RALPH R WILLIS CAREER AND TECHNICAL CENTER
PRACTICAL NURSING PROGRAM

Clinical Manual

2019-2020

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CLINICAL FACILITIES

The student must wear approved clinical attire at all facilities. Failure to dress appropriately can result in an unsatisfactory clinical. Attendance is mandatory for all clinical experiences.
****Confidentiality sheets will be signed at each facility if not signed prior to assignment****

LOGAN REGIONAL MEDICAL CENTER

Location: 20 Hospital Dr., Logan, WV 25601
Contact Information: (304)-831-1101

Parking: You must proceed past all buildings to the end portion of **employee parking**. **Students must park here only. If the student is reported for parking in areas that are not allowed they will receive a "U" for the clinical day.** Be sure to locate a "Bus Stop" sign so the bus will pick you up. Please allow time to catch the bus and ride back down the hill to the hospital and STILL be ON TIME for the clinical experience. Students are encouraged to car pool, as parking is limited for students and employees.

If the student is going to be absent, notification by the student via remind must be done or a "u" will be recorded.

Genesis – Long Term Care

Location: Logan Center
Route 10 & 3 Mile Curve
Logan, WV 25601
Contact Information: (304) 752-2273

Parking: By the gazebo. **If the student is reported for parking in areas that are not allowed they will receive a "U" for the clinical day.**

TRINITY HEALTH CARE- Long Term Care

Location: 1000 W. Park Avenue
Logan, WV 25601
Contact Information: (304) 752-8723

Parking: Bottom of the hill. **If the student is reported for parking in areas that are not allowed they will receive a "U" for the clinical day.**

Clinical Objectives:

At the end of the clinical assignments, the student will be able to:

1. Demonstrate fundamental nursing skills in a safe manner.
2. Apply therapeutic communication skills in the clinical area.
3. Utilize organizational skills and time management concepts in setting priorities for clinical performance.
4. Demonstrate beginning critical thinking decision making skills based on standards of practice, theory, and research.
5. Apply theoretical content to the nursing care of the client in a clinical setting.
6. Implement care plans that reflect an understanding of the legal and ethical responsibilities of the nurse based upon nursing assessment.
7. Perform nursing interventions that reflect caring behaviors in response to bio-psychosocial, cultural, and spiritual care needs.
8. Utilize the nursing process in the care of all clients.
9. Demonstrate responsibility for own behavior and growth as an adult learner and a professional.
10. Provide safe care with delivery of appropriate dependent, independent and collaborative nursing interventions within the health team framework.

Skills Lab Clinical By the completion of the clinical week, the student will become familiar with/ able to perform:	Paperwork
Lab #1 Orient to lab and clinical sites	NA
Lab #2 Nursing Process & Communication	Introduction to Nursing process
Lab #3 Hand hygiene PPE/Standard Precautions Isolation precautions Sterility (Sterile field, don sterile gloves)	Writing Nursing Diagnoses
Lab #4 (Independently perform) Basic skills: Complete bed bath, peri-care (Male & Female), assist w/ bedpan/urinal, back rub, oral care, occupied bed, feeding a patient	Writing Goals
Lab #5 Vital signs and maintaining Temperature Warming Measures and Cooling Measures	Writing Interventions with Rationale
Lab #6 Oxygen and oxygen delivery Pulse oximetry and Incentive spirometry Describe CPT and postural drainage followed by appropriate patient education	Writing Evaluations
Lab #7 Mobility/transfer techniques ROM and Positioning Assistive devices and Immobilization devices followed by appropriate patient education	Completing one Diagnosis with a Care plan
Lab #8 Catheterization Ostomy Care and Care of Urinary Diversion Enemas and Agents to manage stool retention	Completing two Diagnoses with Care plans
Lab #9 Feeding A Patient Tube Feeding and NG tubes Identification of TPN	Completing three Diagnoses with Care plans
Lab #10 Basic Wound care and Surgical/sterile technique	Complete Care Plan
Lab #12 Medication Administration (PO, IM, SQ, SL, IH, Nasal, Rectal, Vaginal) I&O IV site assessment, type of fluid and rate, D/C IV, Gown over IV	Charting Nurses Notes & Flow sheets
Lab #13 All previously learned skills competencies and Patient Education Skills	Orientation to Facility & EHR

LRMC Rehab **The student enters local Healthcare Facilities and performs direct patient care under the supervision of an instructor**	**Paperwork**
LRMC Clinical #1 By the completion of the clinical day, the student will: 1. Identify and locate all vital sign equipment on unit. 2. Identify personal protective equipment (PPE) and locate on unit. 3. Perform hand hygiene using proper technique 4. Identify and locate pulse oximeter on unit. 5. Know how to access computers and electronic health records (EHR). 6. Identify and locate electronic medication administration record (EMAR) in EHR. 7. Identify and locate laboratory and diagnostic results in EHR. 8. Identify and locate nursing notes, assessments, and other pertinent information in EHR. 9. Understand HIPAA guidelines and how they apply to utilizing EHR. 10. Perform head-to-toe assessment	Communication, safety, initial assessment interview Complete assessment and assigned forms
LRMC Clinical #2 By the completion of the clinical day, the student will: 1. Safely utilize controls, locking mechanisms of bed, call lights, and furniture in care area. 2. Locate nurse's station, medication room, kitchen, clean linen room, clean utility room, soiled utility room, and showers on unit. 3. Locate crash cart and know how to call a rapid response or code blue. 4. Identify and differentiate color coded wrist bands and locate on unit. 5. Identify DNR, Living Will, and MPOA papers and locate them in chart. 6. Demonstrate ability to find necessary information in chart and EHR. 7. Utilize appropriate level of precautions (ex. Standard, contact isolation) during patient care. 8. Identify and locate supplies needed to perform a complete bed bath, make an occupied bed, perform perineal care, assist with bedpan and urinal, and perform oral care. 9. Identify and locate TEDs and SCDs on unit. 10. Perform head-to-toe assessment	Communication, safety, initial assessment interview Completing an assessment and Care Plan

Long Term Care (Logan Center/Trinity) **The student enters local Healthcare Facilities and performs direct patient care under the supervision of an instructor**	**Paperwork**
Logan Center/Trinity Clinical #1 By the completion of the clinical day, the student will: 1. Identify and locate automatic and manual blood pressure cuffs on unit. 2. Identify and locate oral, axillary, and rectal thermometers on unit. 3. Identify stethoscope earpiece, tubing, and head (bell and diaphragm). 4. Identify personal protective equipment (PPE) and locate on unit. 5. Perform hand hygiene using proper technique 6. Identify and locate pulse oximeter on unit. Know how to access patient record. 7. Identify and locate items within the patient record. 8. Identify and locate nursing notes, assessments, and other information in patient record. 9. Understand HIPAA guidelines and how they apply to utilizing records. 10. Perform head-to-toe assessment	Communication, safety, initial assessment interview Complete assessment and assigned forms
Logan Center/Trinity Clinical #2 By the completion of the clinical day, the student will: 1. Safely utilize controls, locking mechanisms of bed, call lights, and furniture in care area. 2. Locate nurse's station, medication room, kitchen, clean linen room, clean utility room, soiled utility room, and showers on unit. 3. Locate crash cart and know how to call a rapid response or code blue. 4. Identify and differentiate color coded wrist bands and locate on unit. 5. Identify DNR, Living Will, and MPOA papers and locate them in patient record. 6. Demonstrate ability to find necessary information in patient record. 7. Utilize appropriate level of precautions (ex. Standard, contact isolation) during patient care. 8. Identify and locate supplies needed to perform a complete bed bath, make an occupied bed, perform perineal care, assist with bedpan and urinal, and perform oral care. 9. Identify and locate TEDs and SCDs on unit. 10. Perform head-to-toe assessment	Communication, safety, initial assessment interview Completing an assessment and Care Plan

F O R M S

RALPH R WILLIS CAREER AND TECHNICAL CENTER

PRACTICAL NURSING PROGRAM

Report Sheet

Date _____ Student _____

Situation

Room Number | Patient Initials | Age | DOB | Admission Date

Admitting Physician | Admission Diagnosis

Consults | Code Status

Background **(Chief Complaint)**

Past Medical Hx (Surgery, Trauma, Chronic Illness, etc.)

Allergies | Diet/Tube Feeding

Activity Level | Hygiene Care

Pending Status (Hourly I&O, VS, Blood Sugars, Discharge, Transfer, etc.)

IV Devices | IVF | Pump | Rate

Dressings | Wound Care

Tubes: Foley | NGT | Salem Sump | PEG | Rectal Tube | Drains

Feeding Pump/Rate | Tolerates feeding

Location of drains/surrounding skin

Treatments

Assessment

Current VS: TPR | BP | O2 Sat | RA | O2

Ht./Wt. | Telemetry | Rate/Rhythm

Intake | Output | Scheduled Procedures

Previous Procedures/Dates

Pain | Location | Pain Scale | Last Medicated

Current Meds (See back)

Current Labs (See Lab Sheet)

Assessment outside patient's normal parameter

Recommendations

Clinical Impression **(Priority Nursing Dx.)**

Severity of patient status, any additional concerns

Nursing concerns for the day of care

RALPH R WILLIS CAREER AND TECHNICAL CENTER

PRACTICAL NURSING PROGRAM

Nursing Assessment Data

Pt.Initials:_____ Gender_____ Age_____
Physician(s) _____

Date of Admission_____Admitting Dx: _____

Information Source: _____

Reasons for seeking healthcare (in client's words): _____

_____

Vital Signs

Temperature:_____Pulse:_____Respiration:_____Blood Pressure _____
Height:_____Weight:_____

Past Medical History

Diabetic:	Hepatitis:	Stroke:	Pacemaker:
Hypertension:	Vision Disorder:	Kidney Disease:	Transfusion:
Tuberculosis:	Seizure Disorder:	Thyroid:	Mental Illness:
Lung Disease:	Arthritis:	Ostomy:	Cancer:
Other:	Blood Disorder:	Sexually Transmitted Disease:	

PREVIOUS SURGERIES/DATE

Tonsil:	Lung:	Back:	Heart:
Gallbladder	Appendix	Prostate:	Kidney
D&C	Stomach	Hernia	Eye
Hysterectomy	Breast	Bowel	Thyroid
Other:			

Allergies

Allergies/Reactions: _____

Present Medications/Dose

HOME:	**HOSPITAL:**

***Communication* (Physiologic)**

Can Speak:	Understand English:
Can Read:	Can Write:
Learns Best by:	Understands Gestures:
Include Narrative:	

Safety/Risk Factors *Protection)

>65 yrs <12 yrs:

Disoriented/confused:	Weakness:	Meds/Anesthesia:
Impaired Mobility:	Restraints:	Diuretics:
Sensory Impaired:	High Risks for Fall:	

Include Narrative_____

***Social History* (Role Function)**

Alcohol Use:	Drug Use:	Tobacco Use:
Gender:	Marital Status:	Nationality, culture, ethnicity:
Occupation:	Hygiene:	Anticipates Discharge:
Religious Practice:	Special Religious/Ethnic/Cultural Needs	Potential Problems at Home:
Who lives with client:	Significant others:	

Include
Narrative_____

***Coping Stress*(Interdependence)**

Stressful Situations:	Coping Stress Comm:	Support System

Include
Narrative:_____

Cardiac (Physiologic)

Chest Pain**:**	Varicosities:	Dizziness
Syncope:	Edema:	Calf Pain/Cramps:
Rhythm:	Phlebitis:	Palpitations:
Pulses:		

Include
Narrative:

***Respiratory*(Physiologic)**

Cough: Sputum:	Dyspnea:	Breath Sounds:
Respirations:	Resp. Effort	Orthopnea:
O2 in use:		

Include
Narrative:

***Musculoskeletal* (Physiologic)**

Pain:	Cramping:	Gait:	Stiffness:
Paralysis	Contractures:	Tremors:	Ambulation:

Include
Narrative:

***Neurological*(Physiologic)**

Oriented:	Semiconscious:	Responsive to Stimuli:
Time:	Comatose:	Tactile:
Place:	Disoriented/Confused:	Ambulation:
Person:	CN I-XII(list & name with Assess)	

Include Narrative:

***Gastrointestinal* (Physiologic)**

Nausea/Vomiting:	Constipation:	Hemorrhoids:	Abdomen:
Diarrhea:	Blood in Stool:	Bowel Sounds:	Last BM:

Include
Narrative:

***Urinary* (Physiologic)**

Hemturia:	Incontinence:	Ostomy type:	Burning:
Hesitancy	Voided Last 8 Hrs.	Frequent	Catheter:

Include
Narrative:

***Integumentary* (Self-Concept)**

Mucous Membrane:	Petechiae:	Sclera:	Ecchymosis:
Psoriasis:	Eczema:	Edema:	Rash:
Amputation:	Burns:	Bruises:	

Include Narrative

***Reproduction* (Physiologic)**

MALE		FEMALE	
STD's	Sexually Active:	STD's	LMP:
Contraceptive:	Pain:	Vaginal Bleeding:	Last mammogram:
Scrotal Swelling:	Prostate Problems:	Pain:	Last Pap Smear:
Penile Discharge:		Vaginal Itching:	Gravida/Para:
		Sexually Active:	Menopause:

Include Narrative:

***EENT* (Physiologic)**

Loss of Sight:	Cataracts:	Glaucoma:	Loss of Hearing
Dental Caries:	Edentulous:	Hearing Aid:	Frequent Sore Throats:

Include Narrative:

Rest/Sleep (Physiologic)

Sleep Disturbances:	Sleeping Aids:
Typical Day:	

Include
Narrative:

***Social/Community Assessment* (Role Function)**

Living Will:	Medical Power of Attorney:
Would like to speak with Social Service:	Income<Basic/Health Needs:
No Medical Insurance:	School Age >7 days LOS:
Emotional Difficulties:	Inappropriate Development Age/Growth:
Self Care Needs:	Nursing Home Placement Needed:
Community Resource:	Home Health Agency
Return to Nursing Home:	Suspect Abuse/Neglect
Age>72, Lives Alone:	Organ Donor

Include Narrative:

***Nutritional Assessment* (Physiologic)**

Patient Has:

Loss of Appetite for > 1Week:	Swallowing Impairment:
Nausea/Vomiting/Diarrhea > 48 Hours	Chewing Impairment:
Clear Liq or NPO > 3 Days:	Recent Weight Changes:
24 Hour Diet Recall	

Include
Narrative:

***Functional Assessment* (Role Function)**

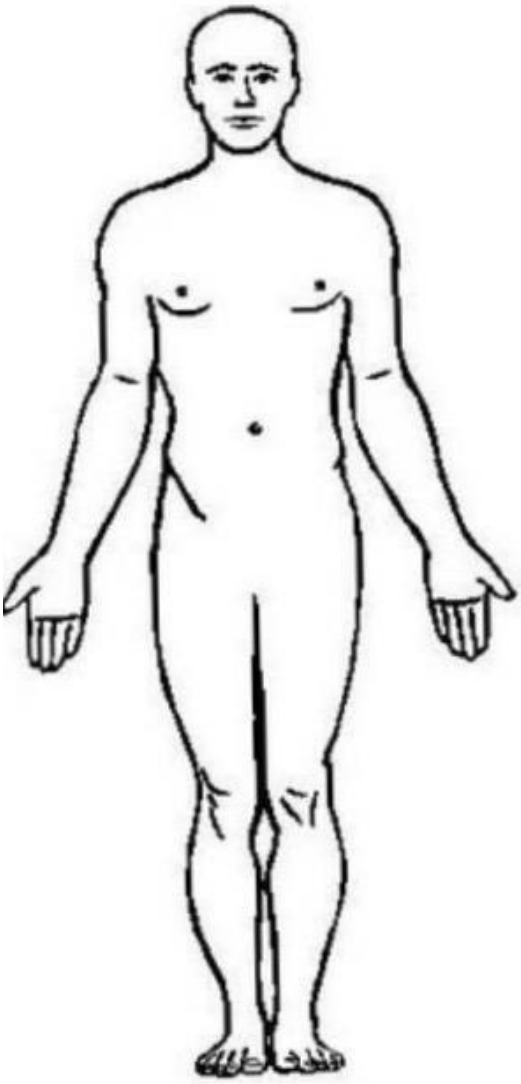
Decreased Gait, Transfer, or Balance:	Increased Musculoskeletal Pain:
Impaired Functional Ability:	Wound Condition Requires Advanced Care:
Impairment of Upper Extremity(s):	Unable to Feed Self:
Diminished Self-Care Capacity	Occupational Therapy Referral Made:

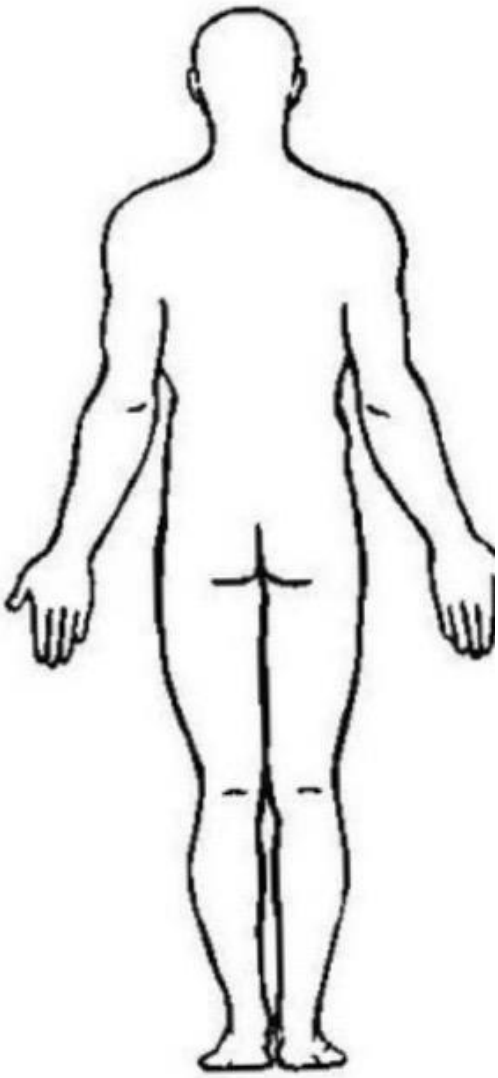
Include
Narrative:

***Developmental Assessment* (Self Concept)**

Erikson's Developmental Level

- Include current level client is in, what level client should be in, and what data made you arrive at this decision.





Nursing Dx #1:

Assessment Data:

Nursing Dx #2:

Assessment Data:

Medical Diagnosis:

Priority Assessment:

Nursing Dx #3:

Assessment Data:

Nursing Diagnosis #1_____

Goal_____

Intervention	Rationale	Evaluation

Goal Evaluation: _____

Nursing Diagnosis #2_____

Goal_____

Intervention	Rationale	Evaluation

Goal Evaluation: _____

Nursing Diagnosis #3_____

Goal_____

Intervention	Rationale	Evaluation

Goal Evaluation: _____