Bakersfield College

LICENSED VOCATIONAL NURSING PROGRAM

ORIENTATION PACKET FOR HEALTHSOUTH REHABILITATION HOSPITAL

CLINICAL INSTRUCTOR:

STEPHANIE ENGLER, RN

STUDENT ORIENTATION TO CLINICAL AGENCY

All students must be oriented to the agency where clinical experience is provided prior to their assignment. It is the responsibility of the clinical instructor to provide this orientation either personally or by arrangement with a staff member. Orientation shall include the following:

1. Parking regulations

2. Cafeteria procedures
    a. Times and duration of meals and coffee breaks
    b. Provision for students carrying lunches
    c. Cost of meals

3. Washroom facilities - both male and female

4. Locker facilities, proper location for storage of books, outer clothing, purses (in trunk of car) and valuable storage.

5. Safety and emergency procedures
    a. Fire regulations
    b. Code blue
    c. Security guard services
    d. Reporting accidents and incidents

6. Absences or tardiness in the clinical area
    a. Who to notify
    b. When to notify
    c. How to notify

7. Location of
    a. Policy and procedure manuals
    b. Fire regulations
        - fire escape route, extinguishers and alarm pull
    c. Disaster plan

8. Learning resource material
    a. Library - rules - privileges
    b. Inservice calender
    c. PDR, dictionaries, medical resource books

9. Location of student assignment
    a. time it will be posted
    b. Choosing an alternative pt.

10. Charting
    a. Procedure for charting
    b. Place for charting

11. Medication administration
    a. Policies and procedure for drug administration
    b. Location and role of pharmacy
    c. Procedure for ordering drugs
    d. Charting medications and treatments

12. Supplies
    a. Location of linens and supplies
    b. Method of ordering needed supplies
    c. Method of charging for supplies used

13. Orientation to patient care unit
    a. Operation of beds and side rails
    b. Location of equipment
        wash and emesis basins, oral care equipment, soap, lotion, etc.
    c. Operation of signal and reading lights
    d. Operation of radios, TVs etc.
    e. Operation of specialized equipment monitors, suction, O2, feeding pumps
    f. Visiting hours

14. Introduction to key personnel

15. Pre and post conference facilities

16. Communications during clinical assignment
    a. Contact in case of emergency
    b. Making outside phone calls

17. Information about the agency
    a. Pertinent history
    b. Bed capacity
    c. Charter

HEALTHSOUTH REHABILITATION HOSPITAL

1. Shift is from 5:45am to 3:15pm. That means you must be on the floor, ready for report at 5:45am.

2. Student parking: East parking lot or back employee lot.

3. Student lunches: Students should take their lunch break at their assigned time; it is your responsibility to be ready to take your break and have another student to cover your patients.

4. Locked supply room is # 1 – 5 – 3

5. Dirty linen hamper is in each client's bathroom and housekeeping empties.

6. Bed linen is changed every Thursday and PRN.

7. Drawsheet and pillowcase is changed every day and PRN.

8. Beds are made a little differently here, check with the nurse assistant for the correct way to make/straighten the beds.

9. Patients are bathed in the evening.

10. **IMPORTANT – ASAP !! First Thing** in the morning check the O.T. schedule, those patients are left in bed for O.T. to dress. Then find your C.N.A. and RN and introduce yourselves and discuss your role – assignment with them, make sure they understand what you will be doing and when you will be leaving for the day.

11. You are expected to stay with your patient during the day. You are to accompany him/her to the various therapies and activities scheduled throughout the day.

12. We are to document all care in the DAR form located in the binder at the nurse's station, and in the client's chart in the charting room behind the nurse's station. Use the student report sheet to assist in documentation and give this to your team leader during report, he/she will <u>Leave this with the RN at the end of the shift.</u>

13. We will leave the floor promptly at 2:00pm and meet for post-conference. You must manage your time to finish your assignment, complete your charting, assist your client to lunch, and report off to your team leader **PRIOR** to post conference. Remember, your team leader still needs to report off to the nurse before he/she can start post conference. You must learn to manage your time and prioritize your responsibilities. Time management is part of your objectives for this semester.

Student Outline of Activities in the Clinical Agency

1. Be on duty and prepared to start by 5:45am. Come in full uniform, and bring your clinical bag – stethoscope, penlight, skills check list, drug and lab book, syllabus, watch, scissors, and black pens.

2. Check patient chart for any new orders, meds, diet, treatment, activities, labs, etc. Greet your patients and offer to assist with AM care before breakfast and begin a visual assessment. In general, how does your patient look? Any immediate needs? Then proceed to systematically check all equipment – IV's, NG's, foleys, O2, drains, etc. Make sure all are hooked u according to current doctor's orders and are functioning correctly. Also check dressings, casts, incisions, pulses, etc. to get a baseline for your days observations.

3. Take vital signs and record ASAP. Be sure to chart them and report them to your team leader.

4. Breakfast – know the diet order and assist you patient with breakfast. If they go the dining room, you are to assist the client with eating. Record the amount consumed, meal %, and cc's of liquid intake. Maintain I&O on all of your patients.

5. Begin your physical assessment. Obtaining subjective information (what your client tells you), and objective information (what you observe and assess). Report any pain or abnormal findings to me STAT.

6. Assist with personal hygiene as necessary. Remember we do not bathe or perform linen changes on the am shift, however clients need to be kept clean and dry. Also, since this is rehab, it is the goal for the client to perform his/her own personal care. We are not to do the care for them, only to assist them to care for themselves.

7. Linen changes are usually limited to pillowcase and draw sheet if needed. Be sure the patient is comfortable, in good alignment with lights adjusted for his comfort.

8. Room care – cleanse the over bed table and nightstand. Move phone, call light and water within reach of our client. Bed must be in low position with side rails up (or according to agency policy). If equipment is needed for activities, make sure they are within reach. Remember the goal is to make the client independent.

9. Documentation – Instructor must see all documentation before it is placed in the chart. Make sure all charting is completed before 1:00pm and you have reported off to the team leader.

10. Attend all procedures and therapies with your patient. When your work is completed, you may sit in patient's room or in the charting area and do paper work, help other students and the staff, but always be available to your clients.

11. Lunch – assist your client to the dining room and help him/her as needed. Remember to record meal % and fluid intake, cc's. Take afternoon vital signs and record in the chart. Report off to the team leader just prior to going to post conference. Hand in your report forms at this time.

BAKERSFIELD COLLEGE NURSING PROGRAM

Student Orientation to the Chart

Chart Review

Remember to place your "Student has the Chart" form in the rack when you review a chart.

Do not choose a chart that has orders written that have not been transcribed or noted.

In the chart, find the following:

1. Where to record vital signs (bedside chart)
2. Where to record I & O (bedside chart)
   - B.M.'s
   - finger sticks
3. Flow sheet for patient care (bedside chart)
   - where and how do you sign this form
   - read yesterday's documentation
4. Special forms - restraint flow sheet (bedside chart)
5. Medication record
   - find the routine meds and prn meds
   - what are the standard times of administration
   - how are the meds documented
6. Progress notes
   - read the last two entries
7. Physician orders
   - read the last three M.D. orders then look to see if they have been implemented
8. History and Physical
   - read it
9. Diagnostic test
   -laboratory test results
   - x-ray results
10. Other
    - where does physical therapy, respiratory therapy document
    - look for other consultations
11. Face sheet
    - find date of birth, religion and next of kin
12. Where will you record the finger stick?

HEALTHSOUTH REHABILITATION Medication Administration Record

Init	Signature

ient:
Patient Id:
Sex:
Physician:
Diagnosis: FX LEFT HIP DIABETES MELLITUS
Height: 64 in. 163 cm. Weight: 172 lb. 78.4 kg.
Note: HTN ALTERNATIVE MEDICATIONS:NONE
Allergies **NKA**

Scheduled Orders	Route	00:00 - 06:29	06:30 - 14:59	15:00 - 23:59
Start: 01/13/2004 18:00 COLACE 100MG CAP AKA: DOCUSATE SODIUM 100MG CAP Stop 02/12/2004 18:00 **2 CAPS (= 200 MG) PO BID** ****NOTE DOSAGE***** Qty: 0 HOLD IF DIARRHEA CHANGE TO ONE CAP PO BID PRN IF POSSITVE BM FOR AT LEAST 24HRS	PO		08:00	18:00 ___
Start: 01/13/2004 18:00 EX-LAX CHOCOLATED LAXATIVE AKA: SENNOSIDES 15 MG EA PIECE Stop 01/23/2004 18:00 **CHEW 1 CHOCOLATED PIECE BID** **HOLD FOR DIARRHEA** Qty: 0 CHANGE TO ONE TAB PO DAILY IF POSITIVE BM FOR AT LEAST 24HRS	PO		08:00	18:00 ___
Start: 01/13/2004 18:00 FERROUS SULFATE 325MG TAB AKA: FERROUS Stop 02/12/2004 18:00 **ONE TAB PO TID WITH MEALS** 0 INCREASE FLUID INTAKE TO PREVENT CONSTIPATION	PO		07:00 12:00 ___	17:00 ___
Start: 01/14/2004 16:00 GLUCOPHAGE 500MG TAB AKA: METFORMIN 500MG TAB Stop 02/14/2004 16:00 **ONE TAB PO DAILY @07 ALONG WITH GLYBURIDE 5 MG TAB TO MAKE GLUCOVANCE 5/500 AS ORDERED** **TAKE WITH FOOD** Qty: 0 ****REQUIERS MONITORING OF RENAL FUNCTION****	PO		07:00	
Start: 01/14/2004 16:00 GLUCOPHAGE 500MG TAB AKA: METFORMIN 500MG TAB Stop 02/14/2004 16:00 **ONE HALF TAB (= 250MG) PO DAILY @17 ALONG WITH GLYBURIDE 2.5MG TO MAKE 1/2 TAB OF GLUCOVANCE 5/500 AS ORDERED** **TAKE WITH FOOD** Qty: 0 ****REQUIERS MONITORING OF RENAL FUNCTION****	PO			17:00 ___
Start: 01/14/2004 16:00 GLYBURIDE 2.5MG TAB AKA: MICRONASE/DIABETA 2.5MG TAB Stop 02/14/2004 16:00 **ONE TAB PO DAILY @1700 ALONG WITH 1/2 TAB OF GLUCOPHAGE 500MG TO MAKE 1/2 TAB OF GLUCOVANCE 5/500 AS ORDERED** Qty: 0	PO			17:00 ___
Start: 01/14/2004 16:00 GLYBURIDE 5MG TAB AKA: MICRONASE/DIABETA 5MG TAB Stop 02/14/2004 16:00 **ONE TAB PO DAILY @07 ALONG WITH 500MG GLUCOPHAGE TAB TO MAKE GLUCOVANCE 5/500 AS ORDERED** 0	PO		07:00	

Patient:
Medicatio

Outcome Based Documentation Charting:

DAR Nursing Note

Focus:

- Identify one primary problem or priority that reflects nursing diagnostic statement/priority that day.

- The nurse identifies a focus based on client concerns or behaviors determined during the assessment. This could include a concern (decreased urinary output) a change in client's condition or behavior (disorientation to time, place and/or person), pain (write data as a narrative sentence) or a significant event in the client's treatment, (return from surgery).

- Write a DAR note when a patient's condition has changed, either positively or negatively. When you complete your clinical day identify the most important focus and the data that supports it. Provide a clear picture of patient's story and what are important concerns for the patient.

D: Data: (Assessment) Objective and subjective assessment data that supports the stated focus or describes the client status at the time of significant event or intervention.

A: Action: (Implementation) What you did. Insights and interventions.

R: Response: (Evaluation) Patient's response to action. What happened? Was the outcome achieved?

Student Example:

87 yr old female who was admitted to transitional care for rehab following fall and resultant humeral head fracture of left arm. This is the note that was written during day of clinical:

D: *Constant ache in left arm. Winces and grasps when arm moved. Pain 8/10. Oxycodone 5 mg given at 0615 and has had no stated change in level of pain.*

A: *Discussed pain scale and alternative methods to relieve pain-breathing exercises, massage to right side and low back. Tylenol 1000 mg given by primary nurse at 0800.*

R: *Continues to c/o pain at 8/10 with no relief with current meds. Report given to primary nurse. Suggested need to increase prn of Oxycodone.*