The Institute for Accelerated RN Success, Inc.

RN Remediation/Refresher Course

Clinical Preceptorship Handbook

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Name

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This Handbook is subject to change, participants will be notified via email of new publications or addendums. As a condition of your enrollment in the Course, You are attesting to adhere to all current rules and policies of the Institution. This course is approved by the Florida Board of Nursing.

GOALS OF RN REMEDIATION/REFRESHER PRECEPTED CLINICAL:

1. Prepare students for the demands and realities of nursing practice.
2. Provide remediation of nursing skills
3. Increase prioritization & organization skills.
4. Ease the transition of graduate to RN role.
5. Increase confidence and competence as Registered Nurse.

RELATIONSHIP BETWEEN PRECEPTOR, STUDENT, CLINICAL COURSE COORDINATOR: This relationship will have positive student learning when all of the following exist:

1. Mutual trust
2. Mutual respect
3. Defined expectations
4. Excellent communication
5. Committed collaboration

PRECEPTOR GUIDE FOR STUDENT ASSIGNMENTS

The clinical component of this course consists of 96 hours over a three to four-week period (The clinical preceptorship consists of eight twelve-hour shifts (either 7Am to 7Pm or 7 Pm to 7 AM); or 12 eight-hour shifts (days, evenings, or nights); or, a match of shifts that have been approved by the course coordinator, over three to four weeks at the assigned clinical facility with a RN preceptor plus one clinical observation experience (simulation). {If necessary, the student can break up the clinical experience based on personal needs as compared to the preceptor's schedule as long as the 96 hours are met}.

The one-to-one relationship that the student has with the preceptor and the real life clinical day provides students with additional opportunities to develop professional and clinical skills. Each day of the clinical experience the student gradually assumes responsibility for the preceptor's typical client care assignment, including the delegation of care to others, and the supervision of the staff members as they implement the delegated aspects of client care. Students will practice and refine skills in clinical decision making and collaboration.

Student Preceptorship Guidelines

THE FOLLOWING GUIDELINES SHOULD BE FOLLOWED IN DELEGATING NURSING TASKS TO THE STUDENTS:

1. STUDENT – RN PRECEPTOR RELATIONSHIP:

a. The student is not working on your license. No one can work under another's license. The student has the right by law to practice incidental to the education process. The standard of care must be the same as that rendered by the RN because everyone has a right to expect competent nursing care, even if provided by a student as part of clinical training (measured against conduct of other reasonably prudent RN's with similar knowledge and experience under same circumstances.

b. Under the law, each person is responsible for his own actions.

c. The preceptor has responsibility to delegate according to the student's abilities and to supply adequate supervision.

d. The RN preceptor has the responsibility to be clear about what the student can or cannot do.

e. When students do not possess the skills needed to carry out an assigned function, acting with reasonable care requires them to refuse to perform the function, even at the risk of appearing insubordinate:

Example: you ask a student to perform tracheostomy suctioning. The student is too embarrassed to tell you she has never done it; If harm comes to the patient, the student is personally liable. The preceptor would be liable if she delegated with knowledge of student's inexperience.

2. DEALING WITH THE RESPONSIBILITY:

a. At the very beginning find out what the student can and cannot do.

b. Let students know that they must inform you if they are unsure and need help or supervision.

c. Delegation to students is based on the student's abilities, and adequate supervision.

d. CHECK THINGS CAREFULLY AT FIRST: THIS IS A NEW SITUATION FOR BOTH OF YOU. TAKE MORE RISKS AS THE EXPERIENCE PROGRESSES.

What Students May Not Perform without presence of RN preceptor

Student alone may not:

- Administer blood products.
- Perform venipuncture or insert intravenous catheters.
- May not administer intravenous push medications.
- Take verbal or telephone orders from prescribing health care professionals.
- May not transcribe any orders from prescribing health care professionals.
- May not perform admission assessments. Student may do an admission assessment and document but the RN must complete the admission assessment.
- May not document patient discharge. Students may participate in the discharge education.

Students are expected to communicate any questions about areas of responsibility with the assigned clinical RN preceptor.

SAMPLE GUIDELINES FOR CLINICAL RESPONSIBILITIES AND ASSIGNMENTS

1. WEEK ONE:

- Students complete course clinical orientation
- Students complete agency, hospital, and unit specific orientation
    - o Medication administration
    - o Review of hospital policies
    - o Unit tour, meet staff and Nurse Manager
- Student follows preceptor and observes implementation of the assignment.
    - o Student observes preceptor delegation
    - o Observe giving and receiving report
    - o Observe documentation including client education, discharge and admission (if possible)
    - o Observe collaboration with team members

- Observe all other aspects of client care management

2. WEEK TWO:

- Day one: Assign student to two clients (including shift report, treatments, teaching, assist with documentation, assist with medication). Participate in client admissions, transfers, and discharges.
- Day two: Take same two clients with same responsibilities, add review of all medications with the nurse.

3. WEEK THREE:

- Day one: Assign student to three clients (including shift report, treatments, teaching, assist with documentation, assist with medication). Participate in client admissions, transfers, discharges.
- Day two: Take same three clients with same responsibilities, add review of all medications with the nurse.
    - Student may begin to delegate part of the assignment to other nursing team members according to the nursing unit's model of care.

3. WEEK FOUR:

- Day one: Assign student to three clients (including shift report, treatments, teaching, assist with documentation, assist with medication). Participate in client admissions, transfers, discharges.
- Day two: Take same three clients with same responsibilities, add review of all medications with the nurse.
    - Student may begin to delegate part of the assignment to other nursing team members according to the nursing unit's model of care.

GUIDELINES FOR MEDICATION ADMINISTRATION

1. Students must be knowledgeable about medication.

2. Students will use PDA resources to look up medication.

3. If medication information is not available in PDA reference then the student will look up the medication on a reputable on-line site or call the pharmacist.

4. Students must follow the ten rights of medication administration

5. Students must assess client's status related to specific drug therapy

6. Students must appropriately communicate assessments and evaluations with regard to medications to preceptor.

7. Students will make decisions with regard to withholding medications, continuing medications in cooperation with preceptor.

8. Student's will know current laboratory values/glucose levels pertinent to Medications.

9. Students will not pull controlled medications without RN present.

10. Students will follow facility policy for recording and wasting narcotics with RN present.

11. Students will be checked for competency by instructor or preceptor for administration of IV, IM, SC medications. This includes changing IV bags.

12. When competency has been established student may administer IV's, IVPB's, IM's, SC's with RN supervision.

13. Students may observe the checking and hanging of blood and blood productions.

14. Students may observe the administration of IV push medications.

15. Students will DOUBLE CHECK each dose of any "high risk" medication per hospital policy, to include, at a minimum: heparin, Lovenox, insulin, potassium narcotics, and cardiovascular medications. High risk medications will be checked with the RN preceptor before administration. Co-signature will be done in accordance with facility policy.

16. Students will check all dosage calculations with preceptor before administering medications.

17. Students will check all newly transcribed medication orders with preceptor before administering the medication. STUDENTS MAY NOT TRANSCRIBE ORDERS.

18. Students will document all medication administration appropriately – immediately after administration (with RN preceptor).

19. Students will provide appropriate client teaching regarding medications.

20. Students are expected to communicate any questions about administration of medications with the preceptor.

Ten Rights of Medication Administration

10 rights when administrating medications are important identifiers or checklists to prevent errors and ensure the safety of the patient and your license as a nurse (JCAHO, 2013).

The following are the 10 Rights of Drug Administration:

1. Right Drug (check if it's the right name and form)

2. Right Patient (ask the name of the client before giving the medication)

3. Right Dose (check the medication sheet and the doctor's order before medicating)

4. Right Route (check the order if it's oral, IV, SQ, IM, etc.)

5. Right Time and Frequency (check the order for when it would be given and when was the last time it was given)

6. Right Documentation (make sure to right the time and any remarks on the chart correctly)

7. Right History and Assessment (secure a copy of the client's history to drug interactions and allergies)

8. Drug approach and Right to Refuse (give the client enough autonomy to refuse to the medication after thoroughly explaining the effects)

9. Right Drug-Drug Interaction and Evaluation (review any medications previously given or the diet of the patient that can yield a bad interaction to the drug to be given)

10. Right Education and Information (provide enough knowledge to the patient of what drug he/she would be taking and what are the expected therapeutic and side effects).

GUIDES FOR STUDENTS DURING PRECEPTED EXPERIENCE

WORKSHEET FOR DAILY STUDENT OBJECTIVES

DIRECTIONS: Use this outline as a framework to think about your personal needs as you develop daily objectives with your preceptor. Share this completed assessment with your preceptor each day. Print one for each day you are in clinical and fill out prior to the clinical day. Take with you, sharing your goals with your preceptor.

1. Communication with:
_____A. staff nurses
_____B. doctors
_____C. ancillary staff
_____D. staff from other departments

2. Organization:
_____A. assignments
_____B. delegation to others
_____C. time management
_____D. receiving and giving report
_____E. computer documentation

3. Specific Nursing Skills:
_____A. nursing procedures
_____B. nursing assessment
_____C. client teaching
_____D. clear and comprehensive documentation
_____E. critical pathways (if applicable)
_____F. collaboration
_____G. discharge planning
_____H. computer or Kardex record system

4. Hospital Rules and Regulations:
_____A. proper use of policy and procedure manual
_____B. work safety procedures
_____C. medication safety procedures

5. Miscellaneous:
_____A. self-confidence
_____B. assertiveness
_____C. conflict resolution
_____D. assuming primary responsibility for identifying own learning needs

GUIDELINES ON
HOW TO ORGANIZE AND PRIORITIZE
CARE TO GROUPS OF CLIENTS

PURPOSE: to assist student in organizing and prioritizing the basic workload of a staff nurse

ORGANIZING STEPS:

1. Obtain assignment
2. Receive report from previous shift.
3. Identify priority alterations based on report and understanding of medical diagnosis; Identify which clients to see first based on priority assessments
4. Complete client assessments/VS
5. Check client charts to identify new orders; check every few hours
6. Collect result of diagnostic tests, progress notes
7. Make rounds on all clients and repeat as frequently as necessary during shift.
   - Perform client care (AM/PM care):
   - VS and document
   - I&O and document
   - Feed clients and record intake; return meal trays
   - Maintain neat client unit
   - Perform ordered treatments
   - Update care plan
   - Safely administer medications
   - Manage IV's and document
   - Provide client teaching/document
   - Provide for client's psychosocial needs
   - Pain assessment, reassessment, document
8. Assist physicians with clients
9. Attend physician rounds on assigned clients
10. Admit new clients/transfer/discharge as assigned
11. Give change of shift report
12. Participate in client conferences, quality improvement activities, and in-service activities
13. Assure equipment safety

DOCUMENTATION GUIDELINES

1. Become familiar with agency flow sheets, checklists. Use them appropriately
2. Determine type of note used for nurse's note.
   - For PIE note keep note problem specific
   - For narrative nurses note include the following:
     - Objective and subjective symptoms
     - Client behavior and mental status
     - Nursing care administered
     - Client responses to medical and nursing care
     - Food and fluid intake
     - Preparation for discharge
     - Client teaching
     - Visitors/doctor visits
3. Use only abbreviations that are approved by the agency
4. Basic charting reminders:
   - Errors should be noted according to agency policy; do not erase; do not scribble; draw horizontal lines to fill in blank spaces in the narrative note
   - Record only facts truthfully and completely
   - Use black ink, and write legibly
   - Chart concurrently rather than once at the end of the shift
   - Use notes from Patient Data Collection Form for each client
   - Document concerns about medical orders
   - Chart for yourself, not for someone else
   - In case of omission, add notation at the end of the note as an addendum
5. Co-signing:
   - Students and preceptors should determine and comply with the co-signing policy of the hospital nursing service department
   - Verify accuracy and completeness of client documentation with preceptor
   - For agencies with computerized information systems, students will review agency requirements and responsibilities for staff nurses and students during orientation.

   - **Students who have not been trained on the facility E.H.R system will not be allowed to chart.**

CHANGE OF SHIFT REPORT GUIDELINES

1. To report to the oncoming personnel about the condition of each client and the nursing care given during the previous shift
2. To keep the nursing staff informed concerning methods of treatment, nursing care, current teaching plans, psychosocial issues, critical problems
3. To identify priority concerns

The nurse uses the computerized and hardcopy chart, kardex, and report sheets to give report

Checklist:

1. Client's name, age, room number, doctors, hospital day post admission or postop, chief complaint, diagnoses, surgical procedures or reason for admission, CODE STATUS, and any changes in the above.
2. Mental status and orientation; summary of critical elements of physical assessment
3. Focus of nursing care that must be given over the next 24 hours (e.g., increased ambulation, encouraging ADL's, teaching).
4. Changes in the client's condition or treatments within the last 24 hours.
5. Emphasis on nursing care needed within the next 2 hours: special symptoms to be observed (increased temperature, bleeding), special treatments (IV's, force fluids, NPO, prn or single medications, specimens to be obtained.
6. Medications: new meds or changes, reason ordered, potential side effects, problems with administration, prn meds with last time given and patient response; frequency required.
7. Treatments: new orders, rationale for treatment, time scheduled, and client response.
8. Diagnostic tests: dates and times scheduled, related special orders, tests completed in the last 24 hours, observations, medications or unusual reactions.
9. Dressing and drainage: amount, color, character, recommendations for care and frequency of dressing change.
10. Learning needs and progress: pre-op and post-op teaching, return demonstration, follow-up and discharge teaching such as medications and dressing changes
11. Plans for discharge and continuity of care agency referral.
12. Need for in-house referral; status of referral and forms.
13. Consultation with other members of the health care team; recommendations for physical therapy, scheduling of tests, need for social services. Status of support network, family; any visitations; special concerns

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RN Remediation/Refresher Preceptorship

Daily STUDENT SELF-ASSESSMENT OF CLINICAL PERFORMANCE

STUDENT NAME: _____

Dates:_____ _____

The following is a daily check list to be completed by the student and reviewed with the preceptor.

Please fill in the date and the number of student hours under the respective day of the week (make additional copy if necessary).

Evaluate clinical performance for each clinical day using the following:

E = Excellent; S = Satisfactory; NI Needs Improvement

Any *areas needing improvement* need goals set for improvement – document under goals.

Daily Assessment	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**	**Day 8**
Date:								
Number of Student Hours:								
1. Subject Knowledge								
2. Professional Behavior								
3. Client Interaction								
4. Psychomotor/Clinical Skills								
5. Safe Performance								
6. Organization								
7. Time management								
8. Collaboration								
9. Flexibility								
10. Clinical Judgment/Critical thinking								
11. Level of involvement in learning								

Goals for Improvement:

Date	Goal(s) – continue on reverse side as needed

Signature of STUDENT: _____ Date: _____

Signature of PRECEPTOR: _____Date: _____

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RN RECEPTOR ASSESSMENT OF REMEDIATION

STUDENT CLINICAL PERFORMANCE

STUDENT NAME:_____

Week beginning: _____

The following is a daily check list to be completed by preceptor and submitted weekly.

Please fill in the date and the number of student hours under the respective day of the week (make additional copy if necessary).

Evaluate clinical performance for each clinical day using the following:

E = Excellent; S = Satisfactory; NI Needs Improvement

Please comment on student progress on improvement goals in the area below.

Daily Assessment	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Fill in date for clinical hours:							
Number of Student Hours:							
12. Subject Knowledge							
13. Professional Behavior							
14. Client Interaction							
15. Psychomotor/Clinical Skills							
16. Safe Performance							
17. Organization							
18. Time management							
19. Collaboration							
20. Flexibility							
21. Clinical Judgment/Critical thinking							
22. Level of involvement in learning							

Progress on Improvement Goals:

_____

_____

_____

_____

_____

_____

Signature of STUDENT:_____**Date:** _____

Signature of PRECEPTOR:_____**Date:**_____

RN Remediation/Refresher Course

Student:_____Date: _____

Preceptor: _____

Preceptor's Clinical Facility: _____
Clinical Unit: _____

Based on the following scale please indicate how you feel the preceptor met the following objectives by placing a mark in the appropriate box:

1: strongly disagree; 2: disagree; 3: agree; 4: strongly agree

The Preceptor:

#	Objectives	1	2	3	4
1.	Possessed clinical knowledge and expertise in area of specialty				
2.	Demonstrated high level of clinical competence in area of specialty				
3.	Stimulated personal and professional growth in nursing				
4.	Utilized effective teaching strategies facilitating the learning experience				
5.	Created an accepting, supportive and positive learning environment				
6.	Was physically present and available as a resource at all times while in the clinical setting				
7.	Was a professional role mode in providing effective, efficient, and safe nursing care				
8.	Observed and assisted in the performance of simple and complex procedures while adhering to agency policy and procedures				
9.	Provided positive and constructive feedback at the daily evaluation meetings setting goals for improvement				

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RN Remediation/Refresher Clinical Preceptor Signature page

I,_____, have reviewed the RN Clinical Preceptorship. (Print RN clinical preceptor name) Guidelines with RN Remediation/Refresher student on _____. I have access to a copy of the RN Clinical Preceptorship Guidelines.

RN Preceptor Signature_____ Date_____

RN Remediation Student Signature_____Date_____

Course Instructor Signature_____Date _____

This signature page will be maintained in the student clinical folder.