be at the assigned clinical area no later than 10 minutes before assigned time. If the student is in the ancillary areas the instructor will alert the student of the arrival time to that area. It is important that students arrive on time to the clinical area to prevent any inconsistency in patient care. Students arriving late may be asked to leave clinical and will need to make up the time missed.

DRESS CODE

Professional appearance is required for all clinical areas. A student will be dismissed from the clinical area for unprofessional dress.

The student will wear the approved student uniform to all clinical experiences including proper photo identification.

Guidelines

1. Exceptional personal hygiene is to be maintained at all times. This includes bathing on a regular basis and the appropriate use of deodorants and antiperspirants as needed. The student is not to use any perfumes, scented lotions or powders when in the clinical setting.
2. With the exception of a wristwatch, wedding ring set, and stud earrings, jewelry is not to be worn with the uniform. Earrings should be small stud earrings and no dangling or hoops allowed when in uniform. Stud earrings and rings are not permitted on any visible part of the body except the ears and fingers. No body piercings should be visible except earrings.
3. Clothing must be clean and neat. School patches are to be placed on the left shoulder of the uniform and lab coat. Proper identification badge is to be worn on the left upper torso and be visible.
4. Makeup is to be used conservatively and in good taste. There is to be no nail polish used and fingernails are to be clean and cut short (no artificial nails).
5. Hair is to be clean, arranged neatly, and kept above the collar of the uniform. Wigs and hairpieces may be worn provided they comply with these criteria.
6. Beards and mustaches are to be neatly trimmed.
7. No open-toe shoes are to be worn with the school uniform. Hose should be white in color and no designer hose should be worn. White nursing shoes in good repair are required.
8. The student should maintain a professional appearance while in the clinical setting.
9. The lab coats are to be worn when the student needs to enter the clinical area in street clothes (also applies to skills lap). Lab coats must have student patch.
10. No gum is allowed while in the clinical area. **Remember to think about**, “What is the impression I want the staff, patients, visitors, etc. to have of me?”
11. Tattoos that are visible are to be covered when in the clinical setting.
12. The student is to have the school identification badge on and displayed on the left side of the upper torso and it must be visible. The uniform will have the proper school emblems **sewn** on the left sleeve of the uniform and lab coat, if worn. The school emblems are not to be pinned in place. The uniform is to be worn for clinical experiences only, unless the student is going directly to class after the clinical experience. The uniform is to be in good repair and show minimal signs of wear. If soiled, stained, torn or has improper fit, the student is to obtain another uniform.

CLINICAL ASSIGNMENTS

Each student will be given a rotation schedule as to what areas they will be reporting to for their clinical experience. It is the responsibility of the student to complete the expected forms for that particular area and return these forms to the clinical instructor. Below is listed the expectations for each rotation and general information.

1. Ancillary Departments (Rehab departments, Surgical Services, OB-GYN services, skilled unit, Radiology departments, dietary, etc.): There are forms for each experience in the ancillary areas that are to be completed for that rotation. This will include a form that the student describes their experiences, the positive and negative aspects, and a form that the evaluator in that area is to complete on the student. The competed form is to be given to the instructor at the end of that rotation for that specific area. The instructor will alert the student on the assigned time to report to that area. **Failure to return the form will be seen as an absence of clinical time.**

2. Clinical areas: The instructor will post the student assignments in the designated clinical area. The student is to go to that unit after school hours and review the patient record. The student is to collect data on the diagnosis, treatments, medication therapies, diagnostic tests, etc. Confidentiality must be maintained at all times with patient related information. Patient information is not to be discussed with families, friends, in public areas, etc. All information from the patient record is to be **shredded at the end of the clinical day**. Any school forms with patient data is to have patient initials only. **Remember that a break in confidentiality could cause expulsion from the program.** The student is to research all treatments and medications prior to the clinical day. The student is to be familiar with the history and treatment regimens of their assigned patient when questioned by the instructor. All students are to complete a care plan on their assigned patient and hand this in to the instructor at the end of the clinical experience. The student is to report to the clinical area no later than 10 minutes prior to assigned time.

3. Breaks and Lunches: The students are not to leave the assigned area without the permission of the instructor. The student will be allowed a 30-minute lunch and if time allows the student will be allowed a 15 minute break. The assigned times for lunches will be determined by the instructor and activities on the unit.

   Note: No food nor drink is permitted in clinical areas.

4. Personal Belongings: All students are encouraged to bring only what is necessary for the clinical day. Do not bring large sums of money, purses, credit cards, etc. to the clinical areas. Cell phones are not allowed in the clinical areas; these must be left in the personal vehicles and used on personal time. Any emergencies that require contacting the student, the family may call the school 757.789.1772 and the school will contact the instructor to relay the message to the student.

5. Charting Documentation: The student will be required to document all patient related care according to the practices of the particular clinical area. All documentation is to be reviewed by the instructor or preceptor and verified by the end of the clinical shift. The student is to have all pertinent patient information completed 30 minutes prior to end of clinical day. The student is to report any unusual findings to the instructor and the nurse assigned to that patient as soon as possible (i.e. abnormal vital signs, atypical assessment findings, etc.) The care plan will be completed and given to the instructor at the end of the day's clinical experience.

6. Patient Care: The student will be responsible for completing the care of the assigned patient. He/she will be using the skills taught in class and will be under the supervision of the instructor. The student is to check the patient record at start of clinical experience to see if there have been any changes in the plan of care. The student is to use their time wisely when in the clinical area. During any "down time" they are to volunteer their help to fellow students, staff members, use the time to research new or unfamiliar medications, treatments, talk with patient and families to learn more history on the patient, etc.

7. Post-Clinical Conference: There will be a post-clinical conference after each clinical experience. All students will meet as a group in the designated area to discuss the clinical encounter. This is the time the students will be able to share their learning experiences and ask the instructor any questions regarding the day's events. The instructor will expect any clinical forms to be handed in during this time. The instructor may also use this time to discuss any pertinent changes in the upcoming clinical schedule.

8. Clinical Failure Days:

   1) No call, no show
   2) More than two (2) tardy days. Third tardy will be a failure day
   3) Unsafe clinical practice as determined by instructor
   4) Insubordination to instructor or staff
   5) Leaving without permission
   6) Breach of confidentiality may result in program dismissal
   7) Failure of a practicum

   Accumulating three (3) failure days will result in program dismissal. The student will receive a written warning and remediation plan after each failure day occurrence.

GUIDELINES FOR STUDENT CLINICAL EVALUATION TOOL

1. The Student's daily achievement of clinical experiences will be graded by the following scale:

    - E = excellent
    - S = satisfactory
    - I = needs improvement
    - U = unsatisfactory
    - NA = Does not apply for that clinical period or experience

2. The Student must meet the following criteria to achieve one of the grade levels:

    E (excellent):
    - The student must demonstrate problem-solving behaviors in safety, treatments, or basic skills related to the care of the client.
    - The student is never late to the clinical experience and is prepared by having all expected data collected and has all equipment and I.D.
    - The student will actively pursue learning experiences when in the clinical setting from healthcare staff and instructors.
    - The student will find productive activities during the clinical periods and not be found sitting idly or in areas not related to the clients care needs, unless directed there by the instructor.

    S (satisfactory):
    - The student will be timely to the clinical experiences and have all expected data completed by the end of the clinical day.
    - The student will come prepared for the clinical experience by having researched all pertinent data related to the care of the client.
    - The student demonstrates safe practices in the care of the client.
    - The student accepts constructive advice from the instructor and health care staff and acts on it appropriately.
    - The student accepts task given by instructor and/or health care workers to use time more wisely in the clinical setting.

    I (needs improvement):
    - The student is not prepared for the clinical experience by not having appropriate equipment and proper I.D.
    - The student has not researched data related to the care of the assigned client.
    - The student is not prepared to hand in all expected forms at the end of the clinical experience.
    - The student does not spend time wisely in the clinical area and is found missing from the assigned area or sitting idly on the unit.
    - The student demonstrates lack of preparedness in the care of the client and requires frequent correcting by the instructor.

    U (unsatisfactory):
    - The student is chronically late (three (3) or more events in the grading period) and unprepared for the clinical experience.
    - The student is chronically late (two (2) events not handed in by the end of the clinical day) in handing in expected clinical forms in to the instructor.
    - The student demonstrates unsafe practices and puts the client's welfare at risk.
    - The instructor has to have student correct or complete required data and tasks in the clinical area three or more times
    - The student is tardy three (3) or more times for post clinical during the grading period due to late completion of data and tasks in the clinical experiences.
    - The student makes multiples errors (Three (3) or more) in the care of the client.

3. The clinical evaluation will be based on the instructor's observations of the student's performance in the clinical setting and pre- and post-clinical conference participation, written assignments, student's interactions with the client, family, other healthcare members and the instructor.

4. A midterm and final performance review will be conducted at an assigned time to determine the student's overall achievement of clinical outcomes. In the case there are areas of improvement or unsatisfactory events the student may be placed on a probationary period. The probationary period will be outlined with to set time frames for goals to be met. During this period there will be frequent reviews to determine if the student can meet the goals that have been set by the school's academic team.

5. If the student has taken any nursing action which is unfit or incompetent by reason of deliberate or negligent acts or omissions, regardless of whether actual injury to the client has occurred, this may result in immediate dismissal from the program.

Please review the clinical expectations contract prior to the clinical experience.

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ____ Instructor __________________________________ Unit ______________________ Semester____________

Midterm _____________________ Final _____________________ Disciplinary ______________________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

PROFESSIONALISM	E**	S	I**	U**	NA	COMMENTS
1. Demonstrates accountability in client care and charting						
2. Maintains a professional appearance and demeanor.						
3. Adheres to policies of the clinical agency.						
4. Adheres to attendance policies. (Per ESCC PN Handbook policies)						
5. Demonstrates preparedness by arriving to clinical area ready to begin care of client and has all required data and equipment.						
6. Maintains privacy and confidentiality of client information according to HIPPA policies.						
7. Uses universal precautions at all times.						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ______________________ Instructor ______________________ Unit ______________ Semester ________

Midterm ______________ Final ______________ Disciplinary ______________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

PREPARATION	E**	S	I**	U**	NA	COMMENTS
1. Gathers information regarding client's history, diagnosis and treatments prior to the clinical experience.						
2. Understands the client's disease process and is able to verbalize this to the instructor.						
3. Researches the client's prescribed medications.						
4. Understands the use of each medication prescribed for the client and able to verbalize this to the instructor.						
5. Prepares a care plan for the assigned client(s).						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ____ Instructor __________________________________ Unit ______________________ Semester____________

Midterm _____________________ Final _____________________ Disciplinary ______________________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

PATIENT CARE	E**	S	I**	U**	NA	COMMENTS
1. Maintains a safe environment for the client at all times.						
2. Organizes care in a timely manner and completes all tasks within the shift.						
3. Identifies needs of individual clients. (cultural, customs, religious)						
4. Provides basic care in a safe and orderly manner.						
5. Makes decisions and reports to appropriate health care workers of any deviations from the normal of each client.						
6. Administers medication safely and accurately. PO_____IV_____SQ_____IM_____ID_____Gtts_____ Inhalations_____Topical_____						
7. Demonstrates knowledge of each medication and appropriate care r/t the medication being administered.						
8. Prepares for and performs procedures using aseptic technique and appropriate precautions.						
9. Gathers subjective and objective data from each client.						
10. Provides compassionate, empathetic, and nurturing care to the client.						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ____ Instructor __________________________________ Unit ______________________ Semester____________

Midterm _____________________ Final _____________________ Disciplinary ______________________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

TEACHING	E**	S	I**	U**	NA	COMMENTS
1. Identifies learning needs of the client and family and incorporates this in the care of the client and family.						
2. Teaches the client and family as needed.						
3. Refers client's needs to the healthcare interdisciplinary team as needed for educational needs.						
4. Evaluates teaching outcomes.						
5. Documents teaching and the outcomes.						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ____ Instructor ___________________________________ Unit _______________________ Semester____________

Midterm ______________________ Final ______________________ Disciplinary _______________________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

DOCUMENTATION	E**	S	I**	U**	NA	COMMENTS
1. Documents care including safety measures.						
2. Documents vital signs.						
3. Documents intake and output.						
4. Documents complete assessments and reassessments as per policy.						
5. Documents special procedures accurately.						
6. Documents scheduled and unscheduled medications administered. Documents follow-up with PRN meds.						
7. Documentation is completed in a timely and organized manner.						
8. Documents care plans on assigned clients.						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ______________________________ Instructor ____________________________ Unit __________________ Semester__________

Midterm ________________ Final ________________ Disciplinary __________________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

TEAMWORK	E**	S	I**	U**	NA	COMMENTS
1. Communicates effectively and accurately to the client.						
2. Communicates effectively and accurately to the family						
3. Communicates effectively and accurately to the healthcare team.						
4. Communicates effectively and accurately to other ancillary departments or health care facilities.						
5. Assists others as able.						
6. Collaborates with instructor and other healthcare providers to facilitate interdisciplinary care.						
7. Demonstrates knowledge of each medication and appropriate care r/t the medication prescribed for the client.						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION TOOL

Student: ________________________ Instructor ________________________ Unit ________________ Semester__________

Midterm ________________ Final ________________ Disciplinary ________________

****--Comments must follow this grade level. Instructor to initial the grade level for each step**

CRITICAL THINKING	E**	S	I**	U**	NA	COMMENTS
1. Evaluates unexpected changes in the client's condition and alerts the appropriate person.						
2. Identifies problem r/t safe environment and promptly notifies appropriate staff. Student is able to discuss why it is a safety hazard.						
3. Problem solves regarding patient care issues and able to offer suggestions as to how care can be adjusted.						
4. Demonstrates organization and time management in the care of 2 or more clients.						

Instructor Comments:

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ESCC PRACTICAL NURSING PROGRAM: CLINICAL EVALUATION FORM

Student: ____ Date ______________________________________

Reason for Evaluation Midterm__________ Final ___________ Disciplinary________________
(Check appropriate reason)

Student's Strengths	**Examples**	**Comments**
Areas need improvement	**Examples**	**Comments**
Instructor's comments:		
Recommendations:		

Student Signature: ____ Instructor signature: ____

Student may add comments on back of form.
Reviewed 7/31/13

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ESCC PRACTICAL NURSING PROGRAM: PN Mid-Semester Clinical Evaluation Form

Student:______________________________ Date:______________________________

Instructor: ______________________________ Semester: ______________________________

	Excellent No infraction	**Satisfactory** 1 infraction	**Improvement** 2 infractions	**Unsatisfactory** Failure day acquired	**Improvement plan developed**
Professionalism					
• Follows dress code • No absences/tardy • Maintains confidentiality • Shows respect to instructor/staff/classmates					
Preparation					
• Completes client research form • Completes medication research					
Patient Care					
• No safety breaches with client • No medication errors • Completes care during clinical experience					
Documention					
• Documentation complete • Care plan completed					
Team Work					
• Communicates with instructor/staff about client data • Assists fellow students					
Critical Thinking					
• Alerts instructor/staff of unexpected findings • organizes care as student assignments grow					

Developed: 9/24/09 reviewed: 10/07/2010-+

Student signature: ____

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ESCC PRACTICAL NURSING PROGRAM: CARE PLAN FORM

Student: ______________________ Date ______________________ Unit ______________ Rm ____________

Client Initials ____________ Diagnosis ____ Age ____________

Nursing Diagnosis: (an actual or potential health problem that the nurse can legally and independently treat)	
Interventions (any treatment performed by the nurse to enhance outcomes)	**Rationale (how the interventions will assist the client to the set goals)**
1.	
2.	
3.	
Expected goal/outcomes: (status at end of treatment)	

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ESCC PRACTICAL NURSING PROGRAM: STUDENT CLINICAL RESEARCH FORM

Unit ____________________ Date __________________ Student ________________________________

Client Initials _____________ Diagnosis ____

Age ___________ Allergies ______________________________ Medical ________ Surgical _____________

Medical History:

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Surgical History:

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Recent Vital Signs: T _________ P _______ R _______ BP ______ Recent Wt _____________________

Activity and restrictions: ____

Labs and Radiology Reports: (indicate ↑ and ↓)

Hct ___________ Hgb __________ WBC _____________ RBC ___________ Plat ____________ Albumin ___________

Glucose ____________ Na _____________ K ____________ Chlor ____________ Pt/PTT _______________________

CXR ____ Misc X-Ray ____

Treatments:

IV fluids ____ Resp. TX ______________________________

Dressings ____

Drains ____

Accucheks ____ Miscellaneous ___________________________

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Write medications on back of form: include actions, reasons prescribed, and precautions of each medication.

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ESCC Practical Nursing Program
Clinical Ancillary Evaluation Tool

Student Name: ______________________________ Date(s) of Experience _____________________

Clinical Experience __________________________ Designated Staff _________________________

Time in: ___________________________________ Time out:_______________________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The Student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and/or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives:

- The student will be able to verbalize the roles of the various staff members in the ancillary area in relation to the plan of care.
- The student will be able to verbalize the communication skills that occur between the various departments to validate the continuity of care for the clients.
- The student will be able to list safety and HIPPA standards that were in place in the ancillary department.
- Eastern Shore Rural Health Pediatrics
  - Assist the nurse with pediatric weights and vital signs.
  - Assist the non invasive procedures such as ear lavage
  - Assist the respiratory treatments such as pulse oximetry, nebulization, oxygen, etc.
  - Observe children of all developmental levels.
  - Apply pediatric developmental principles to all interactions with children.

Skills Completed during this Clinical Experience:

Ancillary staff member's initials to validate skills listed: __________________________

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Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student

	Satisfactory	Unsatisfactory	No Applicable
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member to do so.			
Integrity/Accountability			
Follows instructions by staff			
Seeks assistance when needed.			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client/Family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

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Staff Member: ____

Student Assignment

1. What are the roles of the various staff members in this department and how do they relate to the care of the client?

2. What is the nurse / client ration in this department?

3. How does the care in this department vary from the care in the acute care setting of a medical – surgical unit?

4. How did the staff members prioritize / plan the care of the clients seen in this department?

5. List the types of clients seen in this department – diagnosis, client complaints, etc.

6. How was safety and HIPPA standards carried out in this department?

7. What infection control standards were used in this department?

8. What communications techniques were used in the interactions with the clients / families?

9. What treatments were seen and how were they beneficial for the client?

10. What medications were administered and what were the reasons they were given to the client?

11. How does this department fall into the interdisciplinary team caring for the client?

12. List two nursing diagnosis that would relate to one or more clients seen in the department and three interventions that were done for that client related to the nursing diagnosis.

Behavioral Health Specific

13. If in behavioral health environment, list the various mental health disorders seen and describe how the interaction with these clients differ from an acute care setting.

14. Describe an interaction you had with a behavioral health client.

15. What safety standards are used in this department that may not be used in other areas?

16. Describe the activities or group therapies seen in the department, how do they differ from other areas?

Student may attach additional notes or write on the back of this form.

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STUDENT EVALUATION

Name ______________________________ Date ______________________________

Agency ______________________________ Department ______________________________

1. What were your experiences in this Department? (i.e. treatments, areas visited, etc.)

2. What is the importance of this department in the plan of care for the clients?

3. How did this experience benefit (or not benefit) you?

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ESCC Practical Nursing Program
Clinical Ancillary Evaluation: (Pediatrics) Rural Health Clinics

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives: The student will be able to observe and assist with a clinic patient admissions/ management:

- Data Collection
    - Obtain vital signs, oxygen saturation, glucose testing, height and weights.
    - Verbalize an understanding of the role of the nurse in the interdisciplinary team of the Medical Office.
    - Recognize the different stages of growth and development in the pediatric patients seen in the clinic.
    - Apply knowledge of growth and development in providing care for each individual child / adolescent.
    - Assess level of pain
    - Verbalize cultural impact on the plan of care for the patient and family seen in the medical clinics
- Medication Administration
    - Verbalize understanding of classification and action of common medications used in the medical clinics.
    - Administer medications appropriately with supervision.
    - Recognize the need for pain medication.
    - Verbalize understanding and assist patient with non-pharmacologic methods of pain management.
- Experience / Skills
    - Identify procedures performed in the assessment of a child and note the difference in relation to an adult assessment.
    - Verbalize and demonstrate an understanding of safety measures appropriate for each child’s growth and development.
    - Assist in well-infant / child visits.
    - Utilize therapeutic communication skills, guidance and support in interacting with the child and family and record observations in the proper sequence and format.
    - Observe and assist with nursing care of the clinic patient to include but not limited to:
        - Basic assessment of the well infant / child visit
        - Performance of basic nursing skills safely and effectively
        - Collection of data on the patient’s health status in a systematic and objective manner.
        - Provide basic health information to the child and family using age appropriate methods.
- Planning / Teaching
    - Verbalize how the physical and emotional safety of the patient is protected in the medical clinics.
    - Verbalize the contrast of treatments in the clinic compared to in hospital treatment of injuries and diseases.
    - Assist in discharge instructions for the client being discharged from the medical clinic.
    - Verbalize how the family is incorporated into the plan of care of the child/ adolescent in the medical clinic.
- Communication / Documentation
    - Verbalize a list of services available to the family through the facility.
    - Verbalize correct terminology when reporting observations
    - Accurately and efficiently give and receive report to RN
    - Accurately and efficiently provide pertinent information to physician
    - Accurately chart in a timely manner
    - Identify common medical conditions seen in the clinic.

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned preceptor is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member to do so			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor Signature: ______________________________________

Student Assignment

1. In the Medical Office what were the roles and responsibilities of the nurse?
2. What age groups were seen during the clinical experience on the Medical Offices and how was the care adapted to the growth and developmental level of each child?
3. What safety measures are in place in the facility to protect the children?
4. How did the staff members prioritize / plan the care of the children seen in this department?
5. List the services offered by the Medical offices that are offered to the children and families in the community.
6. How was HIPPA standards carried out in this department?
7. What infection control standards were used in this department?
8. How was communications techniques used in the interactions with the children / families cared for in the Medical Office?
9. How were the parents/ care giver involved in the care of the child?
10. What treatments were seen and how were they beneficial for the child?
11. What medications were administered and what were the reasons they were given to the client?
12. List two nursing diagnosis that would relate to one or more clients seen in the department and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Ancillary Evaluation Tool – Wound Clinic / ET Nurse

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives:

Wound clinic / ET nurse: The student will be able to observe and assist with a patient admissions/ management:

- Data Collection
  - Obtain vital signs, oxygen saturation, glucose testing.
  - Determine the phase of wound healing; primary, secondary, and tertiary intention.
  - Determine the stage of a pressure ulcer
  - Verbalize the normal findings and complications of wound healing.
  - Assess level of pain
  - Verbalize cultural impact on treatment plan
  - Verbalize understanding of nursing care for acute and chronic wound care.
- Medication Administration
  - Verbalize understanding of classification and action of common medications used in wound care.
  - Administer medications appropriately with supervision.
  - Recognize the need for pain medication.
  - Verbalize understanding and assist patient with non-pharmacologic methods of pain management.
- Experience / Skills
  - Observe and assist in the care of the patient undergoing hyperbaric therapy.
  - Assist in wound care therapies and dressing changes.
  - Observe in wound debridement and application of wraps or special dressings.
- Planning / Teaching – assist and provide ongoing teaching and discharge planning.
  - Nutritional status and wound healing
  - Safety measures
  - Signs and symptoms of complications to be reported to clinic
  - Wound care
- Communication / Documentation
  - Accurately and efficiently give and receive report to RN
  - Accurately and efficiently provide pertinent information to physician
  - Accurately chart in a timely manner

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor: ____

Student Assignment

1. Describe the role of the wound nurse / nurse in the wound clinic?
2. Describe three clients seen using the following:
   a. History of the wound development
   b. Give description and stage of wound
   c. Explain the treatment modality.
3. How does the assessment of the client being treated for skin disorders vary from the basic assessment done in a medical- surgical unit?
4. How did the staff members prioritize / plan the care of the clients they cared for in this department?
5. What infection control practices were noted in the care of clients in the wound clinic?
6. What communications techniques were used in the interactions with the clients / families?
7. How was pain management handled during the wound care?
8. Discuss several medications that were administered and what were the reasons they were given to the client?
9. List two nursing diagnosis that would relate to one or more clients seen in this unit and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12;1/3/13

ESCC Practical Nursing Program
Clinical Ancillary Evaluation: Pediatrics

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives: The student will be able to observe and assist with a patient admissions/ management:

- Data Collection
    - Obtain vital signs
    - Assess level of pain
    - Verbalize cultural impact on the pediatric patient and family
    - Verbalize understanding of nursing care for common disorders noted in the pediatric patient.
    - Recognize the different stages of growth and development in the pediatric patients seen on the unit.
    - Apply knowledge of growth and development in providing care for each individual child / adolescent.
    - Verbalize the role of the nurse in the interdisciplinary team of the Pediatric unit.
- Medication Administration
    - Verbalize an understanding of classification and action of common medications used in pediatric nursing.
    - Recognize the need for pain medication.
    - Verbalize understanding and assist patient / family with non-pharmacologic methods of pain management.
- Experience / Skills
    - Observe and assist with nursing care of the patient to include but not limited to:
        - Basic assessment of the infant / child
        - Performance of basic nursing skills safely and effectively
        - Collection of data on the patient's health status in a systematic and objective manner.
        - Provide basic health information to the child and family using age appropriate methods.
    - Utilize therapeutic communication skills, guidance and support in interacting with the child and family and record observations in the proper sequence and format.
- Planning / Teaching
    - Assist in teaching of the child and family prior to discharge from the unit.
    - Verbalize an understanding of the following related to child abuse / neglect:
        - Signs and symptoms which may be present
        - The law regarding mandatory reporting of suspicion of child abuse or neglect.
        - The procedure of reporting suspected cases.
        - Assist in teaching safety measures to family on measures to take to prevent injuries to the child.
- Communication / Documentation
    - Verbalize a list of services available to the family through the facility.
    - Verbalize correct terminology when reporting observations
    - Accurately and efficiently give and receive report to RN
    - Accurately and efficiently provide pertinent information to physician
    - Accurately chart in a timely manner
    - Identify common medical conditions seen on the unit.

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned preceptor is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member to do so			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor Signature: _______________________________________

Student Assignment

1. In the Pediatric unit what were the roles and responsibilities of the nurse?
2. What age groups were seen during the clinical experience on the pediatric unit and how was the care adapted to the growth and developmental level of each child?
3. What safety measures are in place in the unit to protect the children?
4. How did the staff members prioritize / plan the care of the children seen in this department?
5. List the services offered by the pediatric facility that are offered to the children and families.
6. How was HIPPA standards carried out in this department?
7. What infection control standards were used in this department?
8. How was communications techniques used in the interactions with the children / families cared for on the pediatric unit?
9. How were the parents/ care giver involved in the care of the child?
10. What treatments were seen and how were they beneficial for the child?
11. What medications were administered and what were the reasons they were given to the client?
12. List two nursing diagnosis that would relate to one or more clients seen in the department and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Clinical Ancillary Evaluation: School Clinics/Pediatrics

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives: The student will be able to observe and assist with a patient admissions/ management:

- Data Collection
  - Obtain vital signs, glucose testing, oxygen saturation
  - Assess level of pain
  - Verbalize cultural impact on the school age child and family
  - Verbalize understanding of nursing care for common disorders noted in the school health clinic.
  - Recognize the different stages of growth and development in the pediatric patients seen in the school clinic.
  - Apply knowledge of growth and development in providing care for each individual child / adolescent.
  - Verbalize the role of the nurse in the interdisciplinary team of the school health clinic.
- Medication Administration
  - Verbalize understanding of classification and action of common medications used in the school health clinics.
  - Administer medications appropriately with supervision.
  - Recognize the need for pain medication.
  - Verbalize understanding and assist patient with non-pharmacologic methods of pain management.
- Experience / Skills
  - Assist with basic first aid care for minor injuries seen in the school health clinic
  - Observe and assist with nursing care of the clinic patient to include but not limited to:
    - Basic assessment of the school age child
    - Performance of basic nursing skills safely and effectively
    - Collection of data on the patient’s health status in a systematic and objective manner.
    - Provide basic health information to the child and family using age appropriate methods.
    - Assist with Screenings of school age children
- Planning / Teaching
  - Verbalize and understanding of safety measures appropriate for each child’s growth and development.
  - Verbalize how the physical and emotional safety of the patient is protected in the school clinics.
  - Verbalize the contrast of treatments in the clinic compared to in hospital treatment of injuries and diseases.
  - Assist in instructions for the client being discharged from the school health clinic.
  - Verbalize how the family is incorporated into the plan of care of the child/ adolescent cared for in the school clinic.
- Communication / Documentation
  - Verbalize a list of services available to the family through the health clinic.
  - Verbalize correct terminology when reporting observations
  - Accurately and efficiently give and receive report to RN
  - Accurately chart in a timely manner
  - Identify common medical conditions seen in the clinic.

- Utilize therapeutic communication skills, guidance and support in interacting with the child and family and record observations in the proper sequence and format.

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned preceptor is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member to do so			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor Signature: ______________________________________

Student Assignment

1. In the school health clinic what were the roles and responsibilities of the nurse?
2. What age groups were seen in the clinic and how was the care adapted to the growth and developmental level of each child?
3. What safety measures are in place in the school clinic to protect the children?
4. How did the staff members prioritize / plan the care of the children seen in this department?
5. List the services offered by the school clinics that are offered to the children and families.
6. How was HIPPA standards carried out in this department?
7. What infection control standards were used in this department?
8. How was communications techniques used in the interactions with the children / families seen in the clinic?
9. What treatments were seen and how were they beneficial for the child?
10. What medications were administered and what were the reasons they were given to the client?
11. List two nursing diagnosis that would relate to one or more clients seen in the department and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Ancillary Evaluation Tool – PACU / Same Day Unit

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives:

1. **Same day Surgery**: The student will be able to observe and assist with a patient admissions/ management:
   - Data Collection
     - Obtain vital signs, oxygen saturation, glucose testing
     - Assess level of pain
     - Verbalize the cultural impact on the treatment plan for the client in the post-operative phase.
     - Verbalize understanding in the care of the uncomplicated and common complications of the patient in the pre-operative and post-operative phase
     - Verbalize the assessment and nursing care of the client prior to, and following the surgery or a procedure.
     - Verbalize the difference in the care of adult patients versus children.
   - Medication Administration
     - Verbalize understanding of classification and action of common medications used in the same day unit.
     - Verbalize the type, dose, and side effects of pre-operative medications given.
     - State the agents used for reversal of untoward side-effects related to medication / anesthesia administration.
     - Verbalize how the client's routine daily medications may affect recovery (i.e. Digoxin, Coumadin, etc.)
   - Experience / Skills
     - Assist with procedures performed prior to the surgical procedure (i.e. skin preps, IV starts, pre-op medicaions)
     - Assist in the assessment and nursing care of the client following the surgery or a procedure.
     - Verbalize and assist in the immediate care and continuing physical assessment of the client with knowledge of the importance of the A, B, C's (airway, breathing, and circulation). This includes:
       - Checking the patency and adequacy of the airway by listening, looking and feeling for respiratory effort.
       - Recognizing that if the client has no gag reflex, aspiration of secretions or vomitous is a real problem.
       - Being able to immediately use the suction equipment.
       - Initiating use of oxygen by facemask.
     - Observe the client with knowledge of condition of dressings, placement and patency of various drainage tubing's, with observation of changes in type and amount of drainage.
     - Recognizing signs of impairment of circulation by:
       - Immediate and comparative pulse and blood pressure observations.
       - Looking and feeling for such signs as skin color, especially color of Nailbeds and temperature of chest and extremities. (Cold extremities may be the first sign of shock).
   - Planning / Teaching
     - Verbalize how the physical and emotional safety of the patient is protected in the post-operative phase.
     - Assist in the teaching of pre- and post-operative teaching of the client.
     - Verbalize the complications that the client must be instructed on prior to discharge from the unit.
   - Communication / Documentation

- Verbalize correct terminology when reporting observations
- Verbalize and understanding in using the client's database and will be able to relate history, psychological problems, chronic disease, etc, average vital signs and how they may affect the client's recovery.
- Verbalize an understanding for the need of gentle handling during the recovery period.
-

2. **PACU**: The student will be able to observe and assist with a patient admissions/ management:
   - Data Collection
     - Obtain vital signs, oxygen saturation, glucose testing
     - Assess level of pain
     - Verbalize the cultural impact on the treatment plan for the client in the post-operative phase.
     - Verbalize understanding in the care of the uncomplicated and common complications of the patient in the post-operative phase
     - Verbalize the difference in the care of adult patients versus children
     - Verbalize the assessment and nursing care of the client following the surgery or a procedure.
   - Medication Administration
     - Verbalize understanding of classification and action of common medications used in the same day unit.
     - Verbalize the type, dose, and side effects of pre-operative medications given.
     - State the agents used for reversal of untoward side-effects related to medication / anesthesia administration.
     - Verbalize how the client's routine daily medications may affect recovery (i.e. Digoxin, Coumadin, etc.)
   - Experience / Skills
     - Assist in the assessment and nursing care of the client following the surgery or a procedure.
     - Verbalize and assist in the immediate care and continuing physical assessment of the client with knowledge of the importance of the A, B, C's (airway, breathing, and circulation). This includes:
       - Checking the patency and adequacy of the airway by listening, looking and feeling for respiratory effort.
       - Recognizing that if the client has no gag reflex, aspiration of secretions or vomitous is a real problem.
       - Being able to immediately use the suction equipment.
       - Initiating use of oxygen by facemask.
     - Recognizing signs of impairment of circulation by:
       - Immediate and comparative pulse and blood pressure observations.
       - Looking and feeling for such signs as skin color, especially color of Nailbeds and temperature of chest and extremities. (Cold extremities may be the first sign of shock).
     - Observe the client with knowledge of condition of dressings, placement and patency of various drainage tubing's, with observation of changes in type and amount of drainage.
   - Planning / Teaching
     - Verbalize how the physical and emotional safety of the patient is protected in the post-operative phase.
     - Assist in the teaching of post-operative teaching of the client.
     - Verbalize the complications that the client must be instructed on prior to discharge from the unit.
     - Verbalize and understanding in using the client's database and will be able to relate history, psychological problems, chronic disease, etc, average vital signs and how they may affect the client's recovery.
     - Verbalize an understanding for the need of gentle handling during the recovery period.
   - Communication / Documentation
     - Verbalize correct terminology when reporting observations.
     - Verbalize and understanding in using the client's database and will be able to relate history, psychological problems, chronic disease, etc, average vital signs and how they may affect the client's recovery.
     - Verbalize an understanding for the need of gentle handling during the recovery period.

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor: ______________________________________

Student Assignment

1. Describe the hand-off communication that takes place between the OR staff and the PACU / Same Day staff?
2. What safety / HIPPA practices were noted during the care of clients in the PACU / Same Day?
3. Describe the nursing responsibilities of the PACU / Same Day nurse when admitting a client to the PACU / Same Day?
4. How did the staff members prioritize / plan the care of the clients as they recovered in this department?
5. List the types of clients seen in this department – diagnosis, client complaints, etc.
6. What infection control practices were noted in the care of clients in the PACU/ Same Day?
7. What communications techniques were used in the interactions with the clients / families?
8. How was pain management handled in the PACU / Same Day?
9. Discuss several medications that were administered and what were the reasons they were given to the client?
10. What are the criteria the staff uses to determine when a client may be released from the PACU / Same Day?
11. List two nursing diagnosis that would relate to one or more clients seen in this unit and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Ancillary Evaluation Tool – Surgical Suite

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives: OR Observational Experience

The student will be able to observe and assist with a patient admissions/ management:

- Data Collection
    - Obtain vital signs, oxygen saturation, glucose testing
    - Verbalize the potential complications and nursing interventions for the complications in the various types of surgery, such as chest, orthopedic, abdominal, genitor-urinary, vascular, and pelvic.
    - Determine how the nursing process is applied to a client undergoing anesthesia and a surgical procedure.
    - Assess level of pain
    - Verbalize cultural impact of the client undergoing surgery
- Medication Administration
    - Verbalize understanding of classification and action of common medications used in the surgical arena
    - Verbalize the type, dose, and side effects of pre-operative medications given.
    - State the agents used for reversal of untoward side-effects related to medication / anesthesia administration.
    - Verbalize how the client's routine daily medications may affect recovery (i.e. Digoxin, Coumadin, etc.)
- Experience / Skills
    - Identify the primary differences in the roles of the circulating nurse and the scrub nurse.
    - Observe and assist in the pre-operative phase of the client.
    - Assist in the transportation of the client to the various areas of the surgical area.
- Planning / Teaching
    - Verbalize the special problems of various age groups of clients undergoing surgery, especially children and the aged and those with chronic disease.
    - Verbalize ways in which the physical and emotional safety of the client is protected in the surgical suite.
    - Assist in the pre-operative / post-operative teaching
- Communication / Documentation
    - Accurately chart in a timely manner
    - Accurately and efficiently give and receive report to the RN

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor: ______________________________________

Student Assignment

1. Describe the roles of the surgical team and how do they relate to the care of the client undergoing a surgical procedure?
2. How is the client confidentiality protected in the surgical suite?
3. How does the surgical team maintain safety during the client's stay?
4. Describe several "Time out" processes you noted in the surgical suite?
5. List two types of surgical procedures seen and describe the safety precautions carried out, what assessment took place with the client prior to surgery, communication that took place among the team members, and how did the hand-off take place during the various stages of the OR experience for the client.
6. How anesthesia administered and what were the responsibilities of the anesthesiologist / nurse anesthetist?
7. Describe the surgical asepsis techniques observed and other infection control practices?
8. Develop a nursing diagnosis for a surgical client prior to surgery and list 3 to 4 interventions for that diagnosis.
9. Describe how the team adjusted to the needs of various age groups cared for in the surgical suite?
10. What medications were administered and what were the reasons they were given to the client?
11. How does this department fall into the interdisciplinary team caring for the client?

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Clinical Ancillary Evaluation: Maternal / Newborn Experience

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives:

- **Labor / Delivery Phase** : The student will be able to observe and assist with a labor patient admissions/ management:
  - Labor / Delivery Data Collection
    - Obtain vital signs
    - Leopold's maneuvers
    - Determine EDC using Naegle's Rule
    - Determine gravidity / parity status using TPALM method
    - Identify basic FHR pattern
    - Palpate contractions – determining frequency, duration, intensity
    - Identify stages / phases of labor
    - Assess level of pain
    - Verbalize cultural impact on birth experience
    - Verbalize understanding of nursing care for both uncomplicated and common complications of pregnancy/ labor and birth.
  - Medication Administration
    - Verbalize understanding of classification and action of common medications used in labor / delivery.
    - Administer medications appropriately with supervision.
    - Recognize the need for pain medication.
    - Verbalize understanding and assist patient with non-pharmacologic methods of pain management.
  - Experience / Skills
    - Observe non-stress test
    - Observe epidural / spinal anesthesia / administration
    - Observe vaginal delivery
    - Observe cesarean delivery
    - Assist with assigning apgar scoring and immediate newborn care after delivery.
    - Assist mother with breastfeeding at delivery.
- **Postpartum Phase**: The student will be to observe and assist with a postpartum patient to include:
  - Postpartum Data Collection
    - Palpation of level / consistency of fundus
    - Type / amount of lochia
    - Status of lacerations / episiotomy
    - Bladder – normal urine output after vaginal delivery, management of indwelling foley catheter post cesarean.
    - Bonding process
    - Breast / nipple integrity
  - Planning / Teaching – assist and provide ongoing teaching and discharge planning.
    - Postpartum self-care
    - Post-surgical self-care
    - Breastfeeding

        - Infant care
    - Medication Administration
        - Verbalize understanding of classification and action of medications commonly used in postpartum period.
        - Administer medications appropriately with supervision
        - Recognize need for pain medication
    - Communication / Documentation
        - Accurately and efficiently give and receive report to RN
        - Accurately and efficiently provide pertinent information to physician
        - Accurately chart in a timely manner
- **Newborn Nursery** : Assist with newborn admission to nursery following delivery to include:
    - Newborn Data Collection
        - ID checked
        - Weight and measurements
        - Estimation of gestational age
        - Vital signs
        - Verbalizing understanding of both normal and sick newborn nursing care
    - Medication Administration
        - Verbalizing understanding of classification and action of newborn medications
        - Administration of admission medications under supervision
    - Experiences / Skills
        - Observe / assist with male circumcision
        - Perform heel-stick Accucheks under supervision
        - Observe/ assist with newborn hearing screen
        - Observe / assist with metabolic screening
        - Observe / document newborn intake and output, identify normal stool progression in neonate.

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned preceptor is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member to do so			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor Signature: ____

Student Assignment

1. Describe the role of the nurse in the labor and delivery unit / post-partum/ Nursery?
2. How did the nurse's roles differ from labor and delivery to the mother/ Baby unit?
3. (if applicable)
4. How did the staff members prioritize / plan the care of the clients they cared for in this department?
5. What infection control practices were noted in the care of clients?
6. What communications techniques were used in the interactions with the clients / families?
7. How was safety of the newborn managed in the mother / baby unit?
8. How was the family incorporated into the care of the clients on the mother / baby unit?
9. Describe a teaching opportunity you had with the family / patient during your clinical experience.
10. List three medications you observed / administered. Describe the following:
    d. Purpose of drug administered
    e. Method of administration
    f. Side effects to be monitored
    g. Nursing considerations
    h. Patient / family teaching
11. How was the documentation of care done in the area of experience?
12. What were the differences in the care of the vaginal delivery and the cesarean client?
13. How did the nurses encourage bonding of the mother and the infant?

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.
Revised: 12/29/12

ESCC Practical Nursing Program
Ancillary Evaluation Tool – Intensive Care

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives:
The student will be able to observe and assist with a patient admissions/ management:

- Data Collection
  - Obtain vital signs, oxygen saturation, glucose testing
  - Assess level of pain
  - Verbalize cultural impact on treatment plan of the client in critical care
  - Verbalize the need to do immediate and continuing physical assessment of the client with knowledge of the importance of the A, B, C's (airway, breathing, and circulation). :
  - Recognizing signs of impairment of circulation by:
    - Immediate and comparative pulse and blood pressure observations.
    - Looking and feeling for such signs as skin color, especially color of Nailbeds and temperature of chest and extremities. (Cold extremities may be the first sign of shock).
  - Evaluating results of laboratory tests and correlating results with patient management. .
  - Verbalize the legal and ethical issues in critical care nursing.
- Medication Administration
  - Verbalize understanding of classification and action of common medications used in critical care.
  - Recognize the need for pain medication
  - Verbalize understanding and assist patient with non-pharmacologic method of pain management.
- Experience / Skills
  - Observe resuscitation procedures and use of mechanical ventilation equipment, noting various settings.
  - Recognize respiratory complications and assist in checking the patency and adequacy of the airway by listening, looking and feeling for respiratory effort.
  - Assist with the use the suction equipment
  - Assist with the initiation and maintenance of oxygen therapy
  - Assist in the use basic equipment in the ICU during the care of clients.
  - Recognize basic ECG rhythms.
- Planning / Teaching
  - Understanding how the client's database, related history, psychological problems, chronic disease, etc., average vital signs will affect the client's recovery.
  - Observe the client with knowledge of condition of dressings, placement and patency of various drainage tubing's, with observation of changes in type and amount of drainage.
  - Verbalize the need for emotional support for client and family.
- Communication / Documentation
  - Verbalize correct terminology in reporting observations
  - Verbalize to the preceptor critical changes in the assigned client.
  - Accurately and efficiently give and receive report to / from the RN

.**The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.**

Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor: ______________________________________

Student Assignment

1. Describe the role of the nurse in the Intensive Care Unit in the care of the patient?
2. Describe the various types and uses of equipment used in the ICU?
3. How did the staff members prioritize / plan the care of the clients they cared for in this department?
4. What infection control practices were noted in the care of clients in ICU?
5. What communications techniques were used in the interactions with the clients / families?
6. How was safety of the client managed in the critical care unit?
7. Discuss several medications that were administered and what were the reasons they were given to the client?
8. How was the family incorporated into the care of the clients in the ICU?
9. How was the client's pain managed in the critical care unit?
10. What members made up the team of staff that cared for the client in critical care and what were their responsibilities in the care?
11. Why might the health care providers in critical care setting be high risk for burnout syndrome related to stressors?

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Ancillary Evaluation Tool – Emergency Room

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

Objectives: The student will be able to observe and assist with a emergency room patient admissions/ management:

- Data Collection
  - Obtain vital signs, oxygen saturation, glucose testing
  - Assess level of pain
  - Verbalize cultural impact on the plan of care of the client in the emergency unit.
  - Verbalize the responsibilities of an Emergency Room and its role in the delivery of healthcare.
  - Verbalize the need for rapid assessment of patients in the emergency department.
  - Verbalize an understanding of the various areas in the emergency department (i.e. triage, fast track, etc.)
- Medication Administration
  - Verbalize understanding of classification and action of common medications used in Emergency department.
  - Recognize the need for pain medication.
  - Verbalize understanding and assist patient with non-pharmacologic methods of pain management.
- Experience / Skills
  - Assist in the assessment and nursing care of the client following the surgery or a procedure.
  - Observe the client with knowledge of condition of dressings, placement and patency of various drainage tubing's, with observation of changes in type and amount of drainage.
  - Verbalize and assist in the immediate care and continuing physical assessment of the client with knowledge of the importance of the A, B, C's (airway, breathing, and circulation). This includes:
    - Checking the patency and adequacy of the airway by listening, looking and feeling for respiratory effort.
    - Recognizing that if the client has no gag reflex, aspiration of secretions or vomitous is a real problem.
    - Being able to immediately use the suction equipment.
    - Initiating use of oxygen by facemask.
  - Observe code / resuscitation procedures.
  - Verbalize an understanding of various pieces of equipment used in the ER and describes the uses of the equipment.
- Planning / Teaching
  - Verbalize how the physical and emotional safety of the patient is protected in the emergency room.
  - Verbalize the contrast of emergency treatments compared to in hospital treatment of injuries and diseases.
  - Assist in discharge instructions for the client being discharged from the emergency department.
- Communication / Documentation
  - Verbalize an understanding of the relationship of the ER to the accepting units and observe hand-off communication.
  - Accurately and efficiently give and receive report to RN
  - Accurately and efficiently provide pertinent information to physician
  - Accurately chart in a timely manner
  - Verbalize the proper medical terminology in reporting information to ER staff and be able to state the importance of accurate communication in the ER.

- Verbalize the need for adherence to the principles of standard precautions.

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor: ______________________________________

Student Assignment

1. What are three main responsibilities for the emergency room department?
2. Does this emergency room have a Base Station (area used to communicate with ambulances)? What type of communication took place?
3. Give, in your own words, an account of the transfer of care between an ambulance crew and ER staff. Include this in the account:
    a. The client's initial complaint
    b. The condition in which the client was found by the ambulance crew.
    c. The type of assessment done by the ambulance crew upon arrival at the scene of the client.
    d. How the condition and history was transmitted to the ER staff by the ambulance crew.
    e. What kind of information was included in the ambulance crew report to the ER staff.
4. How did the staff members prioritize / plan the care of the clients seen in this department?
5. List the types of clients seen in this department – diagnosis, client complaints, etc.
6. How was safety and HIPPA standards carried out in this department?
7. In terms of "Standard Precautions" what were the steps that the ER staff routinely take to protect themselves from communicable disease? Why is this particularly important in an ER setting?
8. List four pieces of equipment used in the ER, give the function of each.
9. What medications were administered and what were the reasons they were given to the client?
10. List the various levels of care givers in the ER and their responsibilities.
11. List two nursing diagnosis that would relate to one or more clients seen in the department and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

ESCC Practical Nursing Program
Ancillary Evaluation Tool – Behavioral Health

Student Name: ________________________ Date(s) of Experience: ______________

Clinical Experience: ______________________ Preceptor: ______________________

Time in: ____________________ Time out: ________________

Expectations:

- Student is to complete the assigned tasks and return the form to the instructor on the next clinical day or when ancillary experience has been completed.
- The student is to have the designated staff member they are assigned with complete their portion of this form.
- The student is to list all skills completed while in the ancillary department and the staff member is to initial for verification.
- The student is to report on time and follow instructions of the assigned staff member.
- For any problems the student and / or staff member is to contact the clinical instructor or may call ESCC at 757-789-1772 and leave a message.

- Objectives: The student will be able to observe and assist with a patient admissions/ management:
  - Data Collection
    - Obtain vital signs
    - Assess level of pain
    - Verbalize cultural impact on client in behavioral health
    - Differentiate between therapeutic and non-therapeutic coping mechanisms.
    - Verbalize the roles of the various member of the interdisciplinary team caring for clients in the behavioral health setting.
    - Verbalize and understanding for the differences between mental health and mental illness.
    - Verbalize the phases of the nurse-client relationship.
  - Medication Administration
    - Verbalize understanding of classification and action of common medications used in behavioral health.
    - Recognize the need for pain medication.
    - Verbalize understanding and assist patient with non-pharmacologic methods of pain management.
    - Recognize the safety measures used for the client in behavioral health when administering medications.
  - Experience / Skills
    - Demonstrate appropriate communication techniques when caring the client in a behavioral health clinic.
    - Assist in screenings for the behavioral health client.
    - Assist in group sessions in the behavioral unit
    - Identify and perform safety practices n the care of clients in behavioral health.
    - Observe behavioral control procedures for the client that is acting out.
  - Planning / Teaching
    - Verbalize how the physical and emotional safety of the patient/ staff is maintained in the behavioral Health unit
    - Assist in the teaching of client about coping skills, communication, etc.
    - Assist in instructions for the client being discharged from the behavioral health unit.
    - Verbalize how the family is incorporated into the plan of care of the client cared for in the behavioral health unit.
    - Verbalize the legal and ethical issues in behavioral health nursing
  - Communication / Documentation
    - Verbalize a list of services available to the family through the behavioral health unit.
    - Verbalize correct terminology when reporting observations
    - Accurately and efficiently give and receive report to RN
    - Accurately and efficiently provide pertinent information to physician
    - Accurately chart in a timely manner
    - Identify common medical conditions seen on this unit.

- Utilize therapeutic communication skills, guidance and support in interacting with the patient and record observations in the proper sequence and format.
- Differentiate between non-verbal and verbal communication

The Student will have a skills checklist that is to be reviewed with the preceptor at the end of the clinical experience and skills signed off that were performed.

Student Evaluation Form

Assigned staff member is to complete the following evaluation of the student.

	SATISFACTORY	UNSATISFACTORY	NOT APPLICABLE
Professionalism			
Followed dress code for area			
No chewing gum			
No use of cell phone			
Punctual on arrival time and after breaks			
Did not leave unit unless directed by staff member			
Integrity / Accountability			
Follows instructions by staff			
Seeks assistance when needed			
Identifies and reports any errors			
Uses time wisely			
Looks for learning experiences			
Communication Skills			
Client / family			
Ancillary staff			
Other students			
Maintains HIPPA standards			

Please place any additional comments or observations below:

Preceptor: ______________________________________

Student Assignment

1. Describe the role of the nurse in the Behavioral Health Unit in the care of the patient?
2. What safety practices were used to protect the clients and the staff?
3. How did the staff members prioritize / plan the care of the clients they cared for in this department?
4. What infection control practices were noted in the care of clients in the behavioral health unit?
5. What communications techniques were used in the interactions with the clients / families?
6. What activities and group therapies took place during this clinical rotation, how did these activities benefit the client?
7. Discuss several medications that were administered and what were the reasons they were given to the client?
8. How was the family incorporated into the care of the clients in the behavioral health unit?
9. What members made up the team of staff that cared for the client in critical care and what were their responsibilities in the care?
10. List two nursing diagnosis that would relate to one or more clients seen in this unit and three interventions that were done for that client related to the nursing diagnosis.

Student Evaluation of Preceptor

1. How did your preceptor assist you in learning?
2. How could your preceptor have been more helpful?
3. What behaviors did the preceptor model that was helpful to you?
4. What was the most difficult situation you and your preceptor experienced and what did you learn from it?
5. Would you recommend this preceptor for future students? Why or why not?
6. Additional comments:

Student may attach additional notes or write on the back of this from.

Revised: 12/29/12

	Nurse to Nurse COMMUNICATION	
S	**Situation:** • Identify chief compliant and reason for admission, name, age, room#, doc • Admission date	
B	**Background:** • Summarize significant past health history • Describe treatments; diet, fluid therapy-iv, activity • Identify laboratory & diagnostic tests due next 24 • Results laboratory and diagnostic of today	
A	**Assessment:** • Describe assessment including changes in vital signs, head to toe assessment, significant changes during your shift • Orders which have changed this shift.	
R	**Recommendation/Response:** • Describe nursing interventions implemented (what did you do) • Describe patient and family response to nursing interventions • Summarize discharge plans or just plans for patient future care as appropriate	

PNE 161 Skills Practicums

During Nursing in Health Changes I there are two planned nursing skills practicums. These were developed to test the students in basic nursing skills and demonstrate that the students are competent in key skills prior to entering the health care environment.

If the student fails to demonstrate the skill safely and competently, the instructors will develop a remediation plan for the student to complete. With each failure of adequate skill demonstration the student will acquire a "failure". If the student fails to safely and competently demonstrate the required skills at the third attempt, the student will be expelled from the program. (See section related to "failure" days).

When the student completes the requirement skills in safe and competent manner then the student may proceed to the next level and enter the clinical setting.

Steps to Skills Practicums

1. Always remember the following steps for each skill:
   a. Check the client's record for an order.
   b. Review the record for any information or precautions for the client.
   c. Gather needed supplies to complete the skill.
   d. Knock on the door. Introduce self, identify the client, and explain the procedure to the client.
   e. Wash hands and set up for the skill.
   f. Position client and bed for procedure.
   g. Perform the skill and explain to the client as you progress through the skill.
   h. After the skill is completed, clean up the client, reposition for comfort and safety, lower the bed, and see that the client has all needed items.
   i. Dispose of trash, wash hands and leave the room and document the event.
2. If you forget one of the required steps, alert the instructor prior to completion of the skill and do the step missed.
3. You are to role play the skill as if this is a real nurse - client scenario.
4. It is okay to slow down the process and take a moment to collect your thoughts.
5. Always remember safety and infection control practices during the skill demonstration.
6. Once skill is completed you will tell the instructor that you are done.

Helpful Hint: *The open lab times are for the student to practice the key skills. It is recommended that students use this time wisely and remember the more the skill is practiced the easier it is to perform under pressure.*

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ESCC PN Program
Clinical Warning Form

Instructor: ____ **Semester:**______________________

Student:____ **Date:** _________________________

This is a written warning for a clinical failure day. The reason for this warning is marked below:

________ No call, no show to a clinical experience
________ Third tardy event to a clinical event.
________ Unsafe clinical practice: see attached for documentation
________ Insubordinate behavior to the instructor/staff: see attached for documentation
________ Leaving the clinical site without permission
________ Breach of confidentiality (May result in program dismissal

A meeting will be set up with you and the appropriate PN staff to discuss a remedial plan for these behaviors. If three failure days are acquired by the student this will result in dismissal from the program.

PN Form developed 10/22/09 Reviewed: 7/31/13 Revised:

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Eastern Shore Community College
PN Mid-Semester Clinical Evaluation Form

Student:____ **Date:** ______________________

Instructor: ____ **Semester:**____________________

	Excellent No Infraction	**Satisfactory** 1 infraction	**Improvement** 2 Infractions	**Unsatisfactory** Failure day acquired	**Improvement Plan Developed**
Professional					
• Follows dress code • No absences/tardy • Maintains confidentiality • Shows respect to instructor/staff/classmates					
Preparation					
• Completes client research form • Completes medication research					
Patient Care					
• No safety breaches with client • No medication errors • Completes care during clinical experience					
Documentation					
• Documentation complete • Care Plan completed					
Teamwork					
• Communicates with instructor/staff about client data • Assists fellow students					
Critical Thinking					
• Alerts instructor/staff of unexpected findings • Organizes care as student assignments grow					

Developed: 9/24/09
Student signature:____

Reviewed 7/31/13

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Appendix A
Handbook and Clinical Guidelines

I have reviewed the clinical guidelines set forth in this handbook and understand the implications in the clinical setting. I have agreed to abide by the guidelines given to me for appropriate behavior in the clinical settings and understand the consequences if I should not follow these guidelines.

Student Signature ____

Date ____________________

Reviewed 7/31/13

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Appendix B
ESCC Practical Nursing Program

I, ______________________________________, certify that I have received a copy of the Student Handbook of the ESCC Practical Nursing Program. I have read the Handbook, have asked any and all questions that I might have concerning the contents and agree to abide by all terms and conditions of the Honor Code, Confidentiality Agreement and the Handbook.

Signature:____

Date:____

Reviewed 7/31/13

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Appendix C
Medical Release Physician Statement of Student Ability to Participate

This is to certify that ________________________________ is able to continue in the ESCC Practical Nursing Program in the clinical area. This is without restriction in the performance of student nurse assignments that may include the physical ability to:

- Lift, move, roll and position dependent patients
- Stand and/or walk while providing patient care for a period of up to 8 hours per clinical day
- Perform strenuous activities in moving equipment (i.e. stretchers, wheelchairs and crash carts)
- Perform emergency care that may include CPR and Heimlich Maneuver

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____
Physician's Signature

____
Physician's Printed Name

____
Date

Reviewed 7/31/13

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Appendix D
Confidentiality Pledge for all Students and Employees of ESCC

I understand that I require information to perform my duties as a student during my clinical experiences. This information may include, but is not limited to, information on patients, employees, students, other workforce members, donors, research, and financial and business operations. Some of this information is made confidential by law (such as "protected health information" or "PHI" under the federal Health Insurance Portability and Accountability Act) or by the institutions policies. Confidential information may be in any form, e.g., written, electronic, oral, overheard or observed. Access to all confidential information is granted on a need-to-know basis. A need-to-know is defined as information access that is required in order to perform my work or volunteer duties or to complete my approved academic requirements. If my duties change or my course of study changes, my need-to-know also may change.

I pledge to review the institution's policies on confidentiality and privacy. I will access, use and disclose confidential information in keeping with these policies and only on a need-to-know basis. Before I make any other use of disclosure of confidential information, I will contact my instructor / supervisor (if applicable) in order to obtain proper permission. If I have no instructor / supervisor or I am the instructor / supervisor, I will assure the use of disclosure is within the law and the institutions policies.

I will not disclose confidential information to patients, friends, relatives, co-workers or anyone else except as permitted by the institution's policies and applicable law and as required to perform my work or volunteer duties or to complete my academic requirements.

I will protect the confidentiality of all confidential information, including PHI, while at the healthcare organization and after I leave the assigned institution. All confidential information remains the property of the assigned institution and may not be removed or kept by me when I leave my clinical experience except as permitted by the institutions policies or specific agreements or arrangements applicable to my situation.

It is important that the entire ESCC student, staff and institution community share a culture of respect for confidential information. To that end, if I observe access to or sharing of confidential information that is or appears to be unauthorized or inappropriate, I will try to make sure that this use or disclosure does not continue. This might include advising the person involved that they may want to check the appropriateness of the use or disclosure with the institution's Privacy Officer or the Health System or Legal Counsel. It may also involve letting my instructor / supervisor (if applicable) or others in authority at the Health System the issue possible issue. Use of the compliance Hotline (if applicable) allows this to be done anonymously, if need be. The assigned institution may have additional policies regarding procedures for reporting possible inappropriate use of disclosure, and I understand that I must follow these policies, if applicable. I understand that signing this pledge and complying with its terms is a requirement for me to work, volunteer or study at the assigned institution.

If I violate this pledge, I will be subject to disciplinary action up to and including termination, severance of volunteer relationship or expulsion from my academic program. In addition, under applicable law, I may be subject to criminal or civil penalties.

I have read the above pledge and agree to be bound by it.

Name:________________________________ Phone: _______________________

Signature:____________________________ Date: ________________________

Empl. ID No. _____________________________________

Dept/School: _____________________________________

Reviewed 7/31/13

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Appendix E
Substance Abuse and Mental Acuity

To protect the interests of our students and patients, we are committed to an alcohol and drug-free work environment. All students must report for class and clinical free of influence of alcohol and illegal drugs. Reporting to class or clinical under the influence of any illegal drug or alcohol; having an illegal drug in a student's system; or using, possessing, or selling illegal drugs while on Shore Health Services property will result in immediate dismissal from clinical practice. Shore Health Services may drug test as a means of enforcing this policy. Students will also be subject to sanctions and penalties in accordance with the ESCC Student Code of Conduct as detailed in the College Catalog and Student Handbook.

It is also recognized individuals may be taking prescription or over the counter drugs, which could impair judgment or other skills required in student performance. Students with questions about the effect of such medication on their performance or who observe an individual who appears to be impaired in the performance of his or her job must immediately consult with an instructor of the nursing program.

As a student of ESCC Practical Nursing Program, I agree to abide by the College and Shore Health Services policy on substance abuse and mental acuity.

________________________________ ________________________________
Student Date

________________________________ ________________________________
Faculty Date

Reviewed 7/31/13

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Appendix F
Honor Pledge

The student will not plagiarize, use other students' materials, assignments and not give information on a test. The student who participates (giver & receiver) in the above activities may be dismissed from the program.

> I will not plagiarize, use other students' material, assignments, or neither give or receive information on tests. Violation of this honor pledge risks dismissal from the program.

Student: ___________________________________

Date:______________________________________

Reviewed 7/31/13

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Appendix G
Facilities Compliance Agreement

1. I agree to comply with the policies, procedures and requirements of all clinical facilities without limitations including safety procedures, confidentiality standards, and continuing education requirements.
2. I agree to maintain a current acceptable physical examination report and immunization record including statement of immunization status to varicella, and immunization against diphtheria, tetanus, polio, measles, mumps, rubella (or positive rubella titer).
3. I agree to maintain other immunizations as may be required by all clinical facilities.
4. I agree to allow ESCC PN program director to release to all clinical facilities all immunization records and other health related information from my student record upon request of all clinical facilities.
5. I agree to not use or disclose any Protected Health information other than as permitted or required in my role as a student at all clinical facilities.
6. I agree to use appropriate safeguards to prevent use of disclosure of the Protected Health Information except use of disclosure in my role as a student at all clinical facilities.
7. I agree to report to all clinical facilities any inappropriate use or disclosure of the Protected Health Information.

Student signature: ___________________________________

Date:____

Developed 8/11/10
Reviewed 7/31/13