# College of the Sequoias Associate Degree Registered Nursing Program

# Student Handbook

**1970-2021**
**51 Years of Nursing Excellence**

*Revised 6/2021*

# College of the Sequoias
# Associate Degree Registered Nursing Program

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# Welcome

*Division of Nursing and Allied Health*
*Associate Degree Registered Nursing Program*

Dear Students,

Welcome to the COS Registered Nursing Program! This handbook is a supplement to the college catalog and the general COS student handbook. The purpose of this handbook is to provide you with information, which is specific to the nursing program. It is important that you keep and refer to this handbook throughout your program of studies. As policies, procedures, and guidelines change, you will be notified and the handbook will be revised.

If at any time throughout your program of studies, you have any questions or problems or you need any assistance; please do not hesitate to contact any of the nursing faculty, the nursing Director, and/or the program Administrative Assistant. Our primary goal is your success, both during nursing school and eventually as a member of the nursing profession.

Sincerely,

Belen Kersten

Director of Nursing

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## History of College of the Sequoias Nursing Program

The College of the Sequoias Associate Degree Registered Nursing Program was established in January of 1970 as the culmination of long term planning among community leaders, college administrators, and members of the health care community to solve an acute nursing shortage. Since the first class was admitted in 1970, over **3,389** associate degree registered nurses have graduated from the College of the Sequoias. Since its inception, the nursing faculty, the college, and the health care community have worked together to provide educational opportunities for students which would enable them, as graduates, to meet the standards of excellence established by a long and proud history of nursing.

## Florence Nightingale Pledge

Florence Nightingale is the founder of modern professional nursing. She was called “The Lady with the Lamp” because she believed that a nurse’s care was never ceasing, night or day. Even though she was born almost two hundred years ago, her ideas about, sanitation and environmental health hold true today. At each pinning ceremony, the International Nurses Pledge is recited. The International Nurses Pledge is based on the Original Florence Nightingale Pledge that was written for Miss Nightingale in 1893. The reciting of the pledge is to remember our nursing heritage, to affirm our dedication to our clients, and to celebrate the graduates’ entry into professional nursing.

*I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty, will I endeavor to aid the physician, in his work, and devote myself to the welfare of those committed to my care?*

# General Information

## Nursing Office Hours (HR 101)

Monday - Friday 8:00am – 4:30pm

## Registration

All nursing classes have controlled registration. The nursing department controls the registration and reserves places in each class for all nursing students throughout the entire program. It is your responsibility to acquire a semester schedule and register each semester using the standard COS registration process. Only registered students will be allowed to attend nursing classes, including clinical classes.

## Program Expenses

Program expenses include items such as registration fees, health exam, books, supplies, student uniforms and accessories, parking, and student health fees. The majority of the cost occurs at the beginning of the first semester. All of these costs are the responsibility of the student.

## Required Documentation

The required documentation must be uploaded to the Online Document Management System prior to attendance in any nursing classes. Students not keeping this information updated will not be allowed to participate in clinical assignments. The original copy of the Student Health form and Physical Exam form must be turned in to the Nursing Office **and** uploaded to the Online Document Management System.

## Current Address and Phone Number

You must keep your most current address and phone number(s) on file with the nursing office. Be sure to include all applicable phone number (cell phone, emergency number, etc.). This information will be kept confidential.

**Note**: This is a ***mandatory*** requirement. No Exceptions.

## Children In Class

Under ***no*** circumstances are children to accompany you to class, skills lab, clinical, or scheduled meetings with instructors. If this occurs, you will be asked to leave. Your absence will be considered unexcused.

## "C" Grade As A Minimum Requirement

All courses, both nursing and general education, required by the COS Nursing program must be completed with at least a minimum **"C" or 75%.**

**Note**: Grades are not rounded up, 74.9% is a failing grade. No Exceptions.

## Student Communication

The student's COS email account is the ***official*** communication from the College of the Sequoias and COS Nursing instructors and staff. It is the student's responsibility to access this account. For further information on navigating the new student e-mail system go to:
http://www.cos.edu/StudentServices/TechnologySupport/Email/Pages/Student-Access.aspx.

## Student-Instructor Communication

Instructors have faculty mailboxes in the college mailroom as well as a mail slot in their office door. All instructors have scheduled office hours, which are posted outside their office doors. Please contact your instructors or the Director to discuss your progress, any problems, or if you need assistance.

## Student Assistance For Learning Disabilities

Any student who believes he/she has a learning disability, which requires special testing, tutoring, a designated reader, etc., is encouraged to contact the Access and Ability Center on campus. Before special testing arrangements can be made, semester faculty must receive official documentation from the center. It is the student's responsibility to arrange for a disability assessment and/or special testing at the beginning of each semester.

## Nursing Computer Lab

The program also maintains a computer lab for use by students for group, and/or instructor-assigned activities. Students should be sure to log-in and log-out when utilizing these resources.

## Work Experience Program

This elective course provides the student enrolled in the Registered Nursing program an opportunity to obtain structured work-study experience under the supervision of Registered Nurses in participating health care agencies. It promotes additional practice and development of skills and confidence through application of previously learned knowledge. The course is broken up into 4 semesters: 193N, 194N, 195N, 196N; additional semesters may be added as needed (193W, 194W, 195W, 196W) for students taking this course in the summer. A student may take up to 16 Units (lifetime) in work experience. The work experience office keeps a history of courses completed and units earned.

## General Information

All work experience students must contact the instructor of record for the course syllabus and information about the course.

## Course Requirements

The course is open to the nursing student currently enrolled in the RN program who:

- Has successfully completed first semester course requirements.
- Is employed by participating clinical agencies that have approved participation in the work experience program; has been assigned to a Registered Nurse for supervision/mentoring.
- Is recommended by College of the Sequoias nursing faculty from the most recent semester completed.
- Will commit to working a minimum of seventy-five, (75), hours per semester. One unit of credit is equal to seventy-five, (75), hours of work within the semester. A student may earn a maximum of four, (4), units per semester.

## Approved Clinical Sites

The approved clinical sites are: Kaweah Delta Health Care District, Sierra View Hospital, and Adventist Health (Hanford, Selma, and Tulare). Other hospitals utilized previously: Madera Community, Valley Children’s Hospital in Madera. If a student would like to work at any other hospital not listed, a Student Affiliation Agreement must exist with the College of the Sequoias District. This request would need to be brought to the attention of the Work Experience Instructor/Coordinator for the Nursing Division for discussion.

## Insurance

All nursing students are covered by an insurance policy that provides coverage for accidents that occur during school sponsored, supervised curricular and co-curricular activities. This policy coordinates with students' personal insurance policies so that duplicate benefits do not result in double compensations. All students are required to have a valid California driver's license and current automobile insurance coverage as required by the State of California. A copy of your license and proof of insurance must be on file with the Online Document Management System by the first week of your first semester, and then updated as necessary throughout the program.

**Note**: This is a ***mandatory*** requirement. **No Exceptions**.

## CPR

Prior to the beginning of the nursing program, and then throughout the program, you are required to show proof of a current Health Care Provider Cardio Pulmonary Resuscitation CPR card from the American Heart Association (AHA only, we do not accept CPR cards from other providers). Please make sure your card is for Health Care Provider. CPR classes are offered throughout the year and at various locations in Visalia and surrounding communities. If you need more information about where classes are offered, please contact the nursing program administrative assistant. Please provide a copy of your current CPR card to the Online Document Management System.

**Note**: This is a ***mandatory*** requirement. **No Exceptions**.

## Immunizations

Verification of the following requirements must be on file with the Online Document Management System at all times. Failure to maintain any of the following requirements will result in ineligibility to participate in clinical processes and/or experiences. Inability to meet clinical participation requirements will result in a failure of the clinical component of the program and dismissal from the COS Registered Nursing Program.

**Note**: This is a ***mandatory*** requirement. **No Exceptions**.

## Required Immunizations

- MMR (Measles/Mumps/Rubella) vaccine - 2 doses required or positive titer
- Varicella (chicken pox) vaccine - 2 doses required or positive titer
- Hepatitis B – 3 dose series or positive titer
- Tetanus/Diphtheria/Pertussis (Td/Tdap) vaccine. All adults who have completed a primary series of a tetanus/diphtheria containing product (DTP, DTaP, DT, Td) should receive Td boosters every 10 years.
- TB Skin test – **2-step** is required at start of program (used for initial skin testing of adult healthcare providers), yearly thereafter.
  **NOTE:** 2-Step TB Skin Test (4 visit approach) – As required by Clinical Facilities
  - Visit 1 (Day 1): First Subdermal PPD Injection is administered
  - Visit 2 (Day 3): PPD is read 48-72 hours after subdermal injection
  - Visit 3 (Day 7-21): Second Subdermal PPD Injection is administered
  - Visit 4: Second PPD is read 48-72 hours after second PPD subdermal injection
  - Chest X-ray May Be Required for positive PPD reactors (Applicant Cost)
- If PPD reactor – symptom questionnaire and chest x-ray (provide copy of results)
- If x-ray is over 12 months, we may accept documentation from the student's Health Care Provider (MD, DO, NP, PA, CNM) stating that the student is asymptomatic.
- Flu Vaccine – Required November 1 through April 1 for current seasonal vaccine

**A-25**

**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE:** San Joaquin Valley Nursing Education Consortium (SJVNEC) Clinical placement System

**PURPOSE:** To describe the means by which student clinical placements are managed by area health care facilities, the responsibilities of participating SJVNEC members, and the responsibilities of College of the Sequoias staff, faculty, and students.

**DESCRIPTION:**

Administrative Assistant:

The administrative assistant of the division will maintain current student data through the Online Document Management System, to include:

1. Immunizations status.
2. Current car/truck Insurance.
3. Current CA driver's license.
4. Active AHA CPR card.
5. Current TB skin test.
6. Background check and urine drug screen completion.
7. N-95 mask fit test

The Online Document Management System automatically generates emails to students reminding them of their verification status and letting each individual student know when a specific record in the system is set to expire. The Online Document Management System will send out an administrative email to the division administrative assistant at set time intervals (30-days before, 15-days before, the day of) sending notification of the status of students who have records set to expire. Each student is required to update the Online Document Management System and upload the required documentation before that specific record is set to expire. Any student who fails to upload and record new verifications will be notified by the Online Document Management System as well as the division administrative assistant.

Every February, Consortium Request Spreadsheets will be created and distributed for each nursing course. The semester team members are responsible for completing the Consortium Request Spreadsheet for each clinical rotation to include clinical sites used, dates of rotations, observation experiences, assigned instructor, orientations dates, post-conference times, and any days/dates students are not on the clinical units. The deadline for submission of the Consortium Request Spreadsheets is by the end of February each year. The Director of Nursing will input data from the Consortium Request Spreadsheets into the SJVNEC computerized clinical placement system. The deadline for clinical rotation data input is due by early March each year.

**Clinical Faculty**

Each nursing team leader, working with full-time and adjunct clinical faculty will complete the Consortium Request Spreadsheets for the Fall, Spring, and Summer semesters of the upcoming year. Information to be included is:

1. Identify semester term and year
2. Dates of each rotation (begin with the first a day of patient care, not orientation date)
3. List any days/dates the students will not be on the unit(s) (e.g., holidays, ATI testing, skills lab day, etc.)
4. Number of students in the rotation
5. Agency/Facility and nursing units utilized
6. Float units (e.g., Endoscopy, OR, Wound Nurse, Home Health, etc.)
7. Locations of observational experiences

It is the responsibility of the clinical faculty to insure that students under their supervision have current information documented in their Online Document Management System. Students whose information is outdated or incomplete will be excused from the clinical lab until the information is complete and current. If the number of absences exceeds the absence policy (see policy B-19) students may fail the clinical lab.

**Nursing Students**

All nursing students are informed of the information that must be kept current for clinical lab placement, beginning with orientation to the first semester course. Students who allow their required documents to lapse will not be allowed in clinical lab until their information is current and on file with the Online Document Management System.

It is the students' responsibility to maintain current required documents in the Online Document Management System (see Policy B-4). Failure to do so will result in dismissal from clinical experiences until the information is received which will result in clinical absences. Required documents must be current and uploaded to the Online Document Management System regardless of school breaks, holidays, or summer break. Example: TB skin test is due July 1st. The student has until July 1st to submit the test results to the Online Document Management System. Any required documents that expire during school holidays and/or breaks, are due no later than the first day the semester begins.

Students will place their background check and urine drug screen orders through the Online Document Management System See attached SJVNEC information.

If the student does not complete or does not pass the Background Check and Urine Drug Screen or refuses to comply with this policy, then the student understands that the Nursing Program will make reasonable efforts to secure alternative clinical experiences for the student but these experiences may not be available. Lack of available clinical experiences will prevent the student from completing the clinical objectives of the Nursing Program resulting in failure of the course.

**Reference:** SJVNEC Background Check/Drug Screen Process

San Joaquin Valley Nursing Education Consortium

Reporting Process

***Policy and Procedure Committee***

**Date Approved/Reviewed/Revised:** 3/2010; 12/2010; 3/2013; 10/2016; 03/2021

**B-1**

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: Informing Nursing Students of Program Changes

**PURPOSE:** To describe the process for informing Nursing students of program changes.

**DESCRIPTION:**

Policies and procedures are communicated to students by means of the Nursing Student Handbook. This handbook is revised regularly to provide current and accurate information. Each Nursing student receives his/her own printed copy of the Handbook upon entering the program. The Student Handbook is also available online via the COS Nursing Website.

Changes in the Nursing Program policies and procedures will be communicated to the Nursing Office staff by the Chairperson of the Policy and Procedure committee. The changes will then be communicated to each student and faculty members via email by Nursing Office Staff once the official changes are received. The online Student Handbook and the hardcopy Policy and Procedure Manual will be updated at that time by Nursing Office Staff.

Additional ways that changes may be communicated are via the course management system of the faculty members.

The program Director and Faculty members are responsible for and should be available to answer questions regarding any changes.

**Policy & Procedure Committee**

**APPROVED/REVIEWED/REVISED**: 2/1987; 5/1993; 11/1998; 11/2001; 2/2004; 10/2011; 5/2012; 4/2021

**B-2**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: STATEMENT OF NON-DISCRIMINATION

**PURPOSE**: This statement reflects the Division's position against discrimination and its commitment to adopting and supporting the non-discrimination policy of the College of the Sequoias.

**DESCRIPTION**:

College of the Sequoias does not discriminate on the basis of race, creed, color, national origin, sex, gender, sexual orientation, age, religion, mental or physical disability, medical condition, genetic information, marital status, military service, or any other basis protected by law in any of its policies, procedures, or practices, in compliance with Title VI of the Civil Rights Act of 1964 (pertaining to race, color, and national origin), Title IX of the Educational Amendments of 1972 (pertaining to sex), Section 504 of the Rehabilitation Act of 1973 (pertaining to handicap), the Age Discrimination Act of 1975 (pertaining to age), and the American with Disabilities Act of 1990.

This non-discrimination policy covers admission and access to, and treatment and employment in, the College's programs and activities, including vocational education. The lack of English language skills will not be a barrier to admission and participation in the College's vocational education programs. Non-Discrimination College of the Sequoias recognizes its obligation to provide overall program and physical accessibility throughout the District for persons with disabilities.

Reference: COS General Catalogue-Compliance and Disclosure Statement
Administrative Procedure 5141

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED**: 2/1987; 5/1987; 11/1998; 11/2001; 2/2004; 5/2011; 2/2018

**B-24**

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: STUDENT GRIEVANCE

**PURPOSE**: To describe the procedure a nursing student follows when filing a grievance.

**DESCRIPTION**:

The District utilizes a formal grievance procedure which can be initiated by any student who reasonably believes a district decision or action has adversely affected his or her status, rights, or privileges as a student. The purpose of this procedure is to provide a prompt and equitable means of resolving student grievances against the District. A full description of the procedure is available on the COS website or upon request from Student Services (See AP 5530). The COS Nursing Division adopts and utilizes this same procedure. Additional information can be found in the COS General Catalog under "Student Rights and Responsibilities".

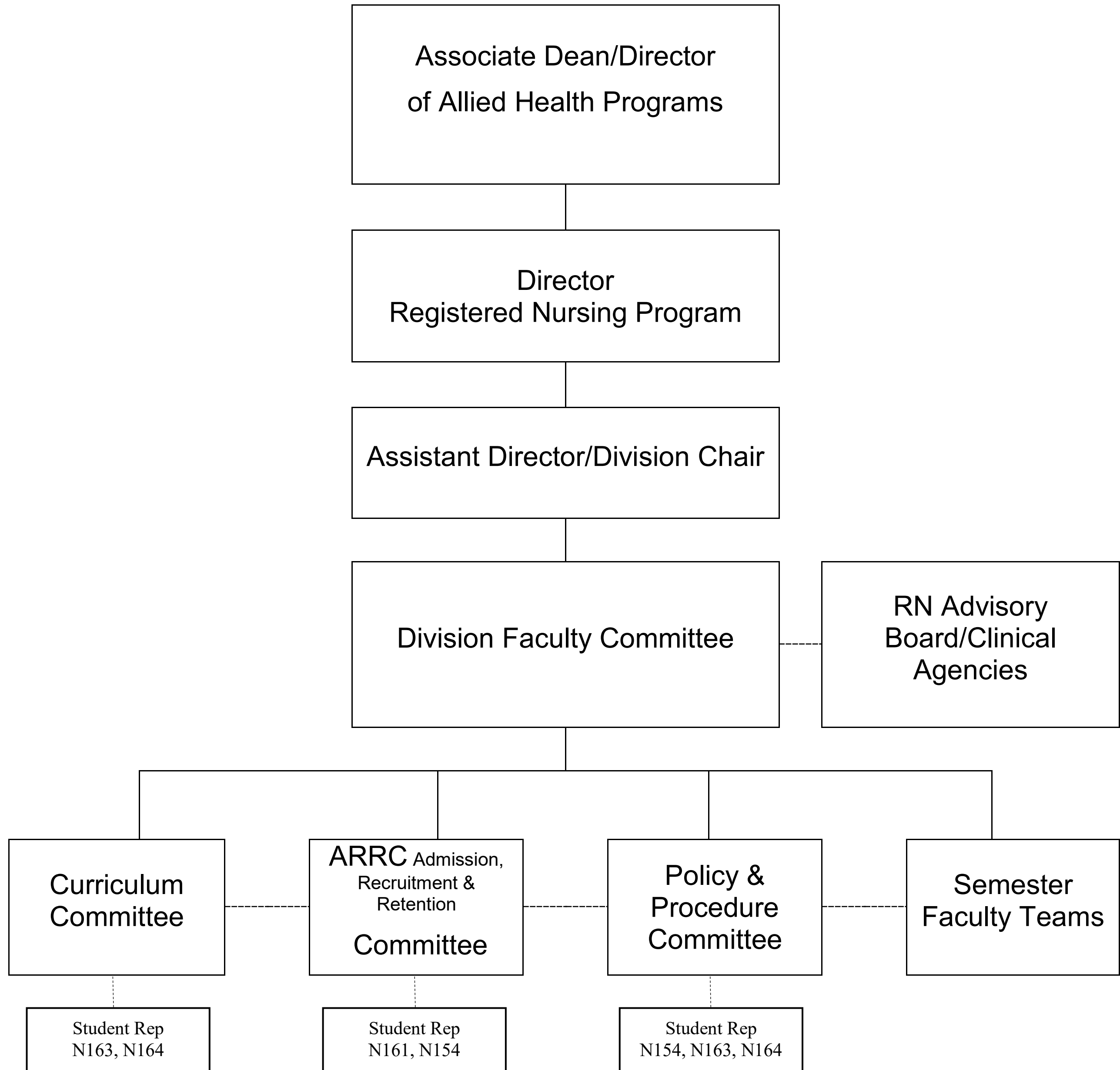
**REFERENCE:** AP 5530 – Student Rights and Grievances
COS Statement of Grievance Form

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED:** 4/2004; 11/2011; 10/2017

# The Nursing Program

**College of the Sequoias**
**Division of Nursing and Allied Health**

Organizational Chart




Reference A-6
Policy & Procedure Manual

**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE:** REGISTERED NURSING PROGRAM PHILOSOPHY

**PURPOSE**: To describe the philosophy of the registered nursing program.

**DESCRIPTION:** The philosophy of the Division of Nursing and Allied Health endorses and supports the mission statement of the College of the Sequoias. The curriculum prepares men and women who complete the program with the knowledge and skill necessary to "function at a level that meets or exceeds the standards of competent performance."

**COS Mission Statement**

**Sequoia Community College District** is dedicated to student learning, success, and equity by providing transfer education, basic skills, and workforce development for our diverse student population.

**COS Vision Statement**

The entire College of the Sequoias community works in an environment of mutual respect to realize the following vision:

COS students achieve their full educational potential. The college strives to provide an educational pathway for every student with regard to background, disability, location, culture, learning modality, and preconceived time frames.

COS promotes an environment that creates a positive attitude among COS employees that carries over to the students and into the community.

COS is a community leader whose contributions positively impact the lives of the population it serves.

Educational programs at COS are aligned to meet the constantly emerging economic and workforce development needs of the community through partnerships with business, government, industry and labor.

**Nursing Mission Statement**

The mission of the COS nursing program is to meet the dynamic health care needs of clients, individuals, families, groups, and communities by preparing future nurses who are qualified to disseminate knowledge that will contribute to the art and science of nursing practice. The mission supports and sustains the goals of COS through the

education of nurses whose practice is client-centered and grounded in evidence based practice.

The nursing faculty believe that:

The **Individual** is a unique, complex biological, psychosocial, cultural, and spiritual being. All people develop in identifiable stages through their life span. Each person possesses dignity and worth with the right to self-determination.

The **Environment/Society** consists of all interactions that possess the potential to define or delineate a person's state of well-being. The individual constantly interacts with a changing environment that has both internal and external dimensions. The internal environment consists of cognitive, developmental, physiological, spiritual, and psychological processes; the external environment consists of physical and socio-cultural processes. Both internal and external processes create conditions which require individuals to adapt. Society is composed of individuals, families, groups, and communities who coexist and adapt.

**Optimal Well-being** represents a desired state on the health illness continuum. Health is a complex, dynamic process of the person interacting positively with the environment. Degrees of health or illness are represented by a continuum, ranging from optimal wellness to illness. Interaction with the environment can alter a person's ability to function, thus changing his/her position on this continuum and requiring adaptation.

**Nursing** is an art and applied science that synthesizes the elements of knowledge, caring and skills to assist the client. The concept of Client includes individuals, families, groups, and communities. The role of the nurse is to join with the client to promote adaptation to altered functional status on the health-illness continuum. Nursing is a theory based discipline in which nurses use cognitive, psychomotor, and affective skills in the application of the nursing process to assist clients to promote, maintain, and/or restore wellness and prevent disease; or to support the client to experience dignity in death. The nursing process is a problem-solving process that requires the use of decision-making, clinical judgment, and other critical thinking skills to assess, identify and prioritize client problems, to assign nursing diagnoses with measurable outcomes, to plan care systematically, and to implement and evaluate the results of the care given. The associate degree nurse functions in a role of provider of care, planner/coordinator of care, client teacher, communicator, and as a professional within the discipline of nursing as well as a member of a multidisciplinary team in a variety of health care settings within the community.

**Nursing Education** occurs at various levels within institutions of higher learning and involves the student, instructor, and environment in a dynamic process to prepare graduates of the nursing program.  The nursing faculty assists the students in developing skills related to problem-solving, scientific inquiry, and critical thinking. Students must transfer knowledge from the social, biological and physical sciences into the application of the nursing process in a variety of settings.  The faculty believes that

together we serve students by being strong role models through commitment to excellence as facilitators of learning, scholars, clinicians, and lifelong learners. The COS nursing program shares the district philosophy in appreciating the cultural, racial and the socioeconomic variations among our students and the community in which they provide healthcare. Principles of teaching and learning are applied to assist students to meet their educational goals. Nursing education course content progresses from the basic to complex client care and from normal to abnormal in order to provide a foundation for further learning.

***Policy & Procedure Committee***

**DATE APPROVED/REVIEWED/REVISED:** 2/2004; 2/2010; 10/2016; 10/2019; 02/2020

A-2

**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE**: CURRICULUM DESIGN & IMPLEMENTATION

**PURPOSE:** To describe how the registered Nursing Program is designed and implemented, and to provide a description of courses/content contained within the program.

**DESCRIPTION:**

CURRICULUM DESIGN

The Nursing Program is organized into three major components: courses required for the Associate Degree, biological and social science courses, and nursing courses. The nursing courses are further organized into three distinct areas: the theoretical portion of the courses present concepts and knowledge essential to the practice of nursing; the skills laboratory portion of the courses allow the development of manual skills required for nursing practice; the clinical laboratory portion of the courses provides the opportunity to apply both knowledge and skills in the direct care of clients. The curriculum is designed to provide the student with a theoretical framework on which to base nursing interventions and a way of processing information to arrive at those interventions, as well as competence in manual skills basic to nursing practice. In the first year, basic nursing science is emphasized. Physical assessment and pharmacology courses are designed to complement and enhance the nursing science component.

The four-semester sequence of nursing courses provides for the progressive development of knowledge and skills. Students learn basic technical and interpersonal skills and provide care to clients across the age continuum whose health-illness problems are stable and predictable as the focus for the first two semesters.

The last two nursing courses focus on the assessment and intervention process for clients experiencing unstable and unpredictable illness states. These courses present the knowledge and skills necessary to care for clients experiencing altered human needs of increasing acuity. The emphasis is on problem-solving the management of care for groups of clients at various developmental levels.

**COURSE DESCRIPTIONS**

**NURS 121 Fundamentals for Nursing: - (**6 units; 3 units theory & 3 units clinical) focuses on fundamental concepts necessary for safe, compassionate, patient-centered nursing care for a diverse patient population with well-defined healthcare concerns with a focus on elderly patients. The course offers an introduction to foundational concepts related to professional practices such as legal and ethical responsibilities of the

Registered Nurse. The student also uses clinical judgment applied to nursing practice. Select nursing skills are taught in the skills laboratory; theory and skills re applied in various clinical settings. *1st Semester*

**NURS 123 Critical Thinking/Clinical Judgement in Nursing:** introduces clinical judgment through a focused study of critical thinking skills and strategies used by the Registered Nurse. The student applies critical thinking skills and strategies at the RN level that underscore the clinical judgment represented in the nursing process as well as dealing with aspects of the healthcare system for safe practice in the current healthcare environment. The major purpose of the course is to teach students the clinical judgment needed to predict and manage potential complications and to decrease the failure to rescue rate which results in improved patient outcomes. This course provides the foundation for the thinking processes applied throughout all nursing courses.
*1st Semester*

**NURS 124 Concepts of Adult Health Nursing 1:** - **(**3 units; 1.5 units theory & 1.5 units clinical) is a continuation of Nursing 121: Concepts of Adult Health Nursing, presenting additional fundamental concepts necessary for safe, compassionate, patient-centered nursing care for a diverse patient population with well-defined healthcare concerns with a focus on elderly patients. The course continues as an introduction to foundational concepts related to professional practice such as legal and ethical responsibilities of the Registered Nurse. The student also uses clinical judgment applied to nursing practice. Select nursing skills are taught in the skills laboratory; theory and skills are applied in various clinical settings. *1st Semester*

**NURS 133 Concepts of Mental Health & Psychiatric Nursing**-(3 units; 1.5 units theory & 1.5 units clinical). This course builds on and applies concepts of nursing practice to the care of patients with various mental health needs, their families, and other support persons. Application of new and previously learned nursing concepts, patient care skills, and clinical judgment occurs in a variety of clinical settings.

*2nd Semester*

**NURS 134 Concepts of Adult Health Nursing 2- (**4 units; 2 units theory & 2 units clinical) This course builds on and applies the concepts of nursing practice from semester 1 to the acquisition and application of adult health nursing theory in the care of diverse adult patients with acute and chronic conditions, their families, and other support persons. Application of knowledge, patient care skills, and clinical judgment occurs in the simulation lab. *2nd Semester*

**NURS 135 Concepts of Nursing Care of the Pregnant Family and the Neonate- (**3 units; 1.5 units theory & 1.5 units clinical). This course builds on and applies concepts of nursing practice to the care of the pregnant family and the neonate. Application of new and previously learned nursing concepts, patient care skills, and clinical judgment occurs in a variety of clinical settings. *2nd Semester*

**NURS 143 Concepts of Pediatric Nursing**- (3 units; 1.5 units theory & 1.5 units clinical). This course continues to build on and expand all previously learned concepts of nursing practice with application to the care of children, their families, and other support persons. Application of new and previously learned nursing concepts, patient care skills, and clinical judgment occurs in a variety of clinical settings. *3rd Semester*

**NURS 144 Concepts of Adult Health Nursing 3** - (6 units; 3 units theory, 3 units clinical). This course continues to build on and expand all previously learned concepts of nursing practice with application to the care of adult patients with complicated conditions, their families, and other support persons. Application of new and previously learned nursing concepts, patient care skills, and clinical judgment occurs in a variety of clinical settings. *3rd Semester*

**NURS 164**- (8 units; 4 units theory & 4 units clinical) A study of complex medical-surgical nursing concepts to promote and restore wellness in complex clients. In the clinical laboratory, students will increase skills to promote and restore optimal wellness. The progressive themes of the Nursing Program are applied through the Nursing Process to attain the client's optimal well-being. *4th Semester (Fall 2021)*

**NURS 166**- (3 units; 0.5 units theory & 2.5 units clinical). A study of the leadership role of the Registered Nurse in providing integrated, cost-effective nursing care to clients by coordinating, supervising, and collaborating with members of the health care team. This course includes theory concepts and laboratory experience. The progressive themes of the Nursing Program are applied through the Nursing Process to attain the client's optimal well-being. *4th Semester (Fall 2021)*

**NURS 174:** Concepts of Adult Health Nursing, 4 - (7 units; 3 units theory & 4 units clinical). This culminating course expands the concepts of nursing practice for the acquisition and application of care of adult patients with complex healthcare needs, their families, and other support persons. Application of knowledge, patient care skills, and clinical judgment occurs in a variety of clinical settings and in the simulation laboratory.
*4th Semester (Spring 2022)*

**NURS 175:** Transition to Registered Nursing Practice - (3 units; 1 units theory & 2 units clinical). This advanced, comprehensive course provides a synthesis of all concepts and nursing content taught throughout the program with application in the simulation lab. This course enables the individual student to recognize areas that need enhancement prior to entering Registered Nursing practice and includes a review for the NCLEX-RN® and strategies for success. *4th Semester (Spring 2022)*

**IMPLEMENTATION OF THE PROGRAM**

Implementation of the Nursing Program is based upon the following principles:

-Courses of study are designed so that the student moves from simple or basic aspects of a topic to the complex or more difficult concepts related to that topic.

-The sequence of topics among nursing courses and between nursing and related science courses are planned to correlate material so far as it is practical or possible.

-Courses are organized to provide didactic instruction, skills laboratory and simulation exercises, seminars and small group discussions, and direct clinical practice with correlation between theory and practice maintained at a high level.

-Learning is structured by program design and consistent use of theory and clinical weekly objectives.

The organization of nursing content and process is structured by the human need's framework, as it relates to Maslow's Hierarchy of Needs and Erikson's 8 Stages of Development, and the Nursing Process. The common curricular threads are essential to all levels of the curriculum. These threads represent content identified by the faculty as appropriate to the practice of an associate degree nurse while satisfying the requirements of the BRN.

**Concept Based Curriculum**: **Students beginning in the fall semester 2020**

**Unifying Theme of the Nursing Program**

The unifying theme for the College of the Sequoias Associate Degree Nursing Program is what the new graduate needs to know and do to provide safe care in the current healthcare environment as a Registered Nurse. This provides the framework that ties together all parts of the curriculum. The overall goal of all components of the nursing program is for students to achieve the end-of-program learning outcomes and competencies which are based on evidence from the nursing and healthcare literature that validates the importance of each learning outcome. To demonstrate this evidence, an explanation of the literature used to develop each learning outcome is provided. The nursing courses are leveled throughout the program to meet that goal. Each course has expected levels of achievement (course learning outcomes and competencies) that serve as defined points for evaluation of student achievement.

Maintaining a program centered on, and organized around, current nursing practice is achieved by constant research and updating related to what is needed to provide safe care in a variety of healthcare environments. To develop and maintain the Associate Degree Nursing Program curriculum, current trends in nursing and health care as well as traditional standards and values of nursing practice are used as the basis for the end-of-program student learning outcomes

To maintain program currency faculty, meet each year to discuss new trends and data that influence nursing care. The program is updated each year as needed based on the evidence from the nationally based literature and from nursing practice in California.

***Policy & Procedure Committee***

**APPROVED/REVIEWED/REVISED:** 2/2004; 5/2006; 2/2010; 11/2012; 3/2013; 9/2015; 8/2020, 10/2020, 12/2020, 05/2021.

**A-3(a)**
**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE**: CONCEPTUAL (ORGANIZING) FRAMEWORK FOR A **CONCEPT BASED** CURRICULUM

**PURPOSE**: TO DESCRIBE THE ORGANIZING FRAMEWORK FOR THE REGISTERED NURSING PROGRAM

**Mission**

The College of the Sequoias Associate Degree Nursing Program endorses and supports the mission of the College of the Sequoias, which follows: “Is a comprehensive community college district focused on student learning that leads to productive work, lifelong learning and community involvement. The College of the Sequoias affirms that our mission is to help our diverse student population achieve its transfer and/or occupational objectives and to advance the economic growth and global competitiveness of business and industry within our region. College of the Sequoias is committed to supporting students’ mastery of basics skills and to providing access to programs and services that foster student success"

“Sequoias Community College District is dedicated to student learning, success, and equity by providing transfer education, basic skills, and workforce development for our diverse student population.” (College of the Sequoias 2020-2021).

The College of the Sequoias Associate Degree Nursing Program adheres to this mission when offering the Associate Degree in Nursing. The mission of the nursing program is to provide a student-centered educational program that prepares diverse students as candidates to become Registered Nurses to provide safe, quality, compassionate, evidence-based nursing care in the current healthcare environment. In alignment with the mission of the College of the Sequoias, the nursing program also provides a solid base for continued lifelong learning as a Professional Nurse.

The nursing program has developed a concept-based curriculum. Delivery of a concept-based curriculum is through an active learning environment that encourages individual student contributions as they learn and achieve. This requires faculty to be actively involved with students in the classroom through mutual respect, responsibility, and collaboration. The teaching skills needed to deliver the concept-based curriculum require consideration of the diverse student backgrounds and perspectives that are representative of our student body.

The nursing faculty and nursing administration use the program’s mission to formulate end-of-program student learning outcomes, which serve as the basis for the development, implementation, and evaluation of the nursing program curriculum. To ensure the educational needs of students are met, student achievement of these student learning outcomes and established program outcomes are used as metrics to determine program effectiveness.

**Vision**
The vision of the College of the Sequoias affirms that: "The entire College of the Sequoias community works in an environment of mutual respect to realize the following vision:
COS students achieve their full educational potential. The college strives to provide an educational pathway for every student with regard to background, disability, location, culture, learning modality, and preconceived time frames.
COS promotes an environment that creates a positive attitude among COS employees that carries over to the students and into the community.
COS is a community leader whose contributions positively impact the lives of the population it serves.

Educational programs at COS are aligned to meet the constantly emerging economic and workforce development needs of the community through partnerships with business, government, industry and labor" (College of the Sequoias 2020-2021).

The College of the Sequoias' Nursing Program supports the vision of the college as stated above and is dedicated to a commitment of excellence in nursing education that will position graduates for practice in dynamic health care environments. The nursing program directly supports the statement related to providing an educational program aligned to meet the constantly emerging economic and workforce development needs of the community. Fulfillment of this vision statement requires educating nursing students to be critical thinkers able to engage in clinical judgment required of the Registered Nurse. The nursing program includes a specific nursing course that provides a foundation for critical thinking/clinical judgment in nursing then builds on critical thinking and questioning throughout the nursing courses.

**Incorporation of the California Board of Registered Nursing Practice Act,**

**Definition of the Practice of Nursing**

The nursing program incorporates the definition of the practice of nursing as a Registered Nurse as presented in the California Nursing Practice Act, Business and Professions Code, Division 2, Chapter 6, Article 2, Section 2725(2013) which states:
The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

> (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
> (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

The nursing program also applies the definition of nursing presented by the American Nurses Association (2010) which states: "Nursing is the protection, promotion, and optimization of heath and abilities, prevention of illness and injury, alleviation of suffering though the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations. This definition encompasses four essential characteristics of nursing: human responses or phenomena, theory application, nursing actions or interventions, and outcomes." (p. 10).

**Unifying Theme of the Nursing Program**

The unifying theme for the College of the Sequoias Associate Degree Nursing Program is what the new graduate needs to know and do to provide safe care in the current healthcare environment as a Registered Nurse. This provides the framework that ties together all parts of the curriculum. The overall goal of all components of the nursing program is for students to achieve the end-of-program learning outcomes and competencies which are based on evidence from the nursing and healthcare literature that validates the importance of each learning outcome. To demonstrate this evidence, an explanation of the literature used to develop each learning outcome is provided. The nursing courses are leveled throughout the program to meet that goal. Each course has expected levels of achievement (course learning outcomes and competencies) that serve as defined points for evaluation of student achievement.

Maintaining a program centered on, and organized around, current nursing practice is achieved by constant research and updating related to what is needed to provide safe care in a variety of healthcare environments. To develop and maintain the Associate Degree Nursing Program curriculum, current trends in nursing and health care as well as traditional standards and values of nursing practice are used as the basis for the end-of-program student learning outcomes

To maintain program currency faculty meet each year to discuss new trends and data that influence nursing care. The program is updated each year as needed based on the evidence from the nationally based literature and from nursing practice in California.

Following are the end-of-program student learning outcomes and competencies; nursing course descriptions; and nursing course learning outcomes and competencies for the College of the Sequoias Associate Degree Nursing Program.

## End-of-Program Student Learning Outcomes for the Associate Degree Nursing Program (NURS 121 – NURS 175)

1. Provide safe, quality, compassionate, evidence-based, patient-centered nursing care to diverse patients across the lifespan in a variety of healthcare settings.
2. Engage in clinical judgment when making patient-centered care and other nursing decisions.
3. Participate in quality improvement processes to improve patient care outcomes.
4. Participate in teamwork and collaboration with all members of the healthcare team including the patient.
5. Employ information management systems and patient care technology to communicate, manage knowledge, mitigate error, and support clinical judgment.
6. Use leadership, management, legal, and ethical principles to guide practice as a Registered Nurse.

**Policy & Procedure Committee**
Approved/Reviewed/Revised: 8/2020, 10/2020.

## Program Outcomes (NURS 161 – NURS 166)

By the end of each semester and at the completion of the program, the student/graduate will:

**Program Outcome #1**: Demonstrate a caring approach that validates the worth and dignity of the client through the effective use of interpersonal processes.

Semester 1 – Recognize and respect the individual dignity and worth of the client.

Semester 2 – Demonstrate effective interpersonal processes in caring for clients with diverse backgrounds.

Semester 3 – Incorporate clients' value/belief systems in providing care.

Semester 4 – Create a climate of acceptance, respect, and positive regard.

**Program Outcome #2**: Safely perform nursing care to assist the client to promote, maintain, or restore an optimal level of well-being.

Semester 1 – Identify and utilize concept of safe client care with emphasis on the older adult.

Semester 2 – Incorporate advancing knowledge of safety principles for clients across the life span.

Semester 3 – Incorporate advancing knowledge of emotional, physical, and environmental safety to restore clients' optimal well-being in a variety of settings.

Semester 4 – Maintain the emotional, physical, and environmental safety for clients with complex barriers to optimum wellness.

**Program Outcome #3**: Satisfactorily perform the psychomotor skills necessary in the delivery of nursing care to clients across the life span.

Semester 1 – Demonstrate basic skills with minimal assistance, stating rationale.

Semester 2 – Demonstrate a mastery of basic nursing skills and modify skills relative to client age.

Semester 3 – Prioritize and perform more complex nursing skills without assistance.

Semester 4 – Select, perform, and evaluate advanced nursing skills which promote, maintain, and restore the client's optimal well-being.

**Program Outcome #4**: Employ critical thinking in applying the nursing process to manage client care.

Semester 1 – Identify elements of critical thinking in each of the steps of the nursing process.

Semester 2 – Utilize the nursing process to construct a plan of care.

Semester 3 – Participate in interdisciplinary care planning for the client.

Semester 4 – Demonstrate critical thinking skills when managing the plan of care for complex clients.

**Program Outcome #5**: Effectively integrate written, verbal, and nonverbal communication modalities in complex client and health team interactions.

Semester 1 – Demonstrate basic verbal, nonverbal, and written communication skills in the care of clients.

Semester 2 – Use age appropriate and therapeutic communication techniques in working with families.

Semester 3 – Apply empathetic and assertive communication techniques in the care clients.

Semester 4 – Optimize opportunities to participate in verbal, nonverbal, and written communication in the multidisciplinary team.

**Program Outcome #6**: Implement principles of health teaching when promoting wellness.

Semester 1 – Identify and apply the basic principles of client education. Recognize their use in caring for older adults.

Semester 2 – Develop and implement individualized client teaching plans with emphasis on health promotion and maintenance.

Semester 3 – Design and implement multiple client teaching plans with emphasis on health promotion and restoration.

Semester 4 – Facilitate client's health education. Evaluate effectiveness and institute changes as identified.

**Program Outcome #7**: Apply principles of growth, development, and adaptation that will result in optimal well-being.

Semester 1 – Identify principles of growth, development, and adaptation in providing nursing care that maintains optimal well-being.

Semester 2 – Differentiate effective and ineffective growth, development, and adaptation when providing nursing care.

Semester 3 – Apply principles of health adaptation when assisting clients in achieving optimal well-being.

Semester 4 – Employ age-specific adaptations when promoting, maintaining, and restoring optimum wellness with clients.

**Program Outcome #8**: Apply legal, ethical, and professional practices while acting as client advocate in providing nursing care to a diverse population.

Semester 1 – Identify and apply the legal, ethical, and professional foundations of nursing practice.

Semester 2 – Expand on the legal, ethical, and professional role of the nurse including the role of client advocate.

Semester 3 – Utilize complex, legal, ethical, and professional guidelines in providing client care.

Semester 4 – Model the legal, ethical, and professional behaviors of the registered nurse.

**A-4**

**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE:** NURSING PROCESS

**PURPOSE:** To describe the Nursing Process as a pervasive theme which provides structure to the nursing curriculum.

**DESCRIPTION:** The Nursing Process is a problem-solving process that requires the use of decision making, clinical judgment, and other critical thinking skills to assess, identify and prioritize client problems, to assign nursing diagnoses with measurable outcomes, to plan care systematically, and to implement and evaluate the results of the care given.

The steps of the Nursing Process include:

1. <u>Assessment</u> Establishing a data base by continuously gathering objective and subjective information about the client's actual and potential problems and needs. The data base includes nursing history, physical assessment, review of the client record and nursing literature, and consultation with the client's support system and the healthcare team. The data base is continuously updated, validated, and communicated

2. <u>Analysis</u> A nursing diagnosis is formulated by analyzing client data related to real or potential problems and needs and the factors which contribute to or cause these problems. Client coping patterns and strengths are also analyzed. When data analysis reveals an actual or potential health problem that nursing interventions can prevent or resolve, the problem is termed a "nursing diagnosis". During this step of the Nursing Process, the nurse interprets and analyzes client data, identifies client strengths and health problems, formulates and validates nursing diagnoses, and prioritizes client problems and needs.

3. <u>Planning</u>: Establishing client goals/outcomes by the nurse, working with the client, that prevent, reduce, or resolve problems identified through assessment and analysis/diagnosis. Includes the determination of related nursing interventions most likely to assist the client in achieving these goals. In addition, a comprehensive plan of care also specifies the nursing assistance needed by the client to meet human needs and the nursing interventions dictated by the plan of medical care. The nurse also communicates the plan of care.

4. <u>Implementation</u>: Involves carrying out the plan of nursing care, including all interventions performed by nurses to promote wellness, prevent disease or illness, restore health, and facilitate coping with altered functioning. During this step of the

Nursing Process, the nurse carries out the plan of care, continues data collection and modifies the plan of care as needed, and communicates and documents care.

5. Evaluation: This step involves the measuring of the extent to which client goals have been met (if nursing interventions were effective in preventing, reducing, and/or resolving client problems). Together, the nurse and client identify factors that either positively or negatively influenced goal/outcome achievement. Client response to the plan of care determines whether nursing care should be continued as is, modified, or terminated. If evaluation points to the need to modify the nursing care plan, then the accuracy, completeness, and relevance of the assessment data, as well as the appropriateness of client diagnoses, goals, and nursing interventions, should all be carefully reviewed and modified. During this step of the Nursing Process the nurse compares actual outcomes with expected outcomes of care, evaluates client compliance, records and communicates client responses to care, and reprioritizes client problems and needs as indicated.

In addition to the nursing process the nursing program also uses Tanner's Clinical Judgement Model (2006) as noted in Linda Caputi's book, "Think Like a Nurse Handbook", 2018:

1. Noticing:
   - Involves data collection about the patient or a healthcare situation
   - Use of assessment techniques including observation and auscultation and thoughtful questioning
2. Interpreting:
   - Make sense of the information gathered during the noticing aspect of care
   - Interpret what the data means—ANALYZE
   - The nurse uses a variety of thinking skills to make sense of the data collected and thinking can be influenced by things such as nurse background and experience, the healthcare environment, and specifics about the patient.
   - This is a very important step because the conclusions at which you arrive based on the data you collect, determine actions you will take for the patient or to solve a healthcare environment problem.
3. Responding:
   - The conclusions you made based on interpretation of the data determine how you will respond to the situation.
   - The decisions made in the interpreting step are important for deciding how and to what degree you will respond.
   - Example: You determine that the patient is due to be ambulated. Now you must ambulate the patient but also decide the distance and length of time you will ambulate the patient.

4. Reflection:
    - Reflective thinking is important to learning and growing as a nurse.
    - Review your thinking and its effectiveness to more deeply understand your ability to think a problem through!
    - Support self-evaluation and fosters growth in your ability to use critical thinking and clinical judgement

**<u>2 Types of Reflection in this step:</u>**

1. **Reflection-IN-action.** Occurs while you are providing care for the patient or addressing the healthcare environment issue. Collect cues from the patient that will let you know whether what you are doing is or isn't working, or what you need to modify for this particular patient.

2. **Reflection ON action.** Occurs upon completion of the task. Critical to improving thinking. In this step you mentally review what just happened to determine what went right and what went wrong. Use what you learn to improve your thinking abilities and your nursing knowledge base; learn from mistakes and learn how to improve care!

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED:** 2/2004; 2/2010; 11/2013; 2/2021

B-16

COLLEGE OF THE SEQUOIAS
DIVISION OF NURSING AND ALLIED HEALTH

**TITLE**: **CREDIT BY EXAMINATION**

**PURPOSE**: This policy describes the general procedure for challenging one or more courses within the COS Nursing Program. This policy applies to the advance placement student and military personnel who have held Military Health Care Occupations.

**DESCRIPTION**:

The credit by examination procedure is described in the current college catalog. The student must file a petition for approval to challenge a course by examination with the Admissions and Records Office. This petition must be approved before the Credit by Exam begins.

*Individuals who have held Military Health Care Occupations, specifically: Basic Medical Technician Corpsman (Navy HM or Air Force BMTCP), Army Health Care Specialist (68W Army Medic) or Air Force Independent Duty Medical Technician (IMDT 4N0X1C) may achieve advanced placement into 2nd semester of the nursing program with documentation of education and experience (within the last two years) qualifying them for the specific Military Health Care Occupation and upon successful completion of the challenge option that consists of two (2) parts – theory portion and clinical portion.

Once approval is received, the process in the division is as follows:

1. The challenge option for each course being challenged contains two (2) parts:

   Part 1: Theory portion Part 2: Clinical portion

2. Students wishing to challenge courses within the COS Nursing Program must notify the Director the semester previous to the course they are challenging Refer to AP4235: Credit for Prior Learning; item 6, credit by exam.

3. If a student chooses to challenge a course, ALL portions (theory & clinical) in that course must be challenged.

4. The student must first achieve a score of at least 75% on the written exam for the theory portion of the course being challenged. If the theory score is below 75%, the student must take the course as scheduled.

5. Once the theory portion has been passed with 75% or more, the student must take the clinical part of the challenge option. If a student earns a satisfactory

(Pass) rating on the clinical portion, the grade earned will be the grade achieved on the written portion. If clinical performance is less than satisfactory, the student will take the course as scheduled.

The clinical portion of the challenge option will be comprised of the challenge procedure of the course.

6. The Student Evaluation Record (SER) will be used to determine the student's clinical competency. Refer to SER.

7. Where applicable, the student must complete a satisfactory nursing care plan/concept map for each clinical rotation being challenged.

**REFERENCE**: Each course's specific challenge procedures (Attached)
AP 4235 Credit By Examination

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED:** 8/1999; 2/2004; 9/2004; 5/2007; 5/2008; 2/2012; 10/2012; 10/2013; 4/2016; 5/2021

# Student Conduct and Performance

## STUDENT ESSENTIAL TECHNICAL STANDARDS

In compliance with the Americans with Disabilities Act, students must be, with or without reasonable accommodations, physically and mentally capable of performing the essential technical standards of the program. 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 the necessary accommodations or modifications can reasonably be made.

The following Essential Technical Standards identify essential eligibility requirements for participation in the College of the Sequoias Registered Nursing Program:

**Work Hours:**

· Able to work up to two 12 hour days per week at hospital sites.

**Work Environment**:

· Exposure to hazardous material and blood borne pathogens requiring safety equipment such as masks, head coverings, glasses, rubber and latex gloves, etc.
· Must be able to meet hospital and college performance standards.
· Must travel to and from training site.

**Cognitive Abilities:**

· Understand and work from written and verbal orders.
· Possess effective verbal and written communication skills.
· Understand and be able to implement related regulations and hospital policies and procedures.
· Possess technical competency in patient care and related areas.
· Perform calculations to determine correct dosage or flow rate.
· Speak to individuals and small groups.
· Conduct personal appraisals and counsel patients and families.

**Physical Demands:**

-Standing and/or walking, continuous, during all phases of patient care.
· Bending, crouching, or stooping several times per hour (e.g., emptying catheter drainage bags, checking chest tube containers, positioning of wheelchair foot supports, during bathing, during dressing changes, during feeding, catheterizations, etc.)

· Lifting and carrying a minimum of 30 pounds several times per hour.

· Lifting, frequently, with weight lifted ranging from 100 – 300 pounds (approximately), rarely 300+ pounds. Lifting should always be done with help.

· Reaching, frequently, overhead, above the shoulder 90 degrees (e.g., during bathing, manipulating IV equipment, obtaining supplies, transferring patient into or out of bed, etc.)

· Twisting, frequently (e.g., transferring patients from chair to bed, feeding patients, performing some sterile procedures, etc.)

· Pushing patients, objects, and equipment, frequently, up to 45 pounds effort (e.g., pushing beds, gurneys, and wheelchairs, etc.)

· Pulling patients, objects, and equipment, frequently, up to 70 pounds effort (e.g., positioning patients in bed, during transfer to and from gurneys, wheelchairs, commodes, etc.)

· Utilizing eyesight to observe patients, manipulate equipment and accessories and/or evaluate radiographs for technical quality under various illumination levels (i.e., illumination varies from low levels of illumination to amber/red lighting to bright light levels)

· Hearing to communicate with the patient and health care team.

· Utilizing sufficient verbal and written skills to effectively and promptly communicate with the patient and health care team.

· Manipulating medical equipment and accessories, including but not limited to switches, knobs, buttons, and keyboards, utilizing fine and gross motor skills (e.g., preparing and administering medications, utilizing medication delivery systems with or without scanning devices, setting up and monitoring IV equipment such as infusion pumps (40 pounds effort), cardiovascular hemodynamic equipment (40 pounds effort), suction equipment (30 pounds effort), performing dressing changes and other procedures, manipulating oxygen equipment, and various other items ranging from 2 – 40 pounds effort).

· Performing the assigned training related tasks/skills responsibilities with the intellectual and emotional function necessary to ensure patient safety and exercise independent judgment and discretion.

· Utilizing the above standards/functions to respond promptly to the patient needs and/or emergency situations.

Upon admission, a candidate who discloses a disability and requests accommodation will be asked to provide documentation of his or her disability for the purpose of determining appropriate accommodations, including modification to the program. The College will provide reasonable accommodations**, but is not required to make modifications that would substantially alter the nature or requirements of the program or provide auxiliary aids that present an undue burden to the College**. To matriculate or continue in the curriculum, the candidate must be able to perform all the essential functions outlined in the Student Essential Technical Standards either with or without accommodation.

Additional assessments may be necessary during the program if your physical, cognitive, or emotional circumstances change. Please see the categories of **pregnancy** and **extended illness/surgery**.

## BRN Standards of Competent Performance

The COS nursing program adopts and adheres to the legal standards of competent performance as defined by the California Board of Registered Nursing and the Business and Professions Code Title 16. Licensed registered nurses as well as nursing students in the State of California are required to meet the following standards:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological, and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

Excerpt from Calif. Code of Regulations, Title 16-Chapter 14 (Authority Cited: Business and Professions Code, Section 2715; Reference: Business and Professions Code, Sections 2725 and 2761).

**A-5**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** ANA CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS

**PURPOSE:** To describe the American Nurses' Association ethical standards.

**DESCRIPTION:** The ANA's position and policy statement on ethical standards for Registered Nurses is as follows:

The development of a code of ethics is an essential characteristic of a profession and provides one means whereby professional standards may be established, maintained, and improved. A code indicates a profession's acceptance of the responsibility and trust with which it has been invested. Each practitioner, upon entering the profession, inherits a measure of that responsibility and trust and the corresponding obligation to adhere to standards of ethical practice and conduct set by the profession.

A code of ethics for the American Nurses' Association (ANA) was originally formulated and adopted by the membership in 1950. The original code has undergone revisions in the intervening years. In 1959, members of the National Student Nurses' Association (NSNA) voted at their convention to endorse the code of ethics of the American Nurses' Association as applicable also to students enrolled in nursing programs. An official representative for the NSNA participated in the discussions held by the ANA's Committee on Ethical Standards for revisions of the code in 1960, 1968, 1976, and 1985.

In June 2001, the ANA House of Delegates voted to accept nine major provisions of a revised *Code of Ethics*. In July 2001, the Congress of Nursing Practice and Economics voted to accept the new language of the nine provisions with interpretive statements resulting in a fully approved revised *Code of Ethics for Nurses with Interpretive Statements.* The revision of the *Code of Ethics for Nurses with Interpretive Statements, a modification of the nine provisions and interpretive statements of 2001, is approved by the ANA Board of Directors (November, 2014).* The *Code of Ethics for Nurses with Interpretive Statements* was published January 2015.

The *Code of Ethics for Nurses with Interpretive Statements* provides a framework for nurses to use in ethical analysis and decision-making. The Code of Ethics establishes the ethical standard for the profession. It is not negotiable in any setting nor is it subject to revision or amendment except by formal process of the House of Delegates of the ANA.

Ethics is an integral part of the foundation of nursing. Nursing has a distinguished history of concern for the welfare of the sick, injured, and vulnerable and for social justice. This concern is embodied in the provision of nursing care to individuals and the community. Nursing encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, and communities. Nurses act to change those aspects of social structures that detract from health and well-being. Individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession but also to embrace them as a part of what it means to be a nurse. The ethical tradition of nursing is self-reflective, enduring, and distinctive. A code of ethics makes explicit the primary goals, values, and obligations of the profession.

The *Code of Ethics for Nurses with Interpretive Statements* serves the following purpose:
- It is a succinct statement of the ethical values, obligations, duties and professional ideals of nurses individually and collectively.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.

Provision 1 – (RESPECT FOR OTHERS): The nurse, practices with compassion and respect for the inherent dignity, worth and unique attributes, of every person.

Provision 2 – (COMMITMENT TO THE PATIENT): The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Provision 3 – (ADVOCACY FOR THE PATIENT): The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

Provision 4 – (ACCOUNTABILITY AND RESPONSIBILITY FOR PRACTICE): The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

Provision 5 – (DUTIES TO SELF AND DUTY TO OTHERS): The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and to continue personal and professional growth.

Provision 6 –(CONTRIBUTION TO HEALTHCARE ENVIRONMENTS): The nurse through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Provision 7 –(ADVANCEMENT OF THE NURSING PROFESSION): The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

Provision 8 –(PROMOTION OF COMMUNITY AND WORLD HEALTH): The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

Provision 9 – (PROMOTION OF THE NURSING PROFESSION): The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

**Reference**: American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements*, Silver Spring, MD: American Nurses Publishing, 2015.
**www.nursebooks.org ; www.nursingworld.org**

***Policy & Procedure Committee*****DATE APPROVED/REVIEWED/REVISED:** 2/2004; 2/2010; 11/2013, 10/2016, 08/2020, 10/2020

**A-25**

**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE:** San Joaquin Valley Nursing Education Consortium (SJVNEC) Clinical Placement System

**PURPOSE:** To describe the means by which student clinical placements are managed by area health care facilities, the responsibilities of participating SJVNEC members, and the responsibilities of College of the Sequoias staff, faculty, and students.

**DESCRIPTION:**

Senior Secretary:

The Senior Secretary of the division will maintain current student data through the Online Document Management System, to include:

1. Immunizations status.
2. Current car/truck Insurance.
3. Current CA driver's license.
4. Active AHA CPR card.
5. Current TB skin test.
6. Background check and urine drug screen completion.

The Online Document Management System automatically generates emails to students reminding them of their verification status and letting each individual student know when a specific record in the system is set to expire. The Online Document Management System will send out an administrative email to the division senior secretary at set time intervals (30-days before, 15-days before, the day of) sending notification of the status of students who have records set to expire. Each student is required to update the Online Document Management System and upload the required documentation before that specific record is set to expire. Any student who fails to upload and record new verifications will be notified by the Online Document Management System as well as the division senior secretary.

Every February, Consortium Request Spreadsheets will be created and distributed for each nursing course. The semester team members are responsible for completing the Consortium Request Spreadsheet for each clinical rotation to include clinical sites used, dates of rotations, observation experiences, assigned instructor, orientations dates, post-conference times, and any days/dates students are not on the clinical units. The deadline for submission of the Consortium Request Spreadsheets is by the end of February each year. The Director of Nursing will input data from the Consortium Request Spreadsheets into the SJVNEC computerized clinical placement system. The deadline for clinical rotation data input is the middle of March each year.

**Clinical Faculty**

Each nursing team leader, working with full-time and adjunct clinical faculty will complete the Consortium Request Spreadsheets for the Fall, Spring, and Summer semesters of the upcoming year. Information to be included is:

1. Identify semester term and year
2. Dates of each rotation (begin with the first a day of patient care, not orientation date)
3. List any days/dates the students will not be on the unit(s) (e.g., holidays, ATI testing, skills lab day, etc.)
4. Number of students in the rotation
5. Agency/Facility and nursing units utilized
6. Float units (e.g., Endoscopy, OR, Wound Nurse, Home Health, etc.)
7. Locations of observational experiences

It is the responsibility of the clinical faculty to insure that students under their supervision have current information documented in their Online Document Management System. Students whose information is outdated or incomplete will be excused from the clinical lab until the information is complete and current. If the number of absences exceeds the absence policy (see policy B-19) students may fail the clinical lab.

**Nursing Students**

All nursing students are informed of the information that must be kept current for clinical lab placement, beginning with orientation to the first semester course. Students who allow their required documents to lapse will not be allowed in clinical lab until their information is current and on file with the Online Document Management System.

It is the students' responsibility to maintain current required documents in the Online Document Management System (see Policy B-4). Failure to do so will result in dismissal from clinical experiences until the information is received which will result in clinical absences. Required documents must be current and uploaded to the Online Document Management System regardless of school breaks, holidays, or summer break. Example: TB skin test is due July 1st. The student has until July 1st to submit the test results to the Online Document Management System. Any required documents that expire during school holidays and/or breaks, are due no later than the first day the semester begins.

Students will place their background check and urine drug screen orders through Online Document Management System by visiting **www.sjvnec.com** web site. See attached SJVNEC information.

If the student does not complete or does not pass the Background Check and Urine Drug Screen or refuses to comply with this policy, then the student understands that the Nursing Program will make reasonable efforts to secure alternative clinical experiences for the student but these experiences may not be available. Lack of available clinical experiences will prevent the student from completing the clinical objectives of the Nursing Program resulting in failure of the course.

**Reference:** SJVNEC Background Check/Drug Screen Process
San Joaquin Valley Nursing Education Consortium
Reporting Process

***Policy and Procedure Committee***
**Date Approved/Reviewed/Revised:** 3/2010; 12/2010; 3/2013; 10/2016

**B-3**

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** STUDENT ACCOUNTABILITY AND COMMITMENT

**PURPOSE:** The purpose of this policy is to describe the accountability and commitment required of students in the Nursing program.

**DESCRIPTION:**

The California Nurse Practice Act requires its practitioners to be fully accountable for their clinical decisions and actions. Each **nursing student is legally accountable** to the level of her/his preparation and does not function under the licensure of another nurse. Accountability is the quality or state of being responsible and answerable for one's decisions, actions, and behaviors. Nurses committed to interpersonal caring hold themselves accountable for the well-being of clients entrusted to their care and are accountable to their patients and their colleagues. They are legally and ethically responsible for any failure to act in a safe and prudent manner. The California Nurse Practice Act gives nurses and student nurses the right to perform a broad range of dependent and independent functions. Enjoying this privilege means that they also assume legal and ethical responsibility for safe and effective performance at all times. Standards of practice have been developed by professional organizations, which serve as guidelines in maintaining quality practice.

For the COS nursing student, accountability means that she/he will be, at all times, willing to learn and practice nursing with commitment and with personal integrity. It means being attentive and responsive to the needs of individual clients and colleagues. As the student acquires nursing knowledge and skills, she/he will assume professional responsibilities and develop competencies which will shape her/his attitude of caring. This attitude of caring and of being accountable develops as the student becomes sensitive to the ethical and legal implications of nursing practice. In nursing, we share a common goal of providing the highest quality of care to every individual entrusted to our care. To successfully achieve this goal, the student should be dedicated to the following actions:

a. Sharing ideas, learning experiences, and knowledge,
b. Upholding the philosophies and policies of the college, the nursing program, the clinical agencies within which the student practices, and the California Board of Registered Nursing,
c. Maintaining the highest ideals, morals, personal integrity, and ethics possible,
d. Making a commitment to being fully accountable, responsible, and answerable for her/his academic and clinical decisions, actions, and behaviors.

**REFERENCE**: BRN Policy Statements (located in the Student Handbook)
***Policy & Procedure Committee/*** **DATE APPROVED/REVIEWED/REVISED:** 5/1999; 1/2001; /2004; 5/2011; 2/2018

# COLLEGE OF THE SEQUOIAS
## DIVISION OF NURSING AND ALLIED HEALTH

**TITLE**: STUDENT LEGAL AND ETHICAL REQUIREMENTS

**PURPOSE**: To provide guidelines for the nursing student regarding legal and ethical requirements to clients, to clinical facilities, to the RN program, and to faculty.

**DESCRIPTION**: Nursing students must always:

1. Be prepared for clinical assignments. Being prepared for clinical assignments consists of, but is not limited to: having completed patient and medication research, completed appropriate paperwork prior to patient care, adhering to nursing student dress code requirements, and bringing required necessary supplies and equipment as outlined in the Clinical Information Packet for each clinical rotation.

2. Consider all client/family information as strictly confidential. Such information shall not be related, posted, discussed or communicated by any means, (e.g., conversation, telephone calls, texting, e-mails, or social networking media), with anyone except instructors, peers, and significant hospital personnel.

3. Submit reports on patients to instructors using patient initials only, never the patient's full name.

4. Remove the name of the patient from copies of documents used in conjunction with learning activities.

5. Consult with the instructor if the student believes that circumstances regarding the patient will interfere with giving effective care (e.g., personal friend, family member).

6. Maintain a professional attitude at all times when caring for patients.

7. Communicate any criticism of an agency, an individual, or an instructor to the Director of the Nursing Program, and refrain from critical discussion outside the school or with other students.

8. Be honest at all times. A student who would cheat on a test ultimately is cheating patients. A student who is less than completely honest in the clinical area jeopardizes patient safety and is subject to termination from the nursing program.

9. Be responsible for his/her own learning, and help promote an atmosphere, which facilitates maximum learning for his/her classmates. A student will not obstruct the learning process of others by causing undue anxiety for any reason, including monopolizing instructor's time.

10. Act professionally.

11. Seek necessary patient referral (with instructor approval) to help solve patient's social problems.

12. Be responsible for reading and familiarizing self with printed college and nursing department policies and procedures.

13. Be aware that continued violations of this policy may be grounds for dismissal from the Nursing program.

14. Maintain current documentation in the Online Document Management System.

15. If a student is repeating a nursing course, the student must meet with the student success coordinator within in the first two weeks of the semester starting.

**REFERENCE**: BRN Policy Statements

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED**: 11/24/87; 11/98; 11/2001; 2/2004; 5/2008; 12/2010; 10/2016

**B-5**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

TITLE: Standards of Student Clinical Conduct/HIPAA Compliance

PURPOSE: This outlines the policy regarding student conduct and responsibility in the clinical setting.

PROCEDURE:

1. "Nursing services may be rendered by a student when these services are incidental to the course of study of one of the following:
   (a) A student enrolled in a board-approved pre-licensure program or school of nursing,
   (b) A nurse licensed in another state or country taking a board-approved continuing education course or a post-licensure course."

   Reference: Calif. Board of Registered Nursing. *Nurse Practice Act;* Article 2; Section 2729; 2016

2. Nursing students are held to the same standards of care as those rendered by the graduate nurse. Nursing care is measured against the BRN "Standards of Competent Performance."

3. Every person has the right to expect competent care even when such care is provided by a student as part of clinical training.

4. The instructor will be the ultimate authority to judge student performance in the clinical setting. It is mandatory that the instructor have unquestioned authority to take immediate corrective action in the clinical area with regard to student conduct, clinical performance, and patient safety (*Nurse Practice Act*).

5. A student may be refused access to any clinical facility for infractions of facility rules and regulations.

6. Students must strictly adhere to HIPAA guidelines (Health Information Portability and Accountability Act) in all clinical facilities. HIPAA is a federal law created in 1996. The key focus of HIPAA is to protect patient privacy by any unauthorized (inappropriate) access, use or disclosure of Patient Health Information (PHI). <u>Examples of PHI include</u>:
   - Names
   - Geographic subdivisions smaller than a state
   - Dates including birthdate, admission date, discharge date, date of death, and all ages over 89
   - Telephone numbers
   - Fax numbers
   - Electronic mail addresses/social networking sites (at NO time should PHI be photographed/cut/copied/pasted and sent to a personal access device of any kind)
   - Social security numbers
   - Medical record numbers
   - Health plan beneficiary numbers
   - Account numbers

- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locater (URL)
- Biometric identifiers, including finger or voice prints
- Full face photographic images and any comparable images
- Internet Protocol address numbers
- Any other unique identifying number characteristic or code

HIPAA Privacy-Friendly Practices:

- Avoid talking in public areas. Be aware of who can hear conversations.
- Keep patient information out of public areas.
- Ask the patient if they want their care discussed while a visitor is present.
- Use privacy curtains when available.
- Shred or destroy PHI before leaving the facility.
- Secure records in all locations.
- Use passwords and keep them confidential.
- Logoff systems when leaving the computer.
- Keep computer screens out of public view.
- Remember email is not confidential and is retrievable.
- Access information on a "need to know" basis in order to perform job duties.
- Report any perceived misconduct or breaches of confidentiality (actual and/or potential) (e.g., facility compliance officer, instructor, etc.).
- Remember individuals' right to privacy at all times.

7. HIPAA violations can result in personal fines up to **$25,000** per patient. The COS nursing faculty recognize a HIPAA violation as a serious breach of patient privacy. Disciplinary action will be determined on a case-by-case basis and could include dismissal from the program.

8. A student involved in an adverse occurrence which causes or has the potential of causing serious harm to another (patient, staff, visitor, other student, etc.) may be asked to withdraw from the program. Such an event will be documented on the "Critical Incident" form and in the student's Student Evaluation Record (SER). The instructor will complete a facility incident report/form as required by the clinical agency.

REFER TO: BRN "Standards of Competent Performance"
COS RN Program Policy B-3 and B-4

**Policy & Procedure Committee**
**APPROVED/REVIEWED/REVISED**: 5/1987; 11/1998; 11/2001; 2/2004; 5/2011; 2/2012; 10/2016; 3/2018

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: **IMAGE OF THE NURSING STUDENT**

**PURPOSE: This policy describes the standards of professional behavior and appearance required of all COS nursing students.**

**DESCRIPTION**

**Student Attire for Direct Client Care**

Only the COS approved student uniform is to be worn in the clinical area or for special events as designated by the Director, Division Chairperson, and/or semester faculty, according to the following specifications:

1. Uniforms are to be clean, pressed, and in good repair at all times. All undergarments (e.g., bra, underwear, socks, t-shirt, etc.) must be white or beige. Any cultural or religious head garments must be clean, pressed, solid white or black (no patterns, designs or beading), tucked into uniform top, and in good repair at all times.
2. Uniforms should not be worn outside the clinical area (i.e. to a place of employment, to the grocery store, while shopping, etc.). If the student is required to return to the COS campus during or after clinical, a clean lab coat may be worn over the uniform.
3. Shoes are to be of **white leather** with rubber heels. No clogs, canvas tennis shoes, high tops, boots, or shoes with open toes or heels are permitted. Shoes and laces must be clean and in good repair at all times.
4. A wrist watch with a second hand, bandage scissors, stethoscope, and name badge are considered essential parts of the uniform.
5. Hair should be clean, styled conservatively, away from face, and up off the neck/collar. Extreme hair fashions are not acceptable including trendy hair coloring. Only neutral-colored, plain hair clips may be worn. Ribbons, colored bands, or other hair ornaments are not allowed. Male students must keep beards and mustaches clean and neatly trimmed. Facial hair may not be any longer than one inch from the face.

~~6.~~ Body art/tattoos must be completely covered whenever possible (e.g., long sleeve white t-shirt, body make-up, bandages/bandaids, dressings, etc.).

7. Acceptable jewelry is limited to a wrist watch, wedding ring/set and one pair of plain, small (no >3mm in size), gold, silver, or pearl studs for pierced ears. Visible pierced areas other than earlobes may not be ornamented, including the tongue/nose/eyebrow/cheek/lip, etc.
8. Gum chewing is not permitted while wearing the school uniform or professional attire with the short lab coat.
9. Cologne and scented cosmetics **CANNOT** be worn when providing patient care as these scents may be offensive to an ill patient.
10. The breath of a student who smokes may be offensive to patients. The scent of smoke should not be detectable on the breath or clothing.
11. The approved short lab jacket may be worn in the clinical setting but not while engaged in direct patient care.
12. The COS-issued name badge must be worn and visible at all times while the student is in a clinical facility (whether dressed in uniform or lab jacket).

13. A white, long sleeved knit shirt is permissible to be worn under the school uniform. No logos or lettering may be present on the shirt.
14. The fingernails are to be kept short, clean, and well-manicured. Students may wear only clear, white or neutral shades of nail polish, but old nail polish must be removed every four (4) days and new polish applied. Artificial nails of any type must not be worn while providing direct patient care.
15. **No false eyelashes** of any kind may be worn while in clinical.
16. Some clinical areas may have more stringent requirements. The students will follow their clinical guidelines. Any deviations from any of the above (e.g. "religious ornamentation, or medical alert bracelets") must be approved by the clinical instructor.

**Student Attire for Clinical Experiences Outside the Hospital**

1. The student must wear professional clothing, this includes the COS polo shirt and the COS-issued name badge. Professional clothing may include skirts, or pants (ankle length), in good repair which fit properly and are clean and pressed, and represent conservative attire. Length of skirts must be no higher than the knees and stockings are required. Jeans, denims, sweatshirts, sweatpants, Capri pants, tank tops, low-cut tops or dresses, halter-tops, miniskirts, and jumpsuits are not considered professional attire. Lab jacket or Vest optional.

2. See items 5 – 9 in the previous section.

**Student Attire for the Psychiatric/Mental Health Setting**

1. The student must portray a positive professional RN image. In psychiatric nursing, uniforms are not worn so as to de-emphasize the fact that the client is "sick". Professional (and appropriate) casual street clothing is worn which helps to reinforce an environment that is as "normal" as possible. Clothing should be comfortable. The student should not wear a lab jacket over their street clothing unless instructed to do so. Any cultural or religious head garments must be clean, pressed, solid white or black (no patterns, designs or beading), tucked into shirt/blouse, and in good repair at all times.

The following are **NOT** considered professional attire:

- Sun dresses, backless or open back tops, no open work dresses or blouses, halter-tops, midriffs, t-shirts, or tank tops
- Capri or chopped pants (slacks/pants must be ankle length)
- Shorts
- Opened toed shoes, sandals, slides, clogs or thong type of footwear (shoes must have some type of back. Tennis shoes may be worn as long as they are clean and in good repair)
- Jeans of any type or color
- Sweat suits
- White leggings, scarves, dangling earrings (earrings must be "posts" only and only **one** per ear and placed in the earlobe)

3. Sleeveless dresses and tops must not gap or be revealing at the neckline or armholes so as not to show any undergarments. Necklines must be modest.

4. The COS-issued name badge must be worn and visible at all times while the student

is in any psychiatric/mental health setting.

5. Hair that is collar length or longer must be worn back away from the face. Long hair is a safety issue with aggressive clients.

5. Fingernails: See #9 under “Student Attire for Direct Client Care”

6. Students who present to any of the psychiatric/mental health settings without the appropriate attire will not receive a clinical assignment and may be sent home. This will be counted as a clinical absence.

**Professional Behaviors**

The COS Nursing student is expected to conduct him/herself in a professional manner at all times while in uniform and/or while representing the school. The following standards of professionalism are considered mandatory for all nursing students:

1. Preparation (for both lectures and clinical)
2. Effective communication (both verbal and non-verbal)
3. Enthusiasm/positive attitude
4. Effective team work/cooperation
5. Accepts and benefits from constructive criticism
6. Recognition of the impact of one’s behavior on others, especially patients; modification of inappropriate behavior
7. Accountability/ legal and ethical responsibilities
8. Respectful and courteous at all times

**Failure to Meet These Standards**

If, in the estimation of the Director, Division Chair, and/or faculty, the student fails to maintain these standards, the student will be counseled and may be sent home from a clinical setting and charged with a clinical absence. Continued violations of this policy can result in clinical failure.

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED**: 12/1998; 11/1999; 11/2000; 11/2001; 2/2004; 5/2006, 5/2008; 4/2010; 9/2013; 11/2015; 5/2016; 10/2017; 10/2018; 11/5/18

**B-19**

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: ATTENDANCE/PARTICIPATION AND PUNCTUALITY POLICY

## PURPOSE

The purpose of the attendance/participation and punctuality policy is to ensure quality education for the student. Theory hours, skills lab hours, and clinical attendance is expected of all students and required by the COS Associate Degree Nursing Program curriculum approved by the Board of Registered Nursing (BRN). Due to the large volume of material covered each day, and because clinical laboratory experience validates learning objectives, it is expected that students will attend all lectures, clinical and other assigned learning experiences. Regular and timely attendance in the classroom and clinical area is necessary for the student to meet the stated objectives and required hours of each course. Attendance and punctuality are considered important professional responsibilities both in the classroom and in the clinical laboratory, as well as vital components of professional behavior and accountability.

### ATTENDANCE POLICY

A. Reporting an Absence
Students are expected to attend all scheduled theory and clinical classes. In the event of absence, the student will notify the theory and/or clinical instructor as soon as possible. If the instructor cannot be reached, the student should contact the nursing office and report the absence to the Division secretary or leave a voice mail message. Students should refer to the individual instructor's course syllabus and/or clinical guidelines for special instructions regarding reporting of absences. The instructor whose class/clinical was missed is responsible for reporting the absence in the attendance record maintained by the teaching team.

B. Making Up a Missed Exam
If a student is absent on a test day, the student must plan with the testing instructor to take the make-up test within one week from the date of the missed test. The student may receive an alternate test version. Please see the course syllabi.

C. Make Up Test Format
The instructor whose test was missed will determine the testing format for the makeup test (i.e. multiple choice, essay, care plan construction, etc.).
D. Maximum Allowable Absences for Theory and Clinical

*Theory:*

*Lecture hours cannot be made up. The maximum number of lecture hours that may be missed is the number of hours the course meets per week.*

Clinical:
Completion of all make-up hours/activities is mandatory to complete the clinical requirement of the course. A student missing orientation/computer training day, a clinical day, skills lab assignment or simulation assignment will be required to complete a make-up assignment by the end of the clinical rotation. **NOTE:** Failure to attend the first orientation/clinical day and/or mandatory computer training will result in dismissal from the course. The student will not be allowed to progress on to the next clinical rotation until all missed clinical days are made up. A grade of "Incomplete" will be given for the course. **NOTE:** Any missed NURS 166 Leadership

shifts will need to be rescheduled and completed before the end of the rotation.

The clinical instructor determines the appropriate make-up assignment. Examples of make-up assignments may include, but are not limited to: completing computer assisted instruction (CAI), a simulation experience, a continuing education offering, a care plan, attending an additional clinical day at the hospital, a community experience or assigned skills lab hours. The instructor will provide the student with the Clinical Absence Tracking form. The student will use the form to track completion of the missed clinical time. Upon completing the absence make-up time and assignment, the student will return the completed form to the instructor. The instructor verifies completion, signs, and dates the form and attaches form to the student SER. The instructor will ultimately determine if student performance of the make-up assignment has met the clinical objectives and hours for the course to assign a "Pass" grade. Failure to complete the make-up assignment for each clinical absence will result in a "No Pass" grade for the course. Due to policies, computer usage, safety issues, and clinical expectations unique to each clinical setting, attendance on the first clinical day (orientation) of each rotation is mandatory.

Covid-19 Clinical Addendum

If clinical days cannot be completed in the hospital setting related to Covid-19 (clinical site availability or illness), alternate clinical experiences including simulation, virtual simulation, or alternate assignments may be assigned by your instructor. The type of alternate assignment is per the instructor's discretion.

Should a student test positive for Covid-19 they will be required to follow current CDC guidelines or facility protocol/guidelines. Clinical can be made up using simulation or alternate assignments per the instructor's discretion.

If missed clinical hours exceed the percentage of time allowed by the DCA Waiver for indirect patient care, then the instructor may offer the student a grade of "incomplete" (If the student is eligible).

*The maximum number of allowable theory and/or clinical hours which a student can miss per semester is as follows:*

| | Theory Days | | Clinical Days |
|---|---|---|---|
| NURS 121 | 1 | | 2 |
| NURS 123 | 1 | | N/A |
| NURS 124 | 1 | | 1 |
| NURS 133 | 1 | | 1 |
| NURS 134 | 1 | | 2 |
| NURS 135 | 1 | | 1 |
| NURS 143 | 1 | | 1 |
| NURS 144 | 1 | | 2 |
| NURS 164 | 1 | | 2 |

| NURS 166 | 1 | | Any missed Leadership shift will be rescheduled |
|---|---|---|---|

E. Covid-19 Addendum
Students who have the inability to access the class related to technological issues must notify their instructor/professor within 15 minutes of the start of class using the communication method indicated as per your instructor's directions (text, email, canvas etc.).
Students should attempt to join class by any means they are capable including computers, tablets, cell phone, or landline.
Students are considered accountable for all missed course content.
F. Consequences of Absences & Tardies
Make-up of missed clinical time is hour for hour as assigned by the clinical instructor. Make-up of clinical hours does not erase the number of total hours missed. Once the maximal clinical hours have been missed with completion of make-up hours, the student will have no more allowable absences. Consequences of further absences/tardies will be determined by the instructor of record in collaboration with the Director of Nursing.

G. Jury Duty
California Law requires any resident who receives a **Summons for Jury Service** to respond, and failure to respond can subject one to a fine, a jail term or both (California Code of Civil Procedure Section 209). However, the Summons contains a section called **"Not Qualified"**, whereby you may be excused from Jury Service for various reasons, such as not being a citizen of the United States. In addition, several **Postponement** options are available, whereas you can postpone your Jury Service to a future date. For example, a full-time student can request postponement of Jury Service to any future date. The nursing faculty strongly advise that jury duty be postponed. (Deleted: to winter/summer break)

**PUNCTUALITY POLICY**
Tardiness is disruptive to the learning of others and is not acceptable for professional nurses. Tardiness results in unsafe patient care due to lack of or abbreviated shift report. The student is considered tardy if they arrive later than the designated start time at the designated location as defined by each theory and/or clinical instructor. Missing twenty minutes of a class session (theory and/or clinical) is counted as an absence. Being late (1-19 minutes) three times equals one absence. All absences related to tardies will require a make-up assignment as per instructor discretion. A student who is tardy on a test day will not be allowed to enter the classroom until after the testing is completed. The student will be counted absent for the time during which the test was conducted.

## *Policy & Procedure Committee*

**DATE APPROVED/REVIEWED/REVISED:** 2/1987; 5/1987; 12/1991; 5/1993; 11/1998; 11/2000; 4/5/2001; 2/2004; 3/2005; 52006; 5/2007; 3/2008; 3/2009; 5/2010; 1/2013; 4/2015; 5/2016; 10/2016; 2/2017; 8/2017

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** UNACCEPTABLE CLASSROOM BEHAVIOR

**PURPOSE:** This policy describes those classroom behaviors, which are considered unprofessional and unacceptable, the procedure for reporting such behavior, and the consequences to the student who engages in such behavior.

**DESCRIPTION**:
Unacceptable classroom behavior/conduct includes, but is not limited to, the following:

1. Interference with the learning of others.
2. Excessive tardiness.
3. Interruptions by excessively talking during class.
4. Intimidation of students and/or faculty (angry, hostile, or violent behavior).
5. Inappropriate/provocative dress/appearance.
6. Unauthorized use of cell phones or other electronic devices during class time.
7. Dishonesty.
8. Sexual harassment.
9. Use of vulgar/obscene language.
10. Any other behavior deemed by Nursing Faculty as unacceptable and which interferes with the learning or safety of others, including those behaviors and activities listed in the COS Code of Conduct.

If an instructor identifies a student who is demonstrating any unacceptable classroom behavior, the instructor will immediately request that the student leave the classroom and may call for assistance from the COS Police Department when deemed necessary. The student will be counted as absent for the missed class time.

The instructor will, as soon as possible, notify the Division Director and/or Division Chairperson of the incident, and document the incident using the report form. The instructor (along with the semester team members and/or the Division Director or Chairperson) will meet with the student to discuss the consequences of their behavior, which may include a remediation plan, failure, or dismissal from the program.

**REFERENCE**: Unacceptable Classroom Behavior Incident Report

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED:** 2/1987; 5/1987; 11/1998; 2/2004; 11/2011; 4/2015; 3/2018

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

## UNACCEPTABLE CLASSROOM BEHAVIOR INCIDENT REPORT

**Student Name**_____________________ **Semester**_________ **Incident Date**____________

| **Description of Incident:** *(Include Names of Witnesses & Others Involved)* |
|---|
| |

Circle the appropriate action: **Dismissal** or **Remediation plan**

| **Terms/Conditions for Remediation in Order to Avoid Dismissal:** (*Include Mtg Dates & Deadlines)* |
|---|
| |

**Date**___________ **Instructor**_____________________ **Student**____________________
*Signature* *Signature*

**Director's Comments:**

**Date**______________ **Director Signature**___________________________

*Original to Director then Student File* *Copy to Student*

**B-22**

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: The Impaired Nursing Student

**PURPOSE**: To describe the COS Nursing program's policy regarding drug and alcohol screening of applicants and drug, alcohol, and mental health screening of currently enrolled students.

**DESCRIPTION**:
The College of the Sequoias registered nursing program maintains contractual agreements with clinical agencies used in the education of nursing students. These agencies require drug and alcohol testing of employees and students. For incoming nursing students, drug and alcohol screening is required as part of the pre-admission process. For currently enrolled students, drug and alcohol and mental health screening is mandatory when there is probable cause and/or reasonable suspicion to believe that the student is under the influence of drugs and/or alcohol or suffering from a mental disorder while in the classroom and/or clinical settings.

The College of the Sequoias Registered Nursing Program believes that students who are impaired due to the use of alcohol, drugs/chemicals, and/or mental illness may have an impairment in judgment, cognitive abilities, interpersonal interactions, and psychomotor skills to the degree that the student is unsafe to deliver client care and to function safely in the role of a professional nurse. Unsafe nursing practice places the clinical site, their staff, the College, faculty, and student in jeopardy for a potential critical incident.

The California Board of Registered Nursing and the faculty of the College of the Sequoias believe that early intervention for addictions and mental illness is the key to assisting the nursing student to recovery. Early intervention may prevent disciplinary action or the inability to be licensed in the State of California.

Behaviors indicative of alcohol abuse, drug/chemical abuse, or mental illness and which pose a danger to self and others include, but are not limited to the following:

- Physical impairment
- Impaired judgment
- Mental or emotional impairment
- Disruptive actions
- Inconsistent behavior patterns

The College of the Sequoias Nursing faculty believe that:

1. Addiction to drugs and/or alcohol and mental illness is a disease and should be treated as such.
2. Psychosocial and health problems involving addiction, substance abuse, and/or mental health issues may affect a student's academic and clinical performance.

3. An impaired nursing student may be a danger to self, a danger to others, or gravely endanger clients in their care.
4. Individuals with drug, alcohol, and/or mental illness can recover with appropriate therapy.
5. All addiction, drug, alcohol, and/or mental illness issues will be handled and dealt with in the strictest of confidence.
6. Students must be honest about their impairment issues and take responsibility for the consequences of such impairment and work toward the goal of recovery. It is the responsibility of the nursing student to voluntarily seek diagnosis and treatment for any suspected illness.

The College of the Sequoias nursing faculty encourage the nursing student to be aware of any impairment by alcohol, drugs, addiction or mental illness. The student is urged to seek immediate help, realizing that such a problem, if left untreated, could prevent the student from satisfactorily completing the course objectives of the program and obtaining licensure to practice nursing in the state of California (Refer to BRN "Impaired Nursing Students" policy EDP-B-03). The Director of Nursing in collaboration with the Student Health Center can provide information and resources regarding treatment.

**PROCEDURE**:

1. All students accepted into the COS Nursing program will be tested for drug and alcohol use as part of the pre-admission process. If the applicant fails to comply with the pre-admission screening test, his/her application to the Nursing Program will be rescinded. The results are made available to area clinical sites to approve the student for clinical placement in their facility (see Policy B-26 Criminal Background Check/Urine Drug Screening).
2. All students enrolled in the COS Nursing Program must sign a statement agreeing to immediate monitored drug, alcohol, and/or mental health screening upon request of the Director of Nursing and/or a nursing instructor when there is probable cause and/or reasonable suspicion to believe that the student is under the influence of drugs and/or alcohol. Failure to comply with testing will be grounds for immediate dismissal from the program.
3. A positive urine drug test makes the applicant ineligible for admission into the nursing program for the academic year. The applicant will need to reapply and comply with any new selection criteria for the application year. The applicant will need to submit another urine specimen at an additional cost to the applicant if the applicant's urine is diluted and/or the laboratory reports questionable specimen collection.
4. Any currently enrolled student who exhibits signs of alcohol abuse, drug abuse, and/or mental illness will be removed from the classroom or clinical setting. For students exhibiting such behaviors, the following procedure is implemented:
    a. The student is immediately removed from the classroom or clinical area.
    b. The instructor will immediately report the incident to the Director of Nursing.

c. Any student suspected of being impaired may be required to find alternative transportation from the site.
d. The student, at the request of the instructor or Director, will go to the contracted lab immediately upon being requested to do so to provide the necessary specimen. Refusal by the student to submit to testing results in dismissal from the Nursing Program. A positive drug screening test will result in dismissal from the Nursing Program and/or further disciplinary action
e. The instructor will complete a Critical Student Incident form (see policy B-20) identifying the behaviors that led to the dismissal from the classroom or clinical setting with required action plan and/or referral.
f. The student will meet with the Director of Nursing within forty-eight hours of the incident. The student will not be allowed to return to the classroom or clinical site until given permission by the Director or designee. The student will be directed to seek appropriate assistance through a health care provider or licensed chemical dependency/mental health counselor and provide the Director with proof of such treatment.
g. To be considered for re-entry to the Nursing Program the student must provide evidence of participation in a recovery or rehabilitation program for a minimum of six months, provide a release to return to the program at the time of re-entry request, and contract to continue active participation in a recovery program and remain clean and/or sober. Re-entry is on a space available basis.
h. The evidence of continued rehabilitation treatment will be provided on a schedule determined by the Director of Nursing. Failure to submit evidence on the determined schedule will result in dismissal from the Nursing Program and a designated status of ineligible to return to the Nursing Program.
i. A second documented incident of impaired behavior results in dismissal from the Nursing Program and a designated status of ineligible to return to the Nursing Program.
j. If a student who has been readmitted into the nursing program after successfully completing a rehabilitation program fails a subsequent drug and alcohol screen, the student will be dismissed from the program and will be ineligible for readmission.

5. Students displaying behaviors consistent with mental or emotional impairment will be removed from the classroom or clinical setting at the discretion of the nursing instructor and counseled verbally and in writing about the behaviors observed. Suggestions may be made by the instructor, as well as, referrals if indicated. If patient and/or student safety is not compromised, the student may return to the clinical area with the nursing instructor’s permission.
6. If patient and/or student safety is compromised, the nursing instructor has the authority and responsibility to take immediate corrective action, which may include:
    a. Removing the student from the classroom or clinical setting.
    b. Utilizing specified (e.g., Tulare County) crisis intervention team.

c. Referral to counseling/professional help.
d. The instructor will complete a Critical Student Incident form (see policy B-20) and a referral to BIT if deemed necessary, identifying the behaviors that led to the dismissal from the classroom or clinical setting with required action plan and/or referral. An incident occurring in either the theory or clinical setting will be addressed in the SER documentation as appropriate.
e. The student will provide evidence of counseling or treatment in a recognized treatment modality and that he/she will be able to function safely and effectively in the classroom and/or clinical setting.

7. Re-entry to the Nursing Program is on a space available basis. Should the student demonstrate evidence of mental or emotional impairment after being readmitted to the program, they will be directed to the Director of Nursing for consideration of options, which may include permanent dismissal from the Nursing Program.

The California Board of Registered Nursing expects that schools of nursing will ensure that instructors have the responsibility and authority to take immediate corrective action with regard to the student's conduct and performance in the clinical setting (refer to BRN guidelines).

All information regarding drug and alcohol testing and resulting actions (i.e. rehabilitation, dismissal) will be kept confidential and will be maintained in a file separate from the student's regular file. Only the Director of Nursing will have access to the file.

**REFERENCE**: *"Impaired Nursing Students: Guidelines for Schools of Nursing in Handling Nursing Students Impaired By Chemical Dependency or Mental Illness"* (EDP-B-03) California Board of Registered Nursing, 11/84 8/10 (See Appendix)

Student Permission for Drug, Alcohol, and Mental Health Screening Form (Attached)

The Signs and Symptoms of an Impaired Nurse (Drugs, Alcohol, and Mental Illness) (Attached)

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED**: 12/2000; 2/2004; 2/2012; 5/2015, 3/2019

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

## STUDENT PERMISSION FOR DRUG, ALCOHOL, AND MENTAL HEALTH SCREENING

I have received a copy of the COS Registered Nursing Program's policy regarding drug, alcohol and mental health screening and I fully and completely understand this policy.

I agree to submit to a pre-admission drug and alcohol screening test as a condition for admission into the nursing program.

I also agree to immediate monitored drug and alcohol testing and/or mental health screening upon request by the Director of Nursing and/or a nursing instructor, such request having been made because of a reasonable suspicion and/or probable cause that I am/was under the influence of drugs and/or alcohol or displaying behaviors consistent with mental impairment while attending clinical activities.

I understand that failure to appear for any requested/required drug and alcohol screening tests or mental health screening will result in either the rescinding of my application to the nursing program or dismissal from the program.

I also understand that all information regarding my drug, alcohol, and mental health screening (such as requests, test results, and consequent actions) will be kept confidential at all times and will only be released by my written consent.

I further understand that this policy and my permission for testing will remain in effect throughout my program of nursing studies from admission into the program through graduation from the program.

Print your name: ________________________________________________

Student Signature: ________________________________________________

Date: ________________________

*Original to Student File*
*Copy to Student*

# COLLEGE OF THE SEQUOIAS
# DIVISION OF NURSING AND ALLIED HEALTH

## The Signs and Symptoms of an Impaired Nurse
## (Drugs, Alcohol, and Mental Illness)

The signs and symptoms of mental and/or emotional illness and/or intoxication or withdrawal include but are not limited to the following:

- Yawning, easily falls asleep when not warranted, complains of insomnia, complaints of wanting to sleep all the time
- Runny nose (rhinorrhea) or eyes (lacrimation) not related to cold or seasonal allergies
- Profuse sweating or chills
- High levels of anxiety, restlessness, fidgeting, difficult time sitting or standing still even for small periods of time
- Depressed all or most of the time, crying easily for no apparent reason
- Voicing suicidal thoughts, engaging in acts that physically hurt the student, any type of self-mutilation, apathy for client, peers, and self
- Overly excited or grandiose, euphoric, emotions change rapidly from one emotion to another, impulsive in words and actions, flight of ideas
- Thoughts are rambling, disorganized, and nonsensical in content
- Belligerence, agitation, irritability, easily angered for no apparent reason, easily frustrated
- Poor decision making and problem solving, a noticeable decline in ability to make healthy, appropriate, sound decisions
- Short attention span, less than what is expected for the situation, unable to focus or stay on task, easily distracted, disoriented, confused, difficulty remembering information
- Slurred speech, incoherent speech, hyper-verbal and talks all the time, appears to be unable to stop self from talking too much, talks in a faster pace/speed than is their usual pattern
- Clumsy, uncoordinated, unsteady gait, exaggerated body movements, holds on to people or objects to ambulate
- Nystagmus, flushed face, eyes darting back and forth, hand and body twitching and tremors (slight to coarse), seizure activity
- Complaints of muscle weakness or rigidity, generalized body weakness, malaise
- Increased or decreased blood pressure, pulse or respirations (abnormal), ALOC
- Changes in appetite (noticeable shift in weight)
- Complaints of nausea, vomiting, diarrhea
- Headaches, frequently taking medication for pain relief
- Auditory or visual hallucinations
- Pervasive distrust and suspiciousness, pervasive pattern of detachment, pervasive pattern of low self-image, identity disturbance, and impulsive behavior that is potentially injurious to self or others, socially isolated
- Inability to focus, concentrate, or perform clinically
- Failure to participate in activities required to meet objectives
- Gross, inappropriate behavior

**College of the Sequoias**
**Division of Nursing and Allied Health**

**TITLE: Criminal Background Check and Urine Drug Screening**

**PURPOSE:**
As part of the San Joaquin Valley Nursing Education Consortium (SJVNEC) Clinical Placement System, the College of the Sequoias Registered Nursing Program will comply with the standardized process for clinical placement in the SJVNEC affiliate clinical facilities. To comply with the SJVNEC, as well as other state, local, and federal regulations, all incoming students will complete a criminal background check and urine drug screening upon acceptance to the program.

*(Note: This policy was also instituted because The Joint Commission (TJC) requires any health care facility that requires employees to have personal criminal background checks must also require the same background check for students and volunteers involved in patient care.)*

**DESCRIPTION:**
Students must have a clear criminal background check and negative urine drug screen to participate in placement(s) in clinical facilities, which the college affiliates with for student clinical learning experiences. The SJVNEC has contracted with Online Document Management System for these services. The nursing division will provide guidelines to the student on how to apply for their background check and urine drug screening.

**Criminal Background Checks**

Background checks will include the following:

- Seven years residence/background history
- Address verification
- Sex offender and Predator Registry database search
- Two names (current legal and one other name)
- Three counties
- OIG search
- Social Security or VISA number verification
- Search through applicable professional certification or licensing agency for infractions if student currently holds a professional license or certification (e.g., respiratory therapist, CNA)
- Drug screen with urine sample

A student with a background check that indicates any of the following felony and/or misdemeanor convictions may be denied clinical placement in healthcare facilities that are part of the SJVNEC:

- Murder
- Felony assault
- Sex offenses/sexual assault
- Abuse
- Felony possession and furnishing (without certificate of rehabilitation)

- Other felonies involving weapons and/or violent crimes
- Class B and Class A misdemeanor theft
- Felony theft
- Fraud

**PROCEDURE:**
Upon receipt of a "flagged" background check, the clinical facility will make the determination whether to accept the student in their facility or deny placement. The clinical site will use the same guidelines used for the acceptance/rejection of an employment application in approving student placement at their site. Final placement status based on background check information is the clinical facilities determination.

If the student's background check is not clear, the student will be responsible for obtaining the necessary documents for record clearance and having the record corrected to clear it. If this is not possible, the student will be unable to attend clinical rotations. Participation in clinical rotations is a mandatory part of the nursing program; therefore, the student who is refused admittance to any healthcare facility will not be able to meet clinical objectives and will be ineligible to continue in the program.

NOTE: Being cleared on the background check for participation in clinical by the clinical facility is a separate process than that of the BRN. The student, upon graduation, will complete an entirely new fingerprint Live Scan process for the NCLEX licensure application process. Permission to take the NCLEX-RN examination based on the Life Scan results is determined by the BRN after review by the Enforcement Division. (See attached, "Board of Registered Nursing Application Instructions for Reporting Prior Convictions").

**Drug Screening:**
The College of the Sequoias Registered Nursing Program maintains a "no tolerance" policy regarding substance abuse. Students must clear a urine drug test. Incoming students with a verified positive test result for alcohol, any illegal drug, or abuse of prescribed or over-the-counter medications or mind-altering substances will be given reasonable opportunity to challenge or explain the results. Where results are confirmed and no medical justification exists (MD note on file), incoming students will not be admitted to the program. Either a positive test result or failure to complete the urine drug screen will result in the offer of acceptance to the program being withdrawn. A student denied enrollment due to a positive drug test or failure to complete the drug test must make a new application to the program and begin the application process again in accordance to the established procedure. The student will not be granted any special consideration in priority and is eligible to re-apply only once.

*(Note: the California Supreme Court has ruled that prescriptions for marijuana do not exempt users from workplace rules, and they may be fired for a drug test that is positive for marijuana. Accordingly, any student who tests positive will have their offer of acceptance withdrawn).*

**Criminal Background Check/Drug Screening Results**

Students must provide information allowing the Online Document Management System to conduct a background check and with authorization to share any flagged results on the background check with healthcare facilities to which students may apply or be assigned for clinical rotations. Online Document Management System will conduct an internal review, verify student information, and send any flagged results to the clinical sites for review.

The results of the urine drug screen (negative/positive/dilute) will be sent to Online Document Management System for input. The Director of Nursing will have access to the results via Online Document Management System. If the student has a verified positive and/or dilute result, they must meet with the Director of Nursing to discuss the results (see Policy B-22). The nursing program does not retain printed urine drug screen results in the office or student files.

The nursing program does not retain printed background check reports in the office or student files and do not review or evaluate any background check information. The Director of Nursing will only receive confirmation from Online Document Management System that students have completed a background check to confirm compliance with this policy.

**Criminal Background Check/Drug Screening Process**

Students will access the SJVNEC website (**www.sjvnecbackground.com**) for information and instructions for completing a background check and urine drug screening. Students are responsible for all costs associated with criminal background checks and drug screening. Students will make payment directly to Online Document Management System. Upon completion, the results will be delivered to the applicant per Online Document Management System protocol.

*(Note: If there is a break in continuous enrollment in the program (more than one semester out of the program), students will be required to repeat background checks and urine drug screening upon re-entry to the program. The student is responsible for all costs associated with repeat background checks and urine drug screening).*

After completing the on-line order application for the urine drug screen and submitting payment for the test, the student will bring the receipt of payment (Chain of custody) to the nursing office. The student will then contact one of the drug screening locations (Quest Diagnostics) listed on the web site to schedule an appointment for the urine drug screen.

Students will be given a deadline date by which the background check and urine drug screen must be completed. Students who do not complete the background check and urine drug screening by the deadline date will not be allowed to register for classes.

Any student who has any concerns about criminal background checks or drug screening is encouraged to contact the Director of Nursing for confidential advising prior to completing either procedure.

**REFERENCE(s):** *"Impaired Nursing Students: Guidelines for Schools of Nursing in Handling Nursing Students Impaired By Chemical Dependency or Mental Illness,"* (EDP-B-03) California Board of Registered Nursing, 11/84, 8/10.

*Board of Registered Nursing Application Instructions for Reporting Prior Convictions (attached)*
Also, review Policy B-22: Drug and Alcohol Testing

***Policy and Procedure Committee***
**Date Approved/Reviewed/Revised:** 9/2009; 5/2012; 10/2016

# Board of Registered Nursing
# Application Instructions for Reporting Prior Convictions

Applications that result in review by the Enforcement Division staff of the BRN need to have appropriate supporting documentation submitted with the application. Without the supporting documentation, the BRN staff cannot make a prompt decision to approve or deny the application. Each case is evaluated on its own merit.

Some of the factors that the BRN evaluates, particularly with DUI, include the age of conviction and the blood alcohol content (BAC). The higher the BAC (above .15), the more likely there is an ongoing problem with alcohol, even with a single DUI. Additionally, if there has been a history of drug use, the BRN will require more proof that chemical dependency is not a current issue. If the conviction is recent, it will probably result in denial. However, based on a number of factors, including mitigation, etc., the BRN may settle on a probationary license. Theft is another big issue. Again, age of conviction makes a difference. Spousal abuse, sexual misconduct or any other kind of violent incident, depending on the age of the incident, will likely end up a denial, but a lot depends on the circumstances and the mitigation.

Include ALL documentation and mitigation evidence along with the application, even if you believe the charge has been expunged. Otherwise, the licensure application process is held up while the BRN waits to receive requested documentation.

You must include all the following information CLEARLY LABELED with the application:

**Written Statement:**

- A written statement from the applicant, in their own words, describing the incident(s), date(s) incident(s) occurred, outcome (ex. paid fine, placed on probation, court ordered classes or rehabilitation), and any rehabilitative efforts or changes to prevent future occurrences.

**Certified Arrest/Incident Reports:**

**NOTE:** Court documents **DO NOT** include arrest reports and **MUST** be requested separately.

- Contact the arresting agency for this report. The arresting agency is the agency that conducted the arrest and/or issued the citation (ex. Highway Patrol, Police Department, Sheriff's Office).
- If the arrest is for **DUI** ensure the Blood/Breath Alcohol Content (BAC) is included in the report.
- Traffic violations involving driving under the influence, injury to persons or providing false information must be reported. The definition of conviction includes a plea of Nolo Contendere (no contest), as well as, pleas or verdicts of guilty. Must include misdemeanor as well as felony convictions.
- Traffic violations over **$1,000** must be reported. If no court papers to send, then you must send a copy of the ticket along with written statement describing the violation.
- If there are no reports on file for the violation (e.g., it happened a long time ago, nothing left in file) you must get something in writing from the arresting agency that it no longer exists.

- Under age, violations still need to be reported.

**Certified Court Documents:**

- Contact the court to get a certified copy of all court documents pertaining to the conviction(s) including satisfaction/compliance with all court ordered probation orders.

**Evidence of Rehabilitation:**

- Include completion certificates of court ordered/voluntary rehabilitation.
- Include letter of “relapse prevention plan” if no formal rehabilitation was completed (e.g., write-up of educational journey towards RN, responsible, good GPA, go to meetings NA/AA, get control logs of person conducting the meetings).

**Reference Letters for Alcohol or Drug Related Convictions:**

- Recent, dated letters from professionals in the community (ex. AA/NA Sponsor, counselor, probation officer, employer, instructor, etc.) who can address an awareness of the past misconduct and current rehabilitation (ex. use/non-use of alcohol/drugs). The letters must be signed and dated by the author of the letter within the last year.

**Reference Letters for all other Convictions:**

- Recent, dated letters from professionals in the community (ex. counselor, probation officer, employer, instructor, etc.) who can address an awareness of the past misconduct and current rehabilitation (ex. honesty/integrity, management of anger/stress). The letters must be signed and dated by the author of the letter within the last year.

**Work Performance:**

- A copy of a recent work evaluation or review, which may or may not be from a health related agency.

Calls to analysts to determine application status should not be made until a file has been in enforcement for at least 4 weeks (not 4 weeks since the application was submitted to the BRN). Phone calls requesting application status further delays the process for everyone.

The goal is to complete enforcement reviews and return files to licensing staff within two weeks of receipt in enforcement. This can only be accomplished if all required documents are included at the time of application and phone calls are limited.

**BRN Enforcement process:**

In instances of prior conviction, the application goes directly to the enforcement unit where all documentation regarding the conviction(s) is gathered and analyzed. When the outcome is denial, the student receives a letter of denial from the BRN, with information that the applicant may elect to be heard (appeal) in front of a judge. The applicant has 60 days to send their decision to appeal to the BRN. The decision to appeal is then sent to the Attorney General’s Office, where a Statement of Issues is made and sent to the applicant. Once the applicant has received the Statement of Issues, all their communication is with the Attorney General’s Office. They may decide to settle or to continue with a hearing.

**B-27**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: STUDENT ILLNESS, INJURY OR PREGNANCY

## PURPOSE:

To describe the program requirements for students in the program who experience an illness, injury or who become pregnant before or during the program. The purpose of the policy is to ensure protection of the students, patients, clinical personnel, and faculty in the clinical setting.

**DESCRIPTION:**
In order to meet course and program learning objectives in the College of the Sequoias Registered Nursing Program, every student must be physically and emotionally able to function fully without restrictions or limitations, in all instructional areas of the program.

**No limited assignments or modified objectives/outcomes are available in the RN Program**, because full participation in clinical activities is necessary to meet the objectives of the program and to allow adequate evaluation of the students' achievement of the objectives.

Therefore, students should strive to maintain a high level of wellness throughout the program, and **must** provide a medical release from their health care provider if they are diagnosed with an illness, an injury, or if they are pregnant or become pregnant during progression in the program.

The release must include:
1. The illness, injury or pregnancy will not prevent their continuance in the program.
2. **There are no restrictions or limitations on the student's activities.**
3. The attached Physical Examination Form

The written clearance must be submitted to both the clinical instructor and Director of Nursing.

If a student does not provide a release that meets program requirements, it may be necessary for a student to withdraw from the program and return, on a space available basis, when the physical restrictions or limitations are lifted.

Students concealing an illness, injury or pregnancy are jeopardizing patient safety and their own safety. A student found to have concealed an illness, injury, or pregnancy will be subject to faculty review and possible permanent dismissal from the program.

**ILLNESS, INJURY, or SURGERY:**
For illnesses exceeding the maximum allowable absences, and depending on the circumstances, a student may be required to submit a medical release from their health care provider that states the student may return to the program without limitations or restrictions.

A student with a potentially communicable illness is required to report to the clinical instructor immediately and then provide written medical clearance before returning to theory course(s), clinical, or skills lab.
Students with casts, splints, crutches, cane, sling or condition/device that impairs mobility or motion will not be allowed in the clinical area. The student will be required to withdraw from the program until such items are no longer needed. The student will considered for readmission/reentry to the program on a space-available basis. Withdrawal from the course

will be the responsibility of the student. The student who has had surgery or an injury **must** have a release form signed by his or her health care provider that states the student may return to the program, with full participation, and without limitations or restrictions.

**PREGNANCY:**
Nursing students who are pregnant and due to deliver during the course of a school semester are encouraged to take a leave of absence for that semester and will be readmitted on a space available basis. Students who begin a semester and then withdraw at any point will also be readmitted on a space available basis.

Any student who elects not to take the leave of absence may continue in the program during pregnancy only with the written permission of her health care provider.

- The release must state that the pregnancy will not prevent the student continuing in the program and that there are no limitations or restrictions on the student's physical activities.
- The student must be able to meet all weekly clinical laboratory objectives.

The student will also be required to sign a program variance that states while every effort is made to protect all students, she will be required to take part in patient care. This patient care routinely requires lifting, as well as the possibility of exposure to infectious disease processes, radiation, and teratogens.

**Immediately upon confirmation of pregnancy, the student must:**
- Notify their theory instructor, clinical instructor and Director of Nursing.
- Provide the estimated date of delivery (calculated by health care provider).
- Submit a written release from their health care provider that states that the pregnancy will not prevent their continuing in the program and that **there are no limitations or restrictions.**
- Report any change in health status immediately.
- The maximum absence policy will apply.
- Observe usual pregnancy precautions while in the clinical area according to agency policy.

**Postpartum:**
- The student may return no sooner than one week postpartum.
- The student must submit a written release from her health care provider that states she may return to the program, full participation, and that **there are no limitations or restrictions.**

See Attachment: Physical Examination Form

**REFERENCE**: Pregnancy Health Waiver
B-19 Attendance and Punctuality Policy
Physical Examination Form

***Policy & Procedure Committee***

**DATE APPROVED/REVIEWED/REVISED:** 3/2011; 2/2018; 3/2019

Physical Examination Form

**STUDENT ESSENTIAL TECHNICAL STANDARDS *To be completed by Health Care Provider (MD, DO, NP, PA,**

**CNM)***

Registered Nursing students must meet the following criteria to ensure the safety and welfare of the patients, the health care team and themselves.

**Is the individual capable of the following:**

Yes [ ] No [ ] Standing and/or walking, continuous, during all phases of patient care.

Yes [ ] No [ ] Bending, crouching, or stooping several times per hour (e.g., emptying catheter drainage bags, checking chest tube containers, positioning of wheelchair foot supports, during bathing, during dressing changes, during feeding, catheterizations, etc.).

Yes [ ] No [ ] Lifting and carrying a minimum of 30 pounds several times per hour.

Yes [ ] No [ ] Lifting, frequently, with weight lifted ranging from 100 – 300 pounds (approximately), rarely 300+ pounds. Lifting should always be done with help.

Yes [ ] No [ ] Reaching, frequently, overhead, above the shoulder 90 degrees (e.g., during bathing, manipulating IV equipment, obtaining supplies, transferring patient into or out of bed, etc.).

Yes [ ] No [ ] Twisting, frequently (e.g., transferring patients from chair to bed, feeding patients, performing some sterile procedures, etc.).

Yes [ ] No [ ] Pushing patients, objects, and equipment, frequently, up to 45 pounds effort (e.g., pushing beds, gurneys, and wheelchairs, etc.).

Yes [ ] No [ ] Pulling patients, objects, and equipment, frequently, up to 70 pounds effort (e.g., positioning patients in bed, during transfer to and from gurneys, wheelchairs, commodes, etc.).

Yes [ ] No [ ] Utilizing eyesight to observe patients, manipulate equipment and accessories and/or evaluate radiographs for technical quality under various illumination levels (i.e., illumination varies from low levels of illumination to amber/red lighting to bright light levels).

Yes [ ] No [ ] Hearing to communicate with the patient and health care team.

Yes [ ] No [ ] Utilizing sufficient verbal and written skills to effectively and promptly communicate with the patient and health care team.

Yes [ ] No [ ] Manipulating medical equipment and accessories, including but not limited to switches, knobs, buttons, and keyboards, utilizing fine and gross motor skills (e.g., preparing and administering medications, utilizing medication delivery systems with or without scanning devices, setting up and monitoring IV equipment such as infusion pumps (40 pounds effort), cardiovascular hemodynamic equipment (40 pounds effort), suction equipment (30 pounds effort), performing dressing changes and other procedures, manipulating oxygen equipment, and various other items ranging from 2 – 40 pounds effort).

Yes [ ] No [ ] Performing the assigned training related tasks/skills responsibilities with the intellectual and emotional function necessary to ensure patient safety and exercise independent judgment and discretion.

Yes [ ] No [ ] Utilizing the above standards/functions to respond promptly to the patient needs and/or emergency situations.

HEALTH CARE PROVIDER STATEMENT

Based on; your medical evaluation, will this individual be able to carry out the essential technical standards as listed above?

Yes [ ] No [ ] If NO please explain the reasons and what accommodations may be necessary to assist the individual in participating in the program:

________________________________________________________________________________

________________________________________________________________________________

______________________________________________

I have read the Student Essential Technical Standards listed for the COS Registered Nursing student and verify that this individual is able to meet the physical demands as described above.

Health Care Provider Signature: ___________________________Date:_____________

Print Name: __________________________________________

Address: __________________________________________________________________

Attach Health Care Provider Business Card Here

Phone Number:_______________________________________

# Safe Practice Guidelines and Policies

# COLLEGE OF THE SEQUOIAS
## DIVISION OF NURSING AND ALLIED HEALTH

**TITLE:** MEDICATION ADMINISTRATION POLICY FOR NURSING STUDENTS

**PURPOSE:** To provide the procedures for both medication administration competency and the administration of medications by students in the clinical setting.

**DESCRIPTION:**

**First Semester Student Competency**

1. Following the delivery of theory content related to pharmacology and math of drugs and solutions, the 1st semester student must pass a 20-item drug dosage calculation exam by scoring at least 85% or more.

2. The student will have two (2) attempts to achieve a score of 85% or more.

3. The exam will be non-multiple choice. The student may use a calculator during the exam.

4. Partial credit will NOT be given (i.e. for setting the problem up correctly). The student must calculate the correct answer for each problem. There are NO exceptions.

5. If a student is not successful in scoring 85% or more on both attempts, the student will fail the course and will need to withdraw from the program.

6. A student who fails the course due to inability to demonstrate basic competency in calculating drug dosages will be allowed to reapply to the nursing program.

**First Semester Medication Administration**

1. A student in the 1st semester who has demonstrated math competency, as described above, will be allowed to administer medications to patients at the discretion of their first semester clinical instructor.

2. NO student will be allowed to administer any type of medication to patients without having DIRECT supervision by the nursing instructor.

3. The student will be given a copy of the medication administration policy for the health care agency to which he/she is assigned. The student is expected to comply with this policy at all times. Failure to comply can result in clinical failure and dismissal from the program.

**Second, Third and Fourth Semester Medication Administration**

1. A student who has demonstrated proficiency in administering by mouth, topical, intramuscular, subcutaneous and other non-intravenous medications, as docu-

mented on the student's Student Evaluation Record (SER), will be allowed "Independent Function" when procuring, preparing and administering these types of medications. A student's clinical instructor, not the agency nurse, will determine the student's competency and level of independence.

2. Although the student will be allowed advancing independence in medication delivery, no student may administer a medication without the clinical instructor having verified student competency in medication administration.

3. For certain health care agencies, a student may be allowed to procure, prepare and administer non-intravenous medications with the support and direction of the agency nurse to which the student is assigned (i.e. the clinical instructor does not need to be present).

**Intravenous Medication Administration**

1. NO student in any semester will be allowed to administer an IV medication or IV solution independently. The student must have his/her clinical instructor present.

2. For certain health care agencies, a student may be allowed to procure, prepare and administer intravenous medications and solutions as long as direct supervision is provided by the agency nurse to which the student is assigned (i.e. the clinical instructor does not need to be present).

**Peripheral Intravenous Saline Flush**

1. 2nd, 3rd and 4th semester students may independently perform peripheral saline IV flushes according to the clinical agency's policy and procedure after having been cleared by a nursing instructor.
2. Students must meet the following criteria:

   Knowledge related to:
   - a. purpose of the flush
   - b. agency protocol for the flush

   Demonstrated skills:
   - a. satisfactory performance in skills lab and/or the clinical setting
   - b. signed/approved for independent function on SER
   - c. identification of physician's order and/or hospital protocol for the flush

   The student will follow the agency procedure specific to the age and type of patient needing peripheral IV saline flushing (refer to the hospital's Procedure Manual and/or approved clinical protocol specific to the clinical unit).

**Prohibited Medications**

1. Each student is expected to comply with the clinical syllabus and guidelines applicable to the semester level within which the student is registered. Included in the clinical syllabus will be specific medications and IV solutions which a student will NOT be allowed to administer (i.e. blood products, chemotherapy, etc.).

2. **Under NO circumstances will a student ever attempt to administer potassium chloride by the IV push route. Such action can result in patient death.**

## Student Orientation to Medication Administration Policies and Procedures

1. Each student will be oriented to the medication administration policies and procedures applicable to the semester level and clinical agency to which the student is assigned.

2. Whenever agency or program policies/procedures related to medication administration change or are revised, students will be notified immediately.

3. This policy is located in the "Student Handbook" which is provided to each Student as he/she begins the program. The student is expected to read/review the policy and be accountable for adhering to it at all times.

## Student SNA and SNI

1. This policy applies to any student engaged in the SNA or SNI role.

## Leadership Student

1. This policy applies to any student in the NURS 166 Leadership course; however, The student's assigned RN preceptor will act as the "clinical instructor" while working with the student.

## Violations of This Policy

1. Any deviation or alteration in this policy/procedure will be immediately reported to both the clinical instructor and the program Director.

2. It is the responsibility of the student, with assistance from the clinical instructor, to complete any and all required documentation/forms (i.e. Notice of Event or Incident Report) required by the agency/unit where the student is assigned.

3. Based on severity and the effects on patient condition, violations may result in clinical failure and/or dismissal from the program.

**REFERENCES:**

Critical Student Incident Form

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED:** 11/1987; 11/1998; 3/2000; 9/2002; 2/2004; 11/2010; 1/2013; 8/2017; 11/2018.

B-10

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** PREVENTION OF TRANSMISSION OF INFECTIOUS DISEASE

**PURPOSE:**
The management of issues related to infectious diseases in schools of nursing is of primary concern to nursing faculty and administration. The rapid increase of blood borne diseases has caused an awareness of the need for policies and guidance. This policy is designed to balance the protection from risk for students, faculty, and clients, while maintaining the individual's right of privacy and equal opportunity. Each nursing student will be provided with guidelines regarding protection from infectious diseases to which the student may be exposed during his/her education. These guidelines are based on information provided by the Center for Disease Control (CDC), the Federal Occupational Safety and Health Administration (OSHA), the California Board of Registered Nursing Statement on Delivery of Health Care, and the National League of Nursing (NLN) guidelines for schools of nursing.

**POLICY:**
Control of microorganisms which cause disease in humans is vital in the health care environment. Although the risk of infection transmission exists, that risk can be minimized by appropriate education and actions taken to avoid transmission. It is the policy of the COS Registered Nursing program that:

1) Use of Universal/Standard precautions, as recommended by the CDC, is an effective means of preventing transmission of infectious disease. Since health care workers are unable to identify all patients with blood-borne disease, blood and body fluid precautions should be consistently used for all patients.

2) Instruction regarding chain of infection, universal precautions, and CDC recommended infection control measures will be given before the student begins clinical experience and will be reinforced at regular intervals. This information will be emphasized and reinforced throughout the student experience and as the student encounters more complex situations.

3) All students will be required to acknowledge in writing that they have been provided with information regarding:

   a. The risk of transmission of infectious disease encountered in the practice of nursing,

   b. Infection control measures consistent with Centers for Disease Control (CDC) and OSHA guidelines.

**PROCEDURE/GUIDELINES:**

**UNIVERSAL/STANDARD PRECAUTIONS**
**According to OSHA guidelines, all body secretions are to be considered contaminated**

**and Universal/Standard precautions should be used when handling the following:**

| | |
|---|---|
| **Blood** | **Urine** |
| **Sputum** | **Stool** |
| **Wound Drainage** | **Vaginal Secretions** |
| **Emesis** | **Amniotic Fluid** |
| **Semen** | **Pleural Fluid** |
| **Saliva** | **Tears/Eye Fluids** |
| **Cerebrospinal Fluid** | **Peritoneal Fluid** |
| **Colostrum/Breast Milk** | |

**Treat all linen soiled with blood/body secretions as potentially infectious.**
**Process all laboratory specimens as potentially infectious**

**HAND WASHING**

1. Wash hands before and after all client or specimen/body fluid contact
2. Wash hands after gloves are removed
3. If hands are not visibly soiled, use an alcohol-based waterless cleanser for routine decontamination in the clinical setting
4. When caring for patients with Clostridium difficile-associated disease, wash hands with soap and water as alcohol based products are ineffective against C-diff spores

**GLOVES/PROTECTIVE EQUIPMENT**

1. Gloves are not a substitute for good hand washing
2. Wear gloves for all potential contact with blood or body fluids
3. Wear gloves if splash with blood or body fluids is anticipated
4. If a glove is torn or damaged, remove them, wash hands, and apply new gloves if care is to continue
5. Wear new gloves each time you perform a procedure and discard after use
6. Wear double gloves if the situation warrants
7. Wear an agency-approved filtration mask if airborne transmission is possible
8. Wear protective eye wear if splatter with blood and body fluid is possible.
9. Wear gown if clothing is likely to come in contact with blood or body fluid
10. Follow agency policy regarding resuscitation during respiratory arrest.

**NEEDLE/SHARPS SAFETY**

1. Use disposable needles/sharps whenever possible
2. Do not re-cap or manipulate needles
3. Consistently activate the safety feature prior to disposal
3. Discard used needles/sharps in the designated puncture proof container

**GUIDELINES REGARDING BLOOD BORNE PATHOGEN EXPOSURE**

**A significant occupational exposure is defined as:**

-A needle stick or cut caused by a needle or sharp that was actually or potentially contaminated with blood/body fluid

-A mucous membrane exposure to blood or body fluids (i.e. splash to the eyes, ears, mouth)

-A cutaneous exposure involving large amounts of body fluid or prolonged contact with body

fluid, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis, or compromised/broken in any way.

**Procedure following exposure:**

1. Wound care/first aid should occur immediately following exposure:
    a. All wounds should be vigorously cleansed with soap and water immediately and for a period of at least 3 minutes
    b. Mucous membranes should be flushed with water or normal saline solution immediately and for a period of at least 5 minutes
    c. Additional treatment should be rendered as indicated.

2. Following immediate wound care/first aid measures:
    a. The student will immediately report to the clinical instructor any incident of exposure.
    b. The clinical instructor will complete a Notice of Accidental Exposure form and submit it to the Nursing Program Director.
    c. Clinical instructor or student will notify the designated agency department of the clinical agency involved for further direction
    d. The involved student will meet with the program director regarding further instructions.
    e. Specific recommendations will be made according to the type of exposure and infectious agent involved.

**REFERENCE:** Notice of Accidental Exposure (Attached)
http:/www.cdc.gov/niosh

***Policy & Procedure Committee***
**Date Approved/Revised/Reviewed:** 3/93; 11/98; 11/2001; 2/2004; 3/2012; 4/2021

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

# NOTICE OF ACCIDENTAL EXPOSURE TO INFECTIOUS AGENT

Student Name: ____________Exposure Date & Time_____________ Date of This Report___________

Brief Description of Incident:

Hospital/Agency/Location Where Exposure Occurred: _________________Client ID #______________

Was Treatment Received Following Exposure? ____Yes ____No If No, State Reason(s):

Where Was Treatment Received? _________________________ Date__________ Time___________

Treatment Received Following Exposure (Check All That Apply):

_____ Wound/area cleansed with soap and water/saline
_____ Mucous membrane(s) flushed with water/saline
_____ Additional treatment: Describe fully:

Reported to Clinical Instructor Yes____ No____ Date/Time__________ Instructor______________
Accidental Exposure Form Completed Yes____ No____ Date/Time__________
Agency Infection Control Officer Notified Yes____ No____ Date/Time __________Name_________________
Source Was Approached for Testing Yes____ No____ Response__________________________________
Source Was Confirmed Positive Yes____ No____ Describe__________________________________
Other Pertinent Information:

Recommendations:
1. If you have been immunized for Hepatitis B or C but have not had an antibody level determined, you should have one done to assure that the immunization was effective and you are protected.
2. If HIV status of the source of exposure (i.e. client) is unknown and/or the source has not been tested for HIV, we recommend that you be tested now for seronegativity, followed by a retest at 3 months and again at 6 months following exposure in order to monitor for serum changes.
3. For both of the above tests, you may see your private physician. For HIV testing, you may consider using either the COS Student Health Center or the Tulare County Health Department.

Confidentiality: Information related to exposure, treatment, and testing will be kept confidential at all times.

Student Signature_____________________________ Date____________

Instructor Signature___________________________ Date____________

*Original to Student File*
*Copies to Student and Director*

## OSHA Guidelines following Percutaneous or per mucosal Exposure

**A significant occupational exposure is defined as:**

- A needle stick or cut caused by a needle or sharp that was actually or potentially contaminated with blood/body fluid.
- A mucous membrane exposure to blood or body fluids (i.e. splash to the eyes, ears, mouth)
- A cutaneous exposure involving large amounts of body fluid or prolonged contact with body fluid, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis, or compromised/broken in any way.

**Procedure following exposure:**

1. Wound care/first aid should occur immediately following exposure:
   a. All wounds should be vigorously cleansed with soap and water immediately.
   b. Mucous membranes should be flushed with water or normal saline solution immediately.
   c. Other treatment will be rendered as indicated.
2. Following immediate wound care/first aid measures:
   a. The student will immediately report to the clinical instructor any incident of exposure.
   b. The clinical instructor will complete a Notice of Accidental Exposure form and submit it to the Nursing Program Director (form available from the Division's administrative assistant).
   c. Clinical instructor or student will notify the Infection Control Officer of the clinical agency involved.
   d. Specific recommendations will be made according to the type of exposure and infectious agent involved.

**B-11**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** **Student Vaccination Requirements**

**DESCRIPTION: **Per the San Joaquin Valley Nursing Education Consortium (June 2018)**

**Vaccinations**
"Students and faculty doing clinical rotations in hospitals clinics and other service agencies must be current in all of their vaccinations in order to be able to participate in their clinical rotation. The nursing program is responsible for ensuring that all students' vaccinations are current and up to date before sending their students into a clinical area".

**Flu Vaccine**
"The influenza (flu) vaccination (injection) is required for all students who will be doing a clinical rotation in any of the service areas of the Consortium (clinical agencies). All flu vaccines will be required before Nov.1 each year. Individuals with a severe allergy to eggs prior history of Guillain-Barre" syndrome or certain other neuro-degenerative disorders may be exempt from this requirement. Proof of vaccination must be presented to their Director prior to November 1. If a student fails to comply for reasons that are not exempt, the student must wear a mask, or will not be allowed in the clinical area. The clinical site may require that a Declination form be signed.
Individuals requesting an exemption due to medical reasons must provide a Physician Letter completed by a California licensed physician who has examined them." "Pregnancy will not be accepted as a medical contraindication".
"Individuals requesting a religious exemption must provide a letter from clergy supporting the exemption and the request must be consistent with prior vaccination history".
Any individual not vaccinated must wear a mask or will not be allowed in the clinical area.

Each declination of vaccination will be individually assessed for validity and a decision made regarding continued progress in the program.

**REFERENCE:** Student Health Form
Informed Refusal Form (Attached)

Faculty/Student Orientations User Guide from the
San Joaquin Valley Nursing Education Consortium (2020) pg. 9

***Policy & Procedure Committee***
**Date Approved/Revised/Reviewed:** 3/1993; 12/1998; 12/2001; 2/2004; 11/2008; 5/2009; 5/2012; 3/2013; 08/2020; 10/2020

# Registered Nursing Program
# Informed Refusal/Immunization Declination Form

**•To be completed by student•**

Name: ______________________ Sex: Male Female Birth Date: ______________

Address: ______________________ City/State/Zip: ______________________

Phone: ______________________ Email: ______________________

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**The following are accepted reasons for declination and must be accompanied with written proof:**

Allergic Reaction - Letter/note from Doctor

Medical Reasons - Letter/note from Doctor

Religious Reasons - Letter from religious leader

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I understand that my exposure to patients, blood, or other potentially infectious materials at healthcare facilities with the following vaccine preventable diseases puts me at risk of acquiring the disease. I have had the opportunity to be vaccinated, however, I choose to decline the vaccination(s) checked below at this time. I understand that by declining vaccine protection I continue to be at risk of acquiring the disease.

☐ Hepatitis B
Reason for Declination : ______________________

☐ MMR
Reason for Declination: ______________________

☐ Influenza
Reason for Declination: ______________________

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*In refusing to receive the above listed vaccines, I am assuming full responsibility for costs incurred should I sustain an exposure during my enrollment in the Nursing Program. I also understand that refusal to receive the vaccine may prohibit me from participating in clinical experiences at agencies utilized by the COS Registered Nursing Program (per the San Joaquin Valley Nursing Education Computerized Clinical Placement Consortium). This will result in my inability to meet the clinical component and objectives of the program, which could result in dismissal from the COS Registered Nursing Program.*

If I should sustain an exposure, I will provide the Division of Nursing documented evidence of medical follow-up within seven (7) days of exposure.

**Student Signature:** ______________________ **Date:** ______________

**Printed Name:** ______________________

**B-12**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** **HIV/AIDS GUIDELINES**

**DESCRIPTION:**

The emergence of the HIV/AIDS virus as a blood borne pathogen is a major health issue and has an impact on all segments of our society. These guidelines are provided in order to protect the rights of a person with the virus and those that interact with them in the course of their program of study as well as to create an informed and supportive faculty and student community. This policy conforms with the College of the Sequoias policy on HIV and is intended to provide clear guidelines in case of exposure/infection among students and clients.

a. The same policy should apply to students, faculty, or staff except where statutes regulate employment or other relationships.

b. Inquiry into HIV status is not part of the student application process.

c. Schools should inform students of potential infectious hazards inherent in nursing education programs, including those that might pose additional risks to the health of HIV positive persons.

d. Qualified individuals cannot/will not be denied admission to the nursing program on the basis of HIV status.

Since prevention is the only means of controlling HIV, it is imperative that students be aware of prevention guidelines. The current Center for Disease Control (CDC) guidelines and recommendations for preventing transmission of HIV, Hepatitis B, and Hepatitis can be accessed by logging on to:

http://www.cdc.gov/niosh/topics/bbp/universal.html

**GUIDELINES:**
Nursing students may enter school without an understanding of the risk of HIV or of the CDC guidelines. As novice practitioners with limited skills, students may have a greater risk of personal injury with sharps, increasing their risk of exposure to HIV.

**Guidelines for Prevention of HIV include the following**:

a. Students will be provided with current information regarding personal health habits, HIV transmission and risk behaviors, and preventive measures as part of their requisite pre-clinical preparation.

b. Students will receive written and verbal information and instructions on universal precautions in accordance with CDC guidelines. (See Policy B-10 Guidelines to Prevent Transmission of Infectious Disease).

c. These instructions will be reinforced throughout the program and clinical supervision provided to permit compliance in all clinical learning experiences. Faculty will be competent role models in the care of HIV infected clients.

**Guidelines for Management of HIV Positive Clients include the following:**

a. All nursing personnel are professionally and ethically obligated to provide client care with compassion and respect for human dignity. No nursing personnel may ethically refuse to treat a client solely because the client is at risk of contracting or has an infectious disease such as HIV or AIDS.

b. Students and faculty will follow rules of confidentiality and individual rights which apply to all clients.

**Guidelines for Exposure to HIV include the following:**

a. See Policy B-10 Guidelines to Prevent Transmission of Infectious Diseases regarding infection control precautions and procedures following exposure.

b. If exposure occurs, the student will be informed of the CDC recommended guidelines for occupational exposure:

Test for HIV to establish seronegativity at the time of the incident,

Retest at 3 months and 6 months following exposure to rule out development of positive serology.

c. If exposure occurs, counseling will be provided by appropriate personnel through the COS Student Health Services.

**REFERENCE:** Notice of Accidental Exposure

***Policy & Procedure Committee***
**Date Approved/Revised/Reviewed**: 3/93; 12/98; 11/2001; 2/2004; 3/2012. 3/2020

**B-13**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: CLINICAL INJURY OR ILLNESS

**PURPOSE**: This policy describes the procedure to be followed when a student is injured or becomes acutely ill during a clinical assignment.

**DESCRIPTION**:

When a student receives an injury or becomes acutely ill in the clinical laboratory setting, the instructor or designated responsible party shall be notified.

**Instructor Responsibility**: A determination shall be made if the student is in need of referral to one or more of the following:

-Emergency Room: used for treating injuries/illnesses requiring immediate assessment and treatment (i.e. trauma).

-Employee Health Service: if available, may be used to provide a record of the injury and/or illness.

-COS Student Health Service: used for immunization, counseling, follow up, etc.

-Private Physician: for health problems that are not emergency in nature and do not involve possible liability on the part of the agency, or for health clearance to return to class.

-No Referral required.

**Note:** Do not send students to the Emergency Room for needle sticks, splashes, or other contamination incidents unless emergency care is needed. Refer to Guidelines to Prevent Transmission of Infectious Disease (policy B-10).

The instructor will then notify the Program Director and/or Division Chair of the incident, document the injury/illness on letterhead (original to be filed and copy to the student), and refer the student to the COS Payroll department for further direction (see flow chart).

**Student Responsibility**: When a student is seen in the Emergency Room for care, he/she will notify his/her own insurance carrier. The student and his/her health insurance company will be billed for services rendered. If a student has private insurance, that insurance provides the primary coverage. COS Student Insurance is a secondary provider for injuries occurring during clinical laboratory assignments. Further expenses may be covered by COS Student Insurance.
If a student has no other health insurance, COS becomes the primary insurer. This insurance may not pay the entire bill for the ER visit. The student is liable for expenses not paid by

student insurance.

When an injury occurs, a claim must be filed with student insurance. In order for charges to be paid, the following items must be submitted to student insurance:

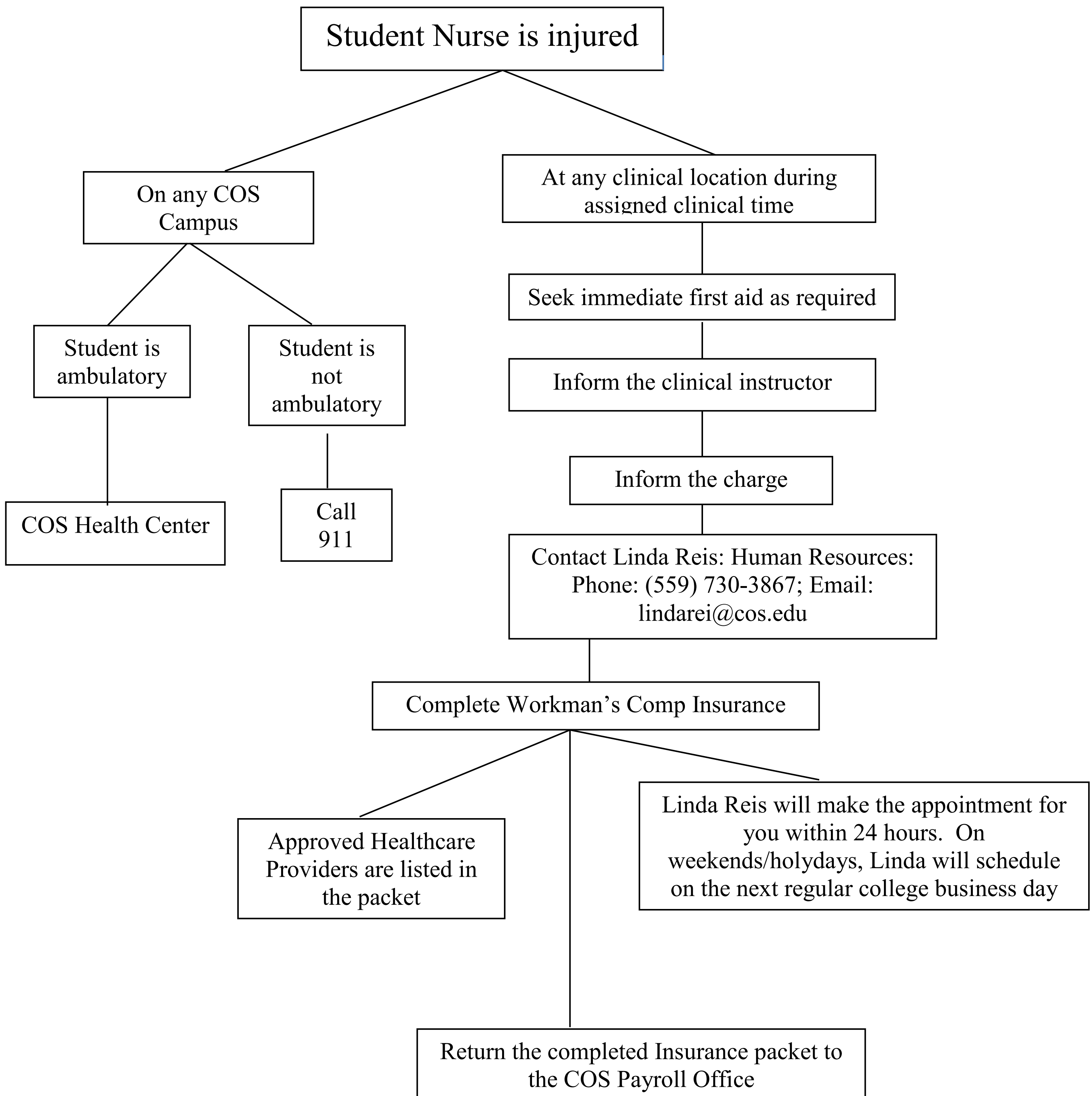
-Claim form (see B-13 flow chart)
-Verification of other insurance
-Itemized bills for services rendered.
-Copy of payments made.
-Physician clearance to return to clinical (copy to nursing office)

After the private carrier (if any) has paid benefits, the Explanation of Benefits Form the student receives must be forwarded to Student Insurance so that any remaining balance can be paid.

**REFERENCE**: Guidelines to Prevent Transmission of Infectious Disease (B-10)
Notice of Accidental Exposure to Infectious Agent Form
Prevention of Transmission of HIV/AIDS (B-12)
Claim Filing Instructions (COS Student Insurance)
B-13 Clinical Injury or Illness Flow Chart

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED:** 6/1994; 12/1998; 3/2004; 5/2010; 4/2015

## B-13: CLINICAL INJURY OR ILLNESS CHART



**B-20**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: CRITICAL STUDENT INCIDENT
**PURPOSE**: This policy describes the procedure for managing and documenting critical violations in students' clinical performance.

**DESCRIPTION**:

1. A Critical Student Incident form will be completed whenever a student is involved in an adverse occurrence in the clinical setting, which causes or has the potential of causing serious harm to another (patient, staff, visitor, other student, etc.).

2. Examples of serious/critical adverse occurrences include, but are not limited to, the following:
   a. serious medication errors endangering or having the potential to endanger a patient
   b. negligent acts resulting in endangerment to another
   c. violations of agency and/or school policies and procedures which endanger another
   d. evidence of being under the influence of drugs/alcohol during clinical rotations
   e. falsification of information
   f. breach of confidentiality (eg. HIPPA)

3. The critical incident shall be immediately reported to all appropriate parties including the Director of the Nursing program.

4. The student will be immediately relieved of further clinical responsibilities.

5. The clinical instructor and the Director shall confer to discuss the nature of the incident and its severity. It is the student's responsibility to make an appointment with the instructor and with the Director within one week from the date of the incident.

6. The student may not continue to participate in clinical experiences until he/she has met with the director or designee and been cleared by the instructor. Failure to do so may result in dismissal from the program.

7. Based on the seriousness of the incident, the student may receive a grade of "Fail" for the clinical portion of the course.

8. Should the student be allowed to continue in the clinical rotation, the Critical Incident form will be attached to the student's Student Evaluation Record (SER). The incident and a written remediation plan will be outlined in the SER and the student's clinical performance will be closely monitored throughout the remainder of the semester.

9. A letter documenting the incident, the remediation plan, and the consequences of further violations in clinical performance will be given to the student with a copy placed in the student's file.

**REFERENCE:** Critical Student Incident Form (Attached)
***Policy & Procedure Committee***

**DATE APPROVED/REVIEWED/REVISED:** 2/1987; 5/1987; 11/1998; 2/2004; 12/2011; 8/2017

**College of the Sequoias**
**Division of Nursing and Allied Health**

# CRITICAL STUDENT INCIDENT

**DATE OF INCIDENT**____________ **STUDENT** _____________________ **COURSE**_______

**Instructor's Description of Incident:**

**Required Action:**

___________________________ _____________
***Instructor Signature*** ***Date***

**Student's Comments:**

___________________________ _____________
***Student Signature*** ***Date***

**Director's Comments:**

**Reviewed by Director:** ___________________________ _____________
***Director Signature*** ***Date***

*Original to Director then Student File* *Copy to Student*

# Student Evaluation and Grading

**B-17**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: STUDENT GRADING

**PURPOSE**: To describe the policy for grading nursing students' theory and clinical performances.

**DESCRIPTION**:

Students will receive a numerical theory grade and a Pass/Fail clinical grade. Any student who does not receive at least a "C" grade for theory and a "Pass" grade for clinical will fail the course.

Examination grades will be posted following testing. Grades will be posted no sooner than 24 hours and no later than 1 week following a test.

Theory grades will be assigned on the following scale:

| | | |
|---|---|---|
| 91 - 100 | A | |
| 81 - 90 | B | **Note: Grades are NOT rounded up.** |
| 75 - 80 | C | **A grade of 74.5 is not rounded up to 75%.** |
| Less than 75 | F | **A grade of 74.9 is a failing grade.** |

Teaching teams will record theory grades and notify students in writing of failing status at midterm before the drop date. Students will be notified of their options at that time:

a. Withdraw prior to the deadline so that the student's grade will be a "W"

b. Continue in the program with the understanding that if the student's scores do not improve; he/she could receive a grade of "F" for the course.

Clinical Pass or Fail grades will be based upon the student's satisfactory clinical performance as outlined in the Student Evaluation Record (SER).

**REFERENCE:** Student Evaluation Record Theory and Clinical/SER (Policy B-18)
Standards of Clinical Conduct (Policy B-5)

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED:** 11/1987; 9/1998; 3/2000; 2/2004; 11/2011; 10/2012; 8/2017

**B-18**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** STUDENT EVALUATION RECORD: THEORY AND CLINICAL

**PURPOSE:** The purpose of the Student Evaluation Record (SER) is to provide on going evaluation for the student of both theory and clinical performance. The SER is correlated to the Registered Nursing program outcomes and is based on current nursing standards. (ANA; QSEN; IOM; BRN see reference)

**DESCRIPTION:**

1. Evaluation is a collaborative, proactive, and ongoing process between student and instructor. It is based on a student's progress in the following areas:
   - Achieving all theory objectives by maintaining a passing grade of 75% or higher on exams
   - Passing all curriculum outcomes and their respective critical behaviors/objectives
   - Passing all theory, clinical, and ATI assignments as described in Course Syllabi
   - No violations of COS, Nursing Program, or Agency policies, procedures, regulations and laws
   - Maintaining current required documents on file with the Nursing Office (CPR; TB test, Immunizations, etc.)
   - No critical incidents in the clinical setting, as documented on the Critical Incident form

2. Each student will be provided with a copy of the SER in their Student Handbook

3. The permanent copy of the SER will be maintained in the Nursing Office for access by all instructors working with the student. This permanent copy will be forwarded to subsequent instructors as the student progresses through the nursing program.

4. Evaluation of student performance is specifically based on meeting objectives related to the Eight(8) Outcomes of the curriculum:
   Caring; Safety; Psychomotor Skills; Critical Thinking; Communication; Health Teaching; Growth, Development, and Adaptation; and Legal/Ethical/Professional Practice.

5. Objectives are leveled (semester-specific) and build upon each other, progressing from basic to complex. They represent the expected competencies of the student as they complete the Associate Degree Nursing Program and are designed to be in compliance with BRN regulations, which require "minimum competency".

6. When problems occur, the student is notified and every effort is made to assist the student through formal remediation, to address and correct the problems as they occur and to provide a supportive and successful learning experience.

7. **Procedure**: The following shall be documented in the SER:

- Dates and total time of all incidents or tardiness and absence
- Notification of Mid-Term warnings (formative evaluation) for theory failure (<75%)
- Theory failure (<75%) at the end of the semester (summative evaluation)
- Skills lab referrals
- Remediation(s)
- Critical student incident involving the clinical setting
- Violations of policies, procedures, regulations, or laws
- Student withdrawal from the program
- Student dismissal from the program

8. Throughout the semester, the instructor(s) of record will maintain the SER and update it as required. Whenever documentation is made, the instructor will meet with the student to discuss the entry. Both the instructor and student will sign the record indication that they met to discuss the entry and that a remediation plan was jointly formulated.

9. For clinical evaluation, the procedure shall be:

- During each rotation, faculty will make entries related to clinical performance as necessary. The instructor will schedule a face-to-face meeting with the student to discuss the entry and to formulate a remediation plan for correction of the problem. Both instructor and student will sign the record and the student will be given a copy of the entry and action plan.
- At the end of each rotation (or at the midterm and end of rotation for 1st semester), the instructor and student will meet face-to-face for a formal evaluation of the student's overall clinical performance throughout the entire rotation. Both instructor and student will sign the record indication that this process was completed.
- To successfully pass a clinical rotation, the student must be in compliance with all Eight (8)-curriculum outcomes and their respective objectives, in order to progress to the next rotation.
- If, during a clinical rotation, a significant problem occurs, instructor and student will discuss it at the time of occurrence and will jointly formulate a specific remediation plan with target dates to achieve remediation. The student will receive a copy of the documentation and the remediation plan.
- If remediation is not successful by the target date, the student will receive a "Failure" for that clinical rotation and will not progress to the next rotation (or next semester if failure occurs during the last rotation).
- If a problem should arise during the last week of a rotation or semester, where adequate remediation time is not available, the remediation plan will carry over to the next rotation or semester, and the incoming instructor will be notified by the out-going instructor prior to the student progressing

- **Critical Student Incident:** If a student is involved in a clinical incident, which is considered serious enough to cause real or potential harm to a client, the incident will be documented on the Critical Student Incident form and the incident will be immediately reported to the Nursing Division Director. The incident will be managed according to the departmental policies and procedures (see Policy and Procedure manual). A copy of form will be attached to the SER.

10. Students who receive a failure in either theory or clinical will be referred to the RN Program

Director to discuss the failure and their options for continuing in the program.

11.

12. If a student questions the failure, he/she will be directed to the "Student Grievance Procedure" located in the Student Handbook.

**REFERENCE**: Student Evaluation Record (Policy B18-1)
Grading Policy (Policy B17)
Critical Incident Report (Policy B20)
Unacceptable Classroom Behavior (Policy B21)
Early Alert Warning Form (Policy B23)
Student Grievance Form (Policy B24)
BRN Standards of Competent Performance (Appendix)
American Nurses Association (ANA)
Quality and Safety Education for Nurses (QSEN)
Institute of Medicine (IOM)
Board of Registered Nursing (BRN)

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED:** 11/1987; 9/1998; 2/2004; 5/2007; 5/2013; 11/2017

**NOTE:** Below are two (2) SER's one for the new Concept Based Curriculum

and one for the previous curriculum which ends December 2021.

**College of the Sequoias**
**Registered Nursing Program**

# Student Evaluation Record: Theory & Clinical

☐

**STUDENT:**_________________________**ENTRY DATE:**__________**GRAD DATE**___________
**( ) LVN**

**Description**
Evaluation is a collaborative and ongoing process based on a student's progress in the following areas:

- achieving all theory objectives and maintaining a passing grade of 75% or higher
- passing all curriculum outcomes and objectives (outlined in the Clinical Evaluation portion of this record)
- passing all theory, clinical and ATI assignments as described in course syllabi
- having no violations of COS, Nursing Program and agency policies, procedures, regulations and laws
- maintaining current required documents on file with the nursing office (i.e. TB test, CPR etc.)
- having no critical incidents in the clinical setting, as documented on the Critical Incident Form

**Timely Documentation and Notification**
Evaluation is a joint process between student and instructors. It is ongoing, proactive, and collaborative. When problems occur, the student is notified and every effort is made to assist the student, through formal remediation, to address and correct problems as they occur and to have a successful learning experience.

**Evaluation of Clinical Performance**
Evaluation of clinical performance is specifically based on meeting the course learning outcomes and competencies.
The following shall be documented in this evaluation record:

- Dates and total time of all incidents of tardiness and absence
- Notification of mid-term warnings (formative evaluation) for theory failure (<75%)
- Theory failure (<75%) at the end of the semester (summative evaluation)
- Clinical Evaluation
- Skills lab referrals
- Remediation(s)
- Critical student incidents involving the clinical setting
- Violations of policies, procedures, regulations and laws
- Student withdrawal from the program
- Student dismissal from the program

Throughout the semester, the instructor(s) of record will maintain this evaluation record and update it as required. Whenever documentation is made, the instructor will meet with the student to discuss the entry. Both the instructor and student will sign the record indicating that they met to discuss the entry and that a correction plan was jointly formulated.

For clinical evaluation, the procedure shall be as follows:

- During each rotation, faculty will make entries related to clinical performance problems as necessary. The instructor will schedule a face-to-face meeting with the student to discuss the entry and to jointly formulate an action plan for correction of the problem. Both instructor and student will sign the record and <u>the student will be given a copy of the entry and action plan.</u>
- At the end of each rotation, the instructor and student will meet face-to-face for a formal evaluation of the student's overall clinical performance throughout the entire rotation. Both instructor and student will sign the record indicating that this process was completed.

- To successfully pass a clinical rotation, the student must be in compliance with all course learning outcomes and competencies in order to progress to the next rotation. If, during a clinical rotation, a significant problem occurs, instructor and student will discuss it at the time of occurrence and will jointly formulate a remediation plan which lists specific actions and target date(s) for successful remediation. The student will receive a copy of the documentation and remediation plan.

- If remediation is not successful by the target date, the student will receive a grade of "Fail" for that clinical rotation and will not progress to the next rotation (or the next semester if failure occurs during the last rotation).

- If a problem should arise during the last week of a rotation or semester, where adequate remediation time is not available, the remediation plan will carry over to the next rotation or semester, and the in-coming instructor will be notified by the out-going instructor prior to the student progressing.

**Critical Student Incident**: If a student is involved in a clinical incident which is considered serious enough to cause real or potential harm to a client, the incident will be documented on the Critical Student Incident form and the incident will be immediately reported to the Nursing Division Director. The incident will be managed according to departmental policies and procedures (refer to P&P Manual). A copy of the incident form will be attached to this record.

# Attendance Record

| TARDINESS | | | | ABSENCE | | | |
|---|---|---|---|---|---|---|---|
| 1st Sem | 2nd Sem | 3rd Sem | 4th Sem | 1st Sem | 2nd Sem | 3rd Sem | 4th Sem |
| Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: |
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# Mid-Term Warning and Theory Failure

| | Mid-Term Warning | Theory Failure |
|---|---|---|
| **N121** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc.<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt. with Director<br>Notes:<br><br>Instructor Signature: |
| **N123** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc.<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt. with Director<br>Notes:<br><br>Instructor Signature: |
| **N124** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc.<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt. with Director<br>Notes:<br><br>Instructor Signature: |
| **N133** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc.<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt. with Director<br>Notes:<br><br>Instructor Signature: |

| | | |
|---|---|---|
| **N134** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br><br>Instructor Signature: |
| **N135** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br><br>Instructor Signature: |
| **N143** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br><br>Instructor Signature: |
| **N144** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br><br>Instructor Signature: |

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|---|---|---|
| **N174** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br><br><br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br><br><br><br>Instructor Signature: |
| **N175** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br><br><br><br>Instructor Signature: | Date:________________Final % Grade: _____________<br>( ) Planning to Return When:____________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br><br><br><br>Instructor Signature: |

# Skills Lab Referrals and Remediation

| Skills Lab Referral | | Remediation |
|---|---|---|
| **1st Sem** | Date: ________________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Date Student Attended Lab: _____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br><br>Instructor Signature: | Date:__________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: __________________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |
| **2nd Sem** | Date: ________________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Team & Director Notified<br>( ) Counseled<br>Date Student Attended Lab: _____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br><br>Instructor Signature: | Date:__________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: __________________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |
| **3rd Sem** | Date: ________________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Team & Director Notified<br>( ) Counseled<br>Date Student Attended Lab: _____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br><br>Instructor Signature: | Date:__________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: __________________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |
| **4th Sem** | Date: ________________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Team & Director Notified<br>( ) Counseled<br>Date Student Attended Lab: _____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br><br>Instructor Signature: | Date:__________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: __________________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |

# Reference Table of Curriculum Outcomes & Competencies

## Semester 1

## NURS 121: Fundamentals for Nursing

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 1:** At a basic level provide safe, quality, evidence-based, patient-centered nursing care to promote and maintain physical and mental health in a variety of healthcare settings for patients with well-defined healthcare concerns. | | |

Competencies:

- At a basic level, collect physical, behavioral, psychological, and spiritual data related to health and illness parameters in patients with well-defined healthcare concerns including developmental and cultural aspects of care.
- Identify patient needs based on assessment data and other collected information.
- Identify assessment data to use as a basis for planning individualized care.
- At a beginning level, implement nursing interventions to prevent illness and maintain physical and mental health for patients with well-defined healthcare concerns with a focus on the elderly.
- Identify factors that create a culture of safety when providing care to adults with a focus on the elderly.
- Reinforce basic teaching that reflects the patient's age, culture, religion, spirituality, and patient preferences.
- Complete assigned care on time.
- Identify patient outcome data that can be used to evaluate the effectiveness of planned nursing care and suggest modification to the plan of care.
- Communicate information about care provided that can be used in a hand-off communication.
- Safely, compassionately, and with beginning competency perform basic nursing skills.
- At a beginning level, accurately document aspects of patient care provided.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 2:** Begin to use basic clinical judgment skills to make patient-centered care decisions for patients with well-defined healthcare concerns. | | |

Competencies:

- Begin to use basic clinical judgment to ensure accurate and safe care.
- Begin to identify potential complications for select patients under study.
- Identify ways to prioritize patient care.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 3:** Discuss quality improvement activities used by the Registered Nurse to improve patient care. | | |

Competencies:

- Identify quality improvement activities used to improve care.

- Discuss how data from quality improvement activities relate to safe patient care.
- Explain the purpose of National Patient Safety Goals when providing basic nursing care in both acute and long-term care environments.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 4:** Identify ways the Registered Nurse collaborates with members of the interprofessional team when providing patient care. | | |

## Competencies:

- Begin to identify pertinent information to share with members of the interprofessional team.
- Discover ways the Registered Nurse works with other members of the healthcare team, including the patient and the patient's family, to provide safe patient care in the clinical setting.
- Discuss the impact of team functioning on safety and quality improvement.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 5:** Begin to use information technology to support and communicate the provision of patient care. | | |

## Competencies:

- Begin to use patient care technologies and communication devices to support safe nursing practice.
- Explain the importance of accurate, complete, and timely documentation of care as part of information technology that enhances safe patient care.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 6:** Describe the scope of practice of the Registered Nurse within the context of legal and ethical practice. | | |

## Competencies

- Relate legal and ethical guidelines used to provide basic nursing care.
- Discuss the purpose of the ANA Standards of Practice.
- Explain the importance of accountability in nursing practice.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

## Mid-Rotation Review Signatures and Date

Student:_______________________________________________ Date: ____________________________________

Clinical Instructor:___________________________________ Date: ____________________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:_______________________________________________ Date: ____________________________________

Clinical Instructor:___________________________________ Date: ____________________________________

**General Comments**

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# NURS 124: Concepts of Adult Health Nursing, 1

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 1:** At a basic level provide safe, quality, evidence-based, patient-centered nursing care to promote and maintain physical and mental health in a variety of healthcare settings for patients with well-defined healthcare concerns. | | |

Competencies:

- At a basic level, collect physical, behavioral, psychological, and spiritual data when caring for patients with well-defined healthcare concerns including developmental and cultural aspects of care.
- Identify patient needs based on assessment data and other collected information.
- Identify assessment data to use as a basis for planning individualized care.
- At a beginning level, implement nursing interventions to prevent illness and maintain physical and mental health for patients with well-defined healthcare concern with a focus on the elderly.
- Identify factors that create a culture of safety when providing care to adults with a focus on the elderly.
- Reinforce basic teaching that reflects the patient's age, culture, religion, spirituality, and patient preferences.
- Complete assigned care on time.
- Identify patient outcome data that can be used to evaluate the effectiveness of planned nursing care and suggest modification to the plan of care.
- Communicate information about care provided that can be used in a hand-off communication.
- Safely, compassionately, and with beginning competency perform basic nursing skills.
- At a beginning level, accurately document aspects of patient care provided.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome *2:*** Begin to use basic clinical judgment skills to make patient-centered care decisions for patients with well-defined healthcare concerns. | | |

Competencies:

- Begin to use basic clinical judgment to ensure accurate and safe care.
- Begin to identify potential complications for select patients under study.
- Identify ways to prioritize patient care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 3:** Discuss quality improvement activities used by the Registered Nurse to improve patient care. | | |

Competencies:

- Identify quality improvement activities used to improve care.
- Discuss how data from quality improvement activities relate to safe patient care.
- Explain the purpose of National Patient Safety Goals when providing basic nursing care in both acute and long-term care environments.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 4:** Identify ways the Registered Nurse collaborates with members of the interprofessional team when providing patient care. | | |

Competencies:

- Begin to identify pertinent information to share with members of the interprofessional team.
- Discover ways the Registered Nurse works with other members of the healthcare team, including the patient and the patient's family, to provide safe patient care in the clinical setting.
- Discuss the impact of team functioning on safety and quality improvement.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 5:** Begin to use information technology to support and communicate the provision of patient care. | | |

Competencies:

- Begin to use patient care technologies and communication devices to support safe nursing practice.
- Explain the importance of accurate, complete, and timely documentation of care as part of information technology that enhances safe patient care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 6:** Describe the scope of practice of the Registered Nurse within the context of legal and ethical practice. | | |

Competencies:

- Relate legal and ethical guidelines used to provide basic nursing care.
- Discuss the purpose of the ANA Standards of Practice.
- Explain the importance of accountability in nursing practice.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**Mid-Rotation Review Signatures and Date**

Student:_______________________________________________ Date: ____________________________________

Clinical Instructor:__________________________________ Date: ____________________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:_______________________________________________ Date: ____________________________________

Clinical Instructor:__________________________________ Date: ____________________________________

**General Comments**

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## Semester 2
## NURS 133: Concepts of Mental Health & Psychiatric Nursing

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 1:** Apply nursing concepts to provide safe, compassionate, quality, evidence-based, patient-centered nursing care to patients with various mental health needs. | | |

Competencies:

- Conduct a head-to-toe and focused physical, behavioral, psychological, and spiritual assessment of health and illness parameters, using developmentally and culturally appropriate approaches for patients with various mental health needs.
- Identify patient needs based on assessment findings and other relevant information.
- Develop an individualized plan of care identifying evidence-based nursing care for patients with various mental health needs.
- Deliver selected aspects of patient-centered care based on an understanding of human growth and development, pathophysiology, pharmacology, nutrition, medical management, and nursing management for patients with various mental health needs.
- Apply factors that promote a culture of safety and caring for patients with various mental health needs.
- Contribute to a teaching plan that reflects the patient's developmental stage, age, culture, religion, spirituality, patient preferences, and health literacy considerations for patients with various mental health needs.
- Deliver care within expected timeframe for patients with various mental health needs.
- Collect data to evaluate the effectiveness and impact of nursing care then use to revise the plan of care.
- Communicate effectively when providing patient-centered transitions of care and hand-off communications.
- Demonstrate safe performance in a compassionate manner of basic psychomotor skills for patients with various mental health needs.
- Accurately document all aspects of patient care.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome *2:*** Demonstrate clinical judgment to make patient-centered care decisions for patients with various mental health needs. | | |

Competencies:

- Begin to apply clinical judgment to ensure accurate and safe nursing care, including addressing anticipated changes in the patient's condition.
- Anticipate common risks for the reproducing family and predict and manage potential complications.
- Determine the best method for prioritizing patient care for patients with various mental health needs.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 3**: Relate quality improvement processes to improve patient care outcomes for patients with various mental health needs. | | |

Competencies:

- Apply quality improvement processes to effectively implement patient safety initiatives and monitor performance measures, including nursing-sensitive indicators.
- Seek information about the clinical microsystem to determine its impact on the nurse's ability to provide safe, quality care.
- Implement National Patient Safety Goals when caring for patients with various mental health needs.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 4:** Contribute to teamwork and collaboration with members of the interprofessional team, the patient, and the patient's support persons when caring for patients with various mental health needs. | | |

Competencies:

- Begin to engage in communication with members of the healthcare team, including the patient and the patient's support network when making decisions and planning care for patients with various mental health needs.
- Determine appropriate interprofessional healthcare professionals with whom to collaborate when developing a plan of care for patients with various mental health needs.
- Describe the use of conflict resolution principles as needed on the patient care unit.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 5:** Apply knowledge of information management systems and patient care technology used to communicate, manage knowledge, mitigate error, and support clinical judgment when caring for patients with various mental health needs. | | |

Competencies:

- Differentiate among various patient care technologies, information systems/technologies, and communication devices to support safe nursing practice.
- Apply concepts related to information technology and information systems to improve patient outcomes and create a safe care environment.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 6:** Apply concepts of leadership, management, legal, and ethical principles to guide practice as a Registered Nurse when caring for patients with various mental health needs. | | |

Competencies:

- Apply legal and ethical frameworks of Registered Nursing practice when caring for patients with various mental health needs.
- Apply the ANA Standards of Practice when caring for patients with various mental health needs.
- Apply principles of accountability for nursing care given by self-and/or delegated to others.
- Explain how leadership and management skills are used when working with other healthcare team members.
- Provide examples of self as a patient advocate when caring for patients with various mental health needs.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**<u>Mid-Rotation Review Signatures and Date</u>**

Student:_______________________________________________ Date: _________________________________

Clinical Instructor:__________________________________ Date: ________________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**<u>Final Review Signatures and Date</u>**

Student:_______________________________________________ Date: _________________________________

Clinical Instructor:__________________________________ Date: ________________________________

**<u>General Comments</u>**

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# NURS 134: Concepts of Adult Health Nursing, 2

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 1:** Apply nursing concepts to provide safe, quality, compassionate, evidence-based, patient-centered nursing care to diverse adult patients with acute and chronic conditions. | | |

Competencies:

- Conduct a head-to-toe and focused physical, behavioral, psychological, and spiritual assessment of health and illness parameters, using developmentally and culturally appropriate approaches for diverse adult patients with acute and chronic conditions.
- Identify patient needs based on assessment findings and other relevant information.
- Develop an individualized plan of care identifying evidence-based nursing care for diverse adult patients with acute and chronic conditions.
- Deliver selected aspects of patient-centered care based on an understanding of human growth and development, pathophysiology, pharmacology, nutrition, medical management, and nursing management for diverse adult patients with acute and chronic conditions.
- Apply factors that promote a culture of safety and caring for diverse adult patients with acute and chronic conditions.
- Contribute to a teaching plan that reflects the patient's developmental stage, age, culture, religion, spirituality, patient preferences, and health literacy considerations for diverse adult patients with acute and chronic conditions.
- Deliver care within expected timeframe for diverse adult patients with acute and chronic conditions.
- Collect data to evaluate the effectiveness and impact of nursing care then use to revise the plan of care.
- Communicate effectively when providing patient-centered transitions of care and hand-off communications.
- Demonstrate safe performance in a compassionate manner of basic psychomotor skills for patients with various mental health needs.
- Accurately document all aspects of patient care.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome *2:*** Demonstrate clinical judgment to make patient-centered care decisions for patients with acute and chronic conditions. | | |

Competencies:

- Begin to apply clinical judgment to ensure accurate and safe nursing care, including addressing anticipated changes in the patient's condition.
- Anticipate common risks for the reproducing family and predict and manage potential complications.
- Determine the best method for prioritizing patient care for diverse adult patients with acute and chronic conditions.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 3**: Relate quality improvement processes to improve patient care outcomes for patients with acute and chronic conditions. | | |

Competencies:

- Apply quality improvement processes to effectively implement patient safety initiatives and monitor performance measures, including nursing-sensitive indicators.
- Seek information about the clinical microsystem to determine its impact on the nurse’s ability to provide safe, quality care.
- Implement National Patient Safety Goals when caring for diverse adult patients with acute and chronic conditions.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 4:** Contribute to teamwork and collaboration with members of the interprofessional team, the patient, and the patient's support persons when caring for diverse adult patients with acute and chronic conditions. | | |

Competencies:

- Begin to engage in communication with members of the healthcare team, including the patient and the patient's support network when making decisions and planning care diverse adult patients with acute and chronic conditions.
- Determine appropriate interprofessional healthcare professionals with whom to collaborate when developing a plan of care for diverse adult patients with acute and chronic conditions.
- Describe the use of conflict resolution principles as needed on the patient care unit.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 5:** Apply knowledge of information management systems and patient care technology used to communicate, manage knowledge, mitigate error, and support clinical judgment when caring for diverse adult patients with acute and chronic conditions. | | |

Competencies:

- Differentiate among various patient care technologies, information systems/technologies, and communication devices to support safe nursing practice.
- Apply concepts related to information technology and information systems to improve patient outcomes and create a safe care environment.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 6:** Apply concepts of leadership, management, legal, and ethical principles to guide practice as a Registered Nurse when caring for patients with acute and chronic conditions. | | |

Competencies:

- Apply legal and ethical frameworks of Registered Nursing practice when caring for diverse adult patients with acute and chronic conditions.
- Apply the ANA Standards of Practice when caring for diverse adult patients with acute and chronic conditions.
- Apply principles of accountability for nursing care given by self-and/or delegated to others.
- Explain how leadership and management skills are used when working with other healthcare team members.
- Provide examples of self as a patient advocate when caring for diverse adult patients with acute and chronic conditions.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**Mid-Rotation Review Signatures and Date**

Student:______________________________________________ Date: ____________________________________

Clinical Instructor:_____________________________________ Date: ___________________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:______________________________________________ Date: ____________________________________

Clinical Instructor:_____________________________________ Date: ___________________________________

**General Comments**

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# NURS 135: Concepts of Nursing Care of the Pregnant Family and the Neonate

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 1:** Apply nursing concepts to provide safe, quality, compassionate, evidence-based, patient-centered nursing care to the pregnant family and neonate. | | |

Competencies:

- Conduct a head-to-toe and focused physical, behavioral, psychological, and spiritual assessment of health and illness parameters, using developmentally and culturally appropriate approaches for the pregnant family and neonate.
- Identify patient needs based on assessment findings and other relevant information.
- Develop an individualized plan of care identifying evidence-based nursing care for the pregnant family and neonate.
- Deliver selected aspects of patient-centered care based on an understanding of human growth and development, pathophysiology, pharmacology, nutrition, medical management, and nursing management for the pregnant family and neonate.
- Apply factors that promote a culture of safety and caring for the pregnant family and neonate.
- Contribute to a teaching plan that reflects the patient's developmental stage, age, culture, religion, spirituality, patient preferences, and health literacy considerations for the pregnant family and neonate.
- Deliver care within expected timeframe for the pregnant family and neonate.
- Collect data to evaluate the effectiveness and impact of nursing care then use to revise the plan of care.
- Communicate effectively when providing patient-centered transitions of care and hand-off communications.
- Demonstrate safe performance in a compassionate manner of basic psychomotor skills for the pregnant family and neonate.
- Accurately document all aspects of patient care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome *2:*** Demonstrate clinical judgment to make patient-centered care decisions for the pregnant family and neonate. | | |

Competencies:

- Begin to apply clinical judgment to ensure accurate and safe nursing care, including addressing anticipated changes in the patient's condition.
- Anticipate common risks for the reproducing family and predict and manage potential complications.
- Determine the best method for prioritizing patient care for the pregnant family and neonate.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 3**: Relate quality improvement processes to improve patient care outcomes for the pregnant family and neonate. | | |

Competencies:

- Apply quality improvement processes to effectively implement patient safety initiatives and monitor performance measures, including nursing-sensitive indicators.
- Seek information about the clinical microsystem to determine its impact on the nurse’s ability to provide safe, quality care.
- Implement National Patient Safety Goals when caring for the pregnant family and neonate.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 4:** Contribute to teamwork and collaboration with members of the interprofessional team, the patient, and the patient's support persons when caring for the pregnant family and neonate. | | |

Competencies:

- Begin to engage in communication with members of the healthcare team, including the patient and the patient's support network when making decisions and planning care for the pregnant family and neonate.
- Determine appropriate interprofessional healthcare professionals with whom to collaborate when developing a plan of care for the pregnant family and neonate.
- Describe the use of conflict resolution principles as needed on the patient care unit.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 5:** Apply knowledge of information management systems and patient care technology used to communicate, manage knowledge, mitigate error, and support clinical judgment when caring for the pregnant family and neonate. | | |

Competencies:

- Differentiate among various patient care technologies, information systems/technologies, and communication devices to support safe nursing practice.
- Apply concepts related to information technology and information systems to improve patient outcomes and create a safe care environment.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 6:** Apply concepts of leadership, management, legal, and ethical principles to guide practice as a Registered Nurse when caring for the pregnant family and neonate. | | |

Competencies:

- Apply legal and ethical frameworks of Registered Nursing practice when caring for the pregnant family and neonate.
- Apply the ANA Standards of Practice when caring for the pregnant family and neonate.
- Apply principles of accountability for nursing care given by self-and/or delegated to others.
- Explain how leadership and management skills are used when working with other healthcare team members.
- Provide examples of self as a patient advocate when caring for the pregnant family and neonate.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**Mid-Rotation Review Signatures and Date**

Student:______________________________ Date: ______________________________

Clinical Instructor:______________________________ Date: ______________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:______________________________ Date: ______________________________

Clinical Instructor:______________________________ Date: ______________________________

**General Comments**

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# Semester 3

## NURS 143: Concepts of Pediatric Nursing

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 1:** Analyze nursing concepts to provide safe, quality, compassionate, evidence-based, patient-centered nursing care to children, their families, and other support persons. | | |

Competencies:

- Conduct a focused and comprehensive physical, behavioral, psychological, and spiritual assessment of health and illness parameters, using developmentally and culturally appropriate approaches when providing care for children.
- Differentiate important data related to patient needs based on assessment findings.
- Develop an individualized plan of care identifying evidence-based nursing care considering individual patient needs.
- Provide patient-centered care based on an understanding of human growth and development, pathophysiology, pharmacology, nutrition, medical management, and nursing management.
- Differentiate among factors that are most important for creating a culture of safety and caring for children.
- Implement priority patient teaching that reflects the patient's developmental stage, age, culture, religion, spirituality, patient preferences, and health literacy considerations when providing care for children.
- Deliver care within expected timeframe when providing care for children.
- Select priority patient outcomes to evaluate the effectiveness and impact of nursing care used to revise the plan of care.
- Demonstrate how to property provide patient-centered transitions of care and hand-off communications, including discharge planning.
- Demonstrate safe, compassionate performance of psychomotor skills when providing care for children.
- Accurately document all aspects of patient care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome** ***2:*** Apply clinical judgment to make complex patient-centered care decisions when providing care for children, their families, and other support persons. | | |

Competencies:

- Apply clinical judgment to ensure accurate and safe nursing care, including addressing anticipated changes in the patient's condition.
- Analyze the patient situation to determine common risks when providing care for children and predict and manage potential complications.
- Prioritize nursing interventions when caring for children.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 3**: Select quality improvement processes to improve patient care outcomes when providing care for children, their families, and other support persons. | | |

Competencies:

- Analyze quality improvement processes to effectively implement patient safety initiatives and monitor performance measures, including nursing-sensitive indicators.
- Apply information about the clinical microsystem to determine its impact on the nurse's ability to provide safe, qualitycare.
- Analyze the use of National Patient Safety Goals in the care of children.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 4:** Initiate teamwork and collaboration with members of the interprofessional team, the patient, and the patient's support persons when providing care for children, their families, and other support persons. | | |

Competencies:

- Analyze own communications with members of the healthcare team, including the patient and the patient's support network when making decisions and planning care for children.
- Engage in communication with the appropriate interprofessional healthcare team member when providing care forchildren.
- Apply conflict resolution principles as needed on the patient care unit.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 5**: Analyze the role of information management systems and patient care technology used to communicate, manage knowledge, mitigate error, and support decision-making when providing care for children, their families, and other support persons. | | |

Competencies:

- Analyze various patient care technologies, information systems/technologies, and communication devices to support safe nursing practice when providing care for children.
- Demonstrate the use of concepts related to information technology and information systems to improve patient outcomes and create a safe care environment.
- Select high quality electronic healthcare resources to plan quality care.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 6:** Analyze leadership, management, legal, and ethical principles to use as a basis for practice as a Registered Nurse when caring for children, their families, and other support persons. | | |

Competencies:

- Apply specific legal and ethical principles of Registered Nursing practice when caring for children.
- Analyze how the ANA Standards of Practice apply to care of children.
- Demonstrate accountability for nursing care given by self-and/or delegated to others.
- Demonstrate how leadership and management skills are used when working with other healthcare team members.
- Provide examples of self-serving as a patient advocate when caring for children.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**Mid-Rotation Review Signatures and Date**

Student:________________________________________ Date: ______________________________

Clinical Instructor:________________________________ Date: ______________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:________________________________________ Date: ______________________________

Clinical Instructor:________________________________ Date: ______________________________

**General Comments**

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## NURS 144: Concepts of Adult Health Nursing, 3

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 1:** Analyze nursing concepts to provide safe, quality, compassionate, evidence-based, patient-centered nursing care to adult patients with complicated conditions, their families, and other support persons. | | |

Competencies:

- Conduct a focused and comprehensive physical, behavioral, psychological, and spiritual assessment of health and illness parameters, using developmentally and culturally appropriate approaches for adult patients with complicated conditions.
- Differentiate important data related to patient needs based on assessment findings.
- Develop an individualized plan of care identifying evidence-based nursing care considering individual patientneeds.
- Provide patient-centered care based on an understanding of human growth and development, pathophysiology, pharmacology, nutrition, medical management, and nursing management.
- Differentiate among factors that are most important for creating a culture of safety and caring for adult patients with complicated conditions.
- Implement priority patient teaching that reflects the patient's developmental stage, age, culture, religion, spirituality, patient preferences, and health literacy considerations for adult patients with complicated conditions.
- Deliver care within expected timeframe for adult patients with complicated conditions.
- Select priority patient outcomes to evaluate the effectiveness and impact of nursing care used to revise the plan ofcare.
- Demonstrate how to property provide patient-centered transitions of care and hand-off communications, including discharge planning.
- Demonstrate safe, compassionate performance of psychomotor skills for adult patients with complicated conditions.
- Accurately document all aspects of patient care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome** ***2:*** Apply clinical judgment to make complex patient-centered care decisions for adult patients with complicated conditions, their families, and other support persons. | | |

Competencies:

- Apply clinical judgment to ensure accurate and safe nursing care, including addressing anticipated changes in the patient's condition.
- Analyze the patient situation to determine common risks when providing care for children, and predict and manage potential complications.
- Prioritize nursing interventions in the care of adult patients with complicated conditions.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 3**: Select quality improvement processes to improve patient care outcomes for adult patients with complicated conditions, their families, and other support persons. | | |

Competencies:

- Analyze quality improvement processes to effectively implement patient safety initiatives and monitor performance measures, including nursing-sensitive indicators.
- Apply information about the clinical microsystem to determine its impact on the nurse's ability to provide safe, quality care.
- Analyze the use of National Patient Safety Goals in the care of adult patients with complicated conditions.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 4**: Initiate teamwork and collaboration with members of the interprofessional team, the patient, and the patient's support persons when caring for adult patients with complicated conditions, their families, and other support persons. | | |

Competencies:

- Analyze own communications with members of the healthcare team, including the patient and the patient's support network when making decisions and planning care for adult patients with complicated conditions.
- Engage in communication with the appropriate interprofessional healthcare team member when developing a plan of care for adult patients with complicated conditions.
- Apply conflict resolution principles as needed on the patient care unit.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 5**: Analyze the role of information management systems and patient care technology used to communicate, manage knowledge, mitigate error, and support decision-making when caring for adult patients with complicated conditions, their families, and other support persons. | | |

Competencies:

- Analyze various patient care technologies, information systems/technologies, and communication devices to support safe nursing practice when caring for adult patients with complicated conditions.
- Demonstrate the use of concepts related to information technology and information systems to improve patient outcomes and create a safe care environment.
- Select high quality electronic healthcare resources to plan quality care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 6:** Analyze leadership, management, legal, and ethical principles to use as a basis for practice as a Registered Nurse when caring for adult patients with complicated conditions, their families, and other support persons. | | |

Competencies:

- Apply specific legal and ethical principles of Registered Nursing practice when caring for adult patients with complicated conditions.
- Analyze how the ANA Standards of Practice apply to care of adult patients with complicated conditions.
- Demonstrate accountability for nursing care given by self and/or delegated to others.
- Demonstrate how leadership and management skills are used when working with other healthcare team members.
- Provide examples of self-serving as a patient advocate when caring for adult patients with complicated conditions.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**Mid-Rotation Review Signatures and Date**

Student:__________________________________ Date: ____________________________

Clinical Instructor:____________________________ Date: ____________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:__________________________________ Date: ____________________________

Clinical Instructor:____________________________ Date: ____________________________

**General Comments**

# Semester 4

## NURS 174: Concepts of Adult Health Nursing, 4

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | ***First Rotation Score*** | ***Second Rotation Score*** |
|---|---|---|
| **Student Learning Outcome 1:** Provide safe, quality, compassionate, evidence-based, patient-centered nursing care to adult patients with complex healthcare needs in a variety of healthcare settings. | | |

Competencies:

- Conduct a comprehensive and/or focused physical, behavioral, psychological, and spiritual assessment of health and illness parameters, using developmentally and culturally appropriate approaches for adult patients with complex healthcare.
- Identify patient needs based on assessment findings of adult patients with complex healthcare needs.
- Develop an individualized plan of care identifying evidence-based nursing care considering individual patient needs.
- Provide patient-centered care based on an understanding of human growth and development, pathophysiology, pharmacology, nutrition, medical management, and nursing management for adult patients with complex healthcare needs.
- Promote factors that create a culture of safety and caring in the adult healthcare environment.
- Provide individualized, patient-specific teaching to adult patients with complex healthcare needs.
- Deliver care within expected timeframe.
- Monitor patient outcomes to evaluate the effectiveness and impact of nursing care to revise the plan of care for adult patients with complex healthcare needs.
- Provide patient-centered transitions of care and hand-off communications.
- Safely perform nursing skills in a caring, compassionate manner.
- Accurately document all aspects of patient care.

| | ***First Rotation Score*** | ***Second Rotation Score*** |
|---|---|---|
| **Student Learning Outcome *2:*** Engage in clinical judgment when making patient-centered care and other nursing decisions for adult patients with complex healthcare needs. | | |

Competencies:

- Use clinical judgment to ensure accurate and safe nursing care for the goal of improving patient outcomes.
- Anticipate risks and predict and manage potential complications for adult patients with complex healthcare needs.
- Prioritize care based on individual patient needs.

| | ***First Rotation Score*** | ***Second Rotation Score*** |
|---|---|---|
| **Student Learning Outcome 3**: Participate in quality improvement processes to improve patient care outcomes for adult patients with complex healthcare needs. | | |

Competencies:

- Use quality improvement processes, including nursing-sensitive indicators, to effectively implement patient safety initiatives and monitor performance measures on the adult health unit.
- Examine the clinical environment to determine its impact on the nurse's ability to provide safe, quality care for adult patients with complex healthcare needs.
- Participate in analyzing errors and identifying system improvements in the adult health environment.
- Implement National Patient Safety Goals in all applicable patient care settings.

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *First Rotation Score* | *Second Rotation Score* |
|---|---|---|
| **Student Learning Outcome 4**: Participate in teamwork and collaboration with all members of the healthcare team including the adult patient with complex healthcare needs. | | |

Competencies:

- Effectively communicate with all members of the healthcare team, including the patient and the patient's support network when making decisions and planning evidence-based nursing care.
- Collaborate with appropriate interprofessional healthcare professionals when developing a comprehensive plan of care for adult patients with complex healthcare needs.
- Use conflict resolution principles as appropriate on the adult healthcare unit.

| | *First Rotation Score* | *Second Rotation Score* |
|---|---|---|
| **Student Learning Outcome 5**: Employ information management systems and patient care technology to communicate, manage knowledge, mitigate error, and support clinical judgment when caring for adult patients with complex healthcare needs. | | |

Competencies:

- Use patient care technologies, information systems/technologies, and communication devices to support safe nursing practice in the adult healthcare environment.
- Evaluate the role of information technology and information systems in improving patient outcomes and creating a safe care environment for adult patients with complex healthcare needs.
- Use high quality electronic sources of healthcare information when planning patient care.

| | *First Rotation Score* | *Second Rotation Score* |
|---|---|---|
| **Student Learning Outcome 6:** Use leadership, management, legal, and ethical principles to guide practice as a Registered Nurse on the adult healthcare unit. | | |

Competencies:

- Practice within the legal and ethical guidelines of Registered Nursing practice when caring for adult patients with complex healthcare needs.
- Analyze patient care within the context of the ANA Standards of Practice.
- Demonstrate accountability for nursing care given by self-and/or delegated to others.
- Apply leadership and management skills when working with other healthcare team members.
- Serve as a patient advocate for adult patients with complex healthcare needs.
- Complete a plan for ongoing professional development and lifelong learning.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**Mid-Rotation Review Signatures and Date**

Student:_______________________________________________ Date: _____________________________________

Clinical Instructor:___________________________________ Date: _____________________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**Final Review Signatures and Date**

Student:_______________________________________________ Date: _____________________________________

Clinical Instructor:___________________________________ Date: _____________________________________

**General Comments**

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# NURS 175: Transition to Registered Nursing Practice

**Grading Scale: P=Pass F=Fail NI=Needs Improvement (MR Only)**

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 1:** Analyze a variety of patient situations to plan safe, quality, evidence-based, patient-centered nursing care within the scope of practice of a Registered Nurse. | | |

Competencies:

- Plan patient-centered care for a variety of patients across the lifespan.
- Analyze nursing care for patients to determine if safe, quality, patient care was delivered.
- Examine evidence-based practices used by the Registered Nurse.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome *2:*** Apply clinical judgment when addressing a variety of patient situations. | | |

Competencies:

- Apply knowledge of Registered Nursing practice using clinical judgment and the nursing process.
- Incorporate risk facts and predict and manage potential complications to case studies that present a variety of patient situations across the life span.
- Prioritize patient care.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 3**: Evaluate quality measures for the purpose of improving patient care. | | |

Competencies:

- Examine patient outcomes to determine if quality measures were implemented.
- Examine nursing care to determine the effect of quality improvement processes used to prevent errors and protect patient safety.
- Review case studies to determine how National Patient Safety Goals apply to the situation.

| | *MR Score* | *Final Score* |
|---|---|---|
| **Student Learning Outcome 4**: Determine the effect of teamwork and collaboration with members of the interprofessional team, the patient, and the patient's support persons. | | |

Competencies:

- Determine pertinent, accurate, and complete information to communicate to the interprofessional team to use for planning patient care.
- Interpret the impact of team functioning on safety and quality improvement.
- Apply conflict resolution principles to patient care scenarios.

**Grading Scale:** **P=Pass** **F=Fail** **NI=Needs Improvement (MR Only)**

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 5**: Demonstrate the use of information technology to support and communicate the provision of patient care. | | |

Competencies:

- Use patient care technologies, information systems/technologies, and communication devices to document nursing care.
- Enter computer documentation accurately and completely.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 6:** Incorporate leadership, management, legal, and ethical principles to guide practice as a Registered Nurse in a variety of healthcare settings. | | |

Competencies:

- Incorporate practice standards and guidelines for legal and ethical conduct to patient situations across the life span in a variety of healthcare settings.
- Determine if care meets acceptable standards of practice.
- Apply leadership and management skills when working with other healthcare team members.
- Determine role as a patient advocate in a variety of patient situations.

| | ***MR Score*** | ***Final Score*** |
|---|---|---|
| **Student Learning Outcome 7**: Articulate personal strategies for success in passing the licensure examination. | | |

Competencies:

- Plan study strategies for preparation for the NCLEX-RN®.
- Develop an action plan for success on the NCLEX-RN®.

**Mid-Rotation Assessment (circle one):** Satisfactory Needs Improvement

**<u>Mid-Rotation Review Signatures and Date</u>**

Student:______________________________ Date: ______________________________

Clinical Instructor:______________________________ Date: ______________________________

**Final Assessment (circle one):** **Pass**-Satisfactory **No Pass**-Unsatisfactory

**<u>Final Review Signatures and Date</u>**

Student:______________________________ Date: ______________________________

Clinical Instructor:______________________________ Date: ______________________________

**<u>General Comments</u>**

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**College of the Sequoias**
**Registered Nursing Program**

# Student Evaluation Record: Theory & Clinical (Old Curriculum)

**STUDENT: ____________________________ENTRY DATE:_________ GRAD DATE_________ ( ) LVN**

**Description**
Evaluation is a collaborative and ongoing process based on a student's progress in the following areas:

- achieving all theory objectives and maintaining a passing grade of 75% or higher
- passing all curriculum outcomes and objectives (outlined in the Clinical Evaluation portion of this record)
- passing all theory, clinical and ATI assignments as described in course syllabi
- having no violations of COS, Nursing Program and agency policies, procedures, regulations and laws
- maintaining current required documents on file with the nursing office (i.e. TB test, CPR etc.)
- having no critical incidents in the clinical setting, as documented on the Critical Incident Form

**Timely Documentation and Notification**
Evaluation is a joint process between student and instructors. It is ongoing, proactive, and collaborative. When problems occur, the student is notified and every effort is made to assist the student, through formal remediation, to address and correct problems as they occur and to have a successful learning experience.

**Evaluation of Clinical Performance**
Evaluation of clinical performance is specifically based on meeting objectives related to the eight (8) outcomes of the curriculum: caring, safety, psychomotor skills, critical thinking, communication, health teaching, growth, development and adaptation, and legal/ethical and professional practice. Objectives are leveled (semester-specific) and build upon each other, progressing from basic to complex skills. They represent the expected competencies of the student as they complete the Associate Degree Nursing Program and are designed to be in compliance with BRN regulations, which require "minimum competency."

**Procedure**:
The following shall be documented in this evaluation record:

- Dates and total time of all incidents of tardiness and absence
- Notification of mid-term warnings (formative evaluation) for theory failure (<75%)
- Theory failure (<75%) at the end of the semester (summative evaluation)
- Skills lab referrals

- Remediation(s)
- Critical student incidents involving the clinical setting
- Violations of policies, procedures, regulations and laws
- Student withdrawal from the program
- Student dismissal from the program

Throughout the semester, the instructor(s) of record will maintain this evaluation record and update it as required. Whenever documentation is made, the instructor will meet with the student to discuss the entry. Both the instructor and student will sign the record indicating that they met to discuss the entry and that a correction plan was jointly formulated.

For clinical evaluation, the procedure shall be as follows:

- During each rotation, faculty will make entries related to clinical performance problems as necessary. The instructor will schedule a face-to-face meeting with the student to discuss the entry and to jointly formulate an action plan for correction of the problem. Both instructor and student will sign the record and <u>the student will be given a copy of the entry and action plan.</u>

- At the end of each rotation, the instructor and student will meet face-to-face for a formal evaluation of the student's overall clinical performance throughout the entire rotation. Both instructor and student will sign the record indicating that this process was completed.

- To successfully pass a clinical rotation, the student <u>must be in compliance with all eight (8)-curriculum outcomes and their respective objectives</u> in order to progress to the next rotation. If, during a clinical rotation, a significant problem occurs, instructor and student will discuss it at the time of occurrence and will jointly formulate a remediation plan, which lists specific actions and target date(s) for successful remediation. The student will receive a copy of the documentation and remediation plan.

- If remediation is not successful by the target date, the student will receive a grade of "Fail" for that clinical rotation and will not progress to the next rotation (or the next semester if failure occurs during the last rotation).

- If a problem should arise during the last week of a rotation or semester, where adequate remediation time is not available, the remediation plan will carry over to the next rotation or semester, and the in-coming instructor will be notified by the out-going instructor prior to the student progressing.

**Critical Student Incident**: If a student is involved in a clinical incident, which is considered serious enough to cause real or potential harm to a client, the incident will be documented on the Critical Student Incident form and the incident will be immediately reported to the Nursing Division Director. The incident will be managed according to departmental policies and procedures (refer to P&P Manual). A copy of the incident form will be attached to this record.

# Attendance Record

| TARDINESS | | | | ABSENCE | | | |
|---|---|---|---|---|---|---|---|
| **1st Sem** | **2nd Sem** | **3rd Sem** | **4th Sem** | **1st Sem** | **2nd Sem** | **3rd Sem** | **4th Sem** |
| Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: |
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| Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: |
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| Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: | Date:<br>( ) Lec ( ) Clin<br>Amt Time: |

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|---|---|
| **Documentation of Actions Due to Tardiness: 1st Sem**<br>*(Include Date, Action, Student & Instructor Signatures)* | **Documentation of Actions Due to Absences: 3rd Sem**<br>*(Include Date, Action, Student & Instructor Signatures)* |
| **Documentation of Actions Due to Tardiness: 2nd Sem**<br>*(Include Date, Action, Student & Instructor Signatures)* | **Documentation of Actions Due to Tardiness: 4th Sem**<br>*(Include Date, Action, Student & Instructor Signatures)* |

# Mid-Term Warning and Theory Failure

| | Mid-Term Warning | Theory Failure |
|---|---|---|
| **N161** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: ______________ Final % Grade: ________<br>( ) Planning to Return When:________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |
| **N151** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: ______________Final % Grade: ________<br>( ) Planning to Return When:________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |
| **N152** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: _____________Final % Grade: ________<br>( ) Planning to Return<br>When:_______________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |
| **N154** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: _____________Final % Grade: ________<br>( ) Planning to Return When:________________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |

| | | |
|---|---|---|
| **N153** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: _______________Final % Grade: _________<br>( ) Planning to Return When:______________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |
| **N163** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: _______________ Final % Grade: _________<br>( ) Planning to Return<br>When:_______________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |
| **N164** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: _______________ Final % Grade: _________<br>( ) Planning to Return When:______________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |
| **N166** | Date: Grade:<br>( ) Warning Letter Sent/File Copy to Ofc<br>( ) Team & Director Notified<br>( ) Counseled<br>Notes:<br><br>Instructor Signature: | Date: _______________ Final % Grade: _________<br>( ) Planning to Return When:______________<br>( ) Not Planning to Return<br>( ) Not Eligible to Repeat (Complete Form)<br>( ) Team & Director Notified<br>( ) Counseled/Student to Make Appt with Director<br>Notes:<br><br>Instructor Signature: |

# Skills Lab Referrals and Remediation

| | Skills Lab Referral | Remediation |
|---|---|---|
| **1st Sem** | Date: _______________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Date Student Attended Lab: ____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br><br>Instructor Signature: | Date:_________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: ______________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |
| **2nd Sem** | Date: _______________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Date Student Attended Lab: ____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br>Instructor Signature: | Date:_________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: ______________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |
| **3rd Sem** | Date: _______________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Date Student Attended Lab: ____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br>Instructor Signature: | Date:_________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: ______________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |
| **4th Sem** | Date: _______________<br>( ) Form Completed/Original to Student<br>( ) Copy to Skills Lab Instructor<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Date Student Attended Lab: ____________<br>( ) Successfully Remediated Skill(s)<br>Notes:<br><br>Instructor Signature: | Date:_________________<br>( ) Written Remediation Plan/Original to Student<br>( ) Copy Attached to this Evaluation<br>( ) Counseled<br>Target Date for Improvement: ______________<br>( ) Remediation Successful ( ) Not Successful<br>Notes:<br><br>Instructor Signature: |

# Reference Table of Curriculum Outcomes & Objectives

| 1st Semester | 2nd Semester | 3rd Semester | 4th Semester |
|---|---|---|---|
| **CURRICULUM OUTCOME 1: CARING** (Continues to maintain Caring behaviors from the previous semesters.) | | | |
| **1st Semester** | **2nd Semester** | **3rd Semester** | **4th Semester** |
| Objective: Recognizes and respects the individual dignity and worth of the client by consistently demonstrating behaviors like providing privacy, listening attentively & attending to client concerns, maintaining confidentiality and involving the client/family in the care process. | Objective: Demonstrates effective inter-personal processes in caring for clients with diverse back-grounds by consistently demonstrating behaviors like being non-judgmental toward clients/ families from diverse back- grounds, cultures, religions and persuasions and having self-awareness of one's personal impact on others. | Objective: Incorporates each client's values & belief systems when providing care by consistently demonstrating behaviors like incorporating age, ethnicity, culture, lifestyle and sexuality in the care planning process. | Objective: Creates a climate of acceptance, respect and positive regard by consisting demonstrating behaviors like individualizing therapeutic interventions, supporting clients' spiritual needs and making appropriate referrals which support coping. |
| **CURRICULUM OUTCOME 2: SAFETY** (Continues to maintain Safety behaviors from the previous semesters.) | | | |
| **1st Semester** | **2nd Semester** | **3rd Semester** | **4th Semester** |
| Objective: Identifies and utilizes concepts of safe client care by consistently demonstrating behaviors like identifying pts, following the 5 Rights of med administration, performing fall risk assessments, practicing universal pre-cautions and properly disposing of hazardous materials. | Objective: Incorporates advancing know-ledge of safety principles for clients across the lifespan by consistently demonstrating behaviors like implementing safe-ty precautions for infants, children and mental health clients, providing a safe environment for pts at risk for suicide or self- harm and accurately calculating drug dosages. | Objective: Implements appropriate safety precautions and interventions for children and high-risk clients by consistently demonstrating behaviors like assessing clients with neutropenia, thrombocytopenia, telemetry, narcotic in-fusions, critical lab values, high fevers, respiratory distress and bleeding. | Objective: Maintains emotional, physical and environmental safety for complex clients with multiple comorbidities by consistently demonstrating behaviors like participating in QI and risk management and collaborating with the multidisciplinary team. |
| **CURRICULUM OUTCOME 3: PSYCHOMOTOR SKILLS** (Continues to maintain competency in previously learned skills.) | | | |
| **1st Semester** | **2nd Semester** | **3rd Semester** | **4th Semester** |
| Objective: Demonstrates basic skills with minimal assistance while stating evidence-based rationales. *Refer to Skills List* | Objective: Modifies basic skills relevant to client age. *Refer to Skills List* | Objective: Prioritizes and performs intermediate skills without assistance. *Refer to Skills List* | Objective: Selects, performs and evaluates advanced skills without assistance. *Refer to Skills List* |
| **CURRICULUM OUTCOME 4: CRITICAL THINKING** (Continues to maintain Crit. Thinking behaviors from previous semesters.) | | | |
| **1st Semester** | **2nd Semester** | **3rd Semester** | **4th Semester** |
| Objective: Identifies elements of critical thinking in each step of the nursing process by consistently demonstrating behaviors like performing accurate health assessments, developing a plan of care and making sound clinical decisions. | Objective: Utilizes critical thinking and the nursing process by consistently demonstrating behaviors like identifying patterns and examining assumptions, prioritizing interventions and assessing alterations in health status. | Objective: Participates in collaborative, interdisciplinary care planning by consistently demonstrating behaviors like problem solving, predicting outcomes, analyzing and evaluating nursing care and participating in care conferences and discharge planning. | Objective: Demonstrates critical thinking skills when managing the care of complex clients with multiple comorbidities by consistently demonstrating behaviors like evaluating options and choices when making clinical decisions, using algorithms and critical pathways and analyzing critical assessment data. |

Continued

## CURRICULUM OUTCOME 5: COMMUNICATION (Continues to maintain Communication behaviors from previous semesters)

| 1st Semester | 2nd Semester | 3rd Semester | 4th Semester |
|---|---|---|---|
| Objective:<br>Demonstrates basic verbal, non-verbal and written com-munication skills when caring for clients by consistently demonstrating behaviors like communicating with clients/ families in a therapeutic man-ner, effectively communicating with members of the health care team, using a trained medical interpreter and accurately documenting care. | Objective:<br>Uses age-appropriate and therapeutic communication techniques when caring for clients across the lifespan by consistently demonstrating behaviors like discussing and documenting plans of care, identifying blocks/barriers to communication and engaging in therapeutic communication with mental health clients. | Objective:<br>Applies empathetic and assertive communication techniques when caring for clients by consistently demonstrating behaviors like assertively communicating clients' needs to other members of the care team (ad-vocacy), using non-judgmental statements and by engaging in collegial dialogue when mana-ging all aspects of client care. | Objective:<br>Optimizes opportunities to participate in communications with the multidisciplinary team by consisting demonstrating behaviors like explaining complex situations to pts/families, pro-viding reports to staff and physicians and making presentations. |

## CURRICULUM OUTCOME 6: HEALTH TEACHING (Continues to maintain Health Teaching behaviors from previous semesters)

| 1st Semester | 2nd Semester | 3rd Semester | 4th Semester |
|---|---|---|---|
| Objective:<br>Identifies and applies basic principles of health teaching by consistently demonstrating behaviors like assessing the pt's readiness to learn, identifying nursing diagnoses r/t pt's know-ledge deficits and designing and implementing a teaching plan. | Objective:<br>Develops and implements individualized pt/family teaching plans by consistently demonstrating behaviors like assessing learning needs and barriers to learning, using age-appropriate techniques and evaluating effectiveness of teaching. | Objective:<br>Designs, implements and evaluates multiple pt/family teaching plans by consistently demonstrating behaviors like focusing on promoting and restoring health, modifying approaches for pts with special learning needs/challenges and measuring teaching effective-ness using behavioral data rather than personal reflection. | Objective:<br>Facilitates clients' health education needs by consistently demonstrating behaviors like serving as a resource to the health care team, providing in-formation so clients/families can make health care choices and adapting teaching content for clients experiencing the stress of a complex and/or life-threatening illness. |

## CURRICULUM OUTCOME 7: GROWTH, DEVELOPMENT & ADAPTATION (GDA)

(Continues to maintain Growth, Development & Adaptation behaviors from previous semesters.)

| 1st Semester | 2nd Semester | 3rd Semester | 4th Semester |
|---|---|---|---|
| Objective:<br>Identifies principles/stages of GDA by consistently demonstrating behaviors like facilitating adaptation, recognizing the special needs of elderly pts r/t the aging process and by assessing developmental level. | Objective:<br>Differentiates between effective and ineffective GDA factors when providing nursing care by consistently demonstrating behaviors like using age-appro-priate pain rating tools, recog-nizing abnormal findings during developmental and health assessments and by identifying risks to achieving normal developmental outcomes. | Objective:<br>Applies principles of health adaptation to client care by consistently demonstrating behaviors like incorporating unique lifespan, coping and adaptation processes in planning care and acknowledging and accepting clients' limitations. | Objective:<br>Employs age-specific adaptations when promoting, maintaining and restoring wellness by consistently demonstrating behaviors like assisting clients with complex comorbidities to adapt to injuries and illnesses and to achieve optimal well-ness. |
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| CURRICULUM OUTCOME 8: LEGAL, ETHICAL & PROFESSIONAL PRACTICE (LEP)<br>(Continues to maintain Legal, Ethical & Professional behaviors from previous semesters.) | | | |
|---|---|---|---|
| **1st Semester** | **2nd Semester** | **3rd Semester** | **4th Semester** |
| Objective:<br>Identifies and applies LEP foundations of nursing practice by consistently demonstrating behaviors like reporting unsafe practices, exhibiting honesty, reliability, accountability, punctuality and preparation and by adhering to all college, program and agency policies, guide-lines, regulations and laws. | Objective:<br>Expands on the LEP role of the nurse, including the role of patient advocate, by consistently demonstrating behaviors like adhering to practice standards, seeking learning opportunities, accepting criticism and by identifying the scopes of practice of other members of the health care team. | Objective:<br>Utilizes complex LEP guide-lines in providing care by consistently demonstrating behaviors like promptly reporting deviations in practice standards by self and others and by being a positive role model to the profession and the community. | Objective:<br>Models the LEP behaviors of the registered nurse is all aspects of care by consistently demonstrating behaviors like ensuring pts' rights, practicing within the BRN Scope of Practice, assuming responsibility for competency and assisting clients/families with ethical dilemmas. |

# RECORD OF CLINICAL EVALUATION

| 1st SEMESTER | | | |
|---|---|---|---|
| Date | Rotation | Narrative Comments/Documentation | Instruct/Student Signatures |
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# RECORD OF CLINICAL EVALUATION

| 2nd SEMESTER | | | |
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| Date | Rotation | Narrative Comments/Documentation | Instruct/Student Signatures |
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# RECORD OF CLINICAL EVALUATION

| 3rd SEMESTER | | | |
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| **Date** | **Rotation** | **Narrative Comments/Documentation** | **Instruct/Student Signatures** |
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# RECORD OF CLINICAL EVALUATION

| 4th SEMESTER | | | |
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| Date | Rotation | Narrative Comments/Documentation | Instruct/Student Signatures |
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**B-23**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

TITLE: EARLY ALERT (MIDTERM WARNING)

PURPOSE: To describe the policy for notifying students of failing grade status at the mid-point of the semester.

DESCRIPTION:

The college utilizes an “early alert” program to notify students at the mid-point of the semester should their midterm grades fall below passing (<75% for the Nursing Division). Consistent with this practice, the Nursing Division notifies a failing student by way of a notification form (see attached) which includes suggestions for improving the theory grade (i.e. study group, tutoring, and meeting with instructors).

Included in the notification are the final drop date and a statement reminding the student of his/her options (dropping/withdrawing or continuing with the possibility of a failing grade and its effects on GPA, class standing, etc.).

The semester team coordinator and/or the instructor of the course will be responsible for preparing and sending a midterm warning form to each failing student at the mid-point of the semester (following midterm examination). A copy of this form will be placed in the student’s file.

REFERENCE: Midterm Warning Notification Form

Policy & Procedure Committee
DATE APPROVED/REVIEWED/REVISED: 3/2004; 11/2007; 10/2008; 11/2012,

COLLEGE OF THE SEQUOIAS
DIVISION OF NURSING AND ALLIED HEALTH

MIDTERM WARNING

Date________ Student__________________ Course________ Grade______%

*This is your official notification that you are currently FAILING your theory class. Your course instructor(s) are committed to assisting you to improve your grade. Please make an appointment with the course instructor right away so that we can discuss an action plan and provide you with some suggestions for being successful in mastering theory content, such as:*

1. *Participating in an effective study group.*
2. *Utilizing the skills lab instructor to help tutor (when they are available and are not helping students to practice skills).*
3. *Practicing NCLEX review test questions.*
4. *Improving study skills.*
5. *Completing ATI practice exams in the course content area(s).*

*You should be aware of your options:*

1. *Continue in the class with the hope that you will improve your grade.*
2. *Withdraw from the class by the final drop date in order to avoid the possibility of a final grade of "F" and its effects on your GPA.*
3. *Withdraw after the final drop date but you will receive a final grade of "F."*

*Both #2 and #3 will count as having taken the class. You can re-enter the nursing program only one more time.*

*I need to meet with you within one week after you have received this letter. At that time, you will present in writing a remediation plan describing how you will be more successful during the rest of the semester.*

_______________________________________

*Instructor Signature*

*Original Copy to Student*
*Copies to Director and Student File*

# Withdrawal and Readmission

**C6**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: Student Withdrawal and Incomplete Grade

**PURPOSE**: To describe the procedures to be followed when a student either withdraws from the program or receives an incomplete grade.

**DESCRIPTION**:
Withdrawal from the program may be based on theory failure, clinical failure or personal reasons such as an extended illness, an injury or a family emergency. In these instances, a student may apply for readmission by contacting the Director. Re admittance is determined on a space-available basis. A student who withdraws due to a theory and/or clinical failure will be allowed only one (1) re admittance.

Withdrawal Due to Theory and/or Clinical Failure
Theory failure is based on achieving a grade below 75%. Clinical failure is based on achieving less than minimum expectations as delineated by the Student Evaluation Record (SER). Clinical failure may also be a result of a serious, critical incident. If a student withdraws prior to the last drop date, the student will receive a grade of "W." If a student leaves the program after the final drop date, the student will receive a grade of "F" for the course. The faculty team coordinator will complete a Student Withdrawal Form and forward it, along with the semester team's recommendations regarding eligibility for readmission, to the Director. The student will make an appointment with the Director for an exit interview. The Director will have the final determination regarding a student's readmission and any recommendations for remediation activities.

Withdrawal Due to Personal Reasons
A student who must leave the program due to personal reasons, such as an illness or family emergency, and cannot take an Incomplete status can withdraw from the program and receive a grade of "W" if the withdrawal occurs prior to the last drop date. The faculty team coordinator will complete a Student Withdrawal Form and forward it, along with the semester team's recommendations regarding eligibility for readmission, to the Director. The student will make an appointment with the Director for an exit interview. The Director will have the final determination regarding a student's readmission.

Incomplete Grade
If, after the final drop date, a student cannot complete course requirements due to an illness, injury, and/or family emergency, the student can request a grade of

"Incomplete." If an Incomplete is given, the student must complete required course work within one year from the date the incomplete grade was submitted. The student is not required to re-enroll or pay additional laboratory fees. The formal process for obtaining an incomplete grade is initiated in the college's Admissions and Records office. The student will also meet with the semester team and the Director to discuss the terms and conditions for satisfying the Incomplete, including specific course work and deadlines. The student will not be allowed to progress to the next semester or graduate until the Incomplete has been satisfied and the student receives a passing grade for the course.

Instructor Documentation
The instructor of record will complete the Student Withdrawal form at the time the student gives notice of his/her intent to withdraw. The teaching team will document their recommendations for re-entry and will assign a readmission category (refer to Nursing Division Policy C-9).

**REFERENCE**: Student Withdrawal Form

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED**: 5/92, 12/98; 5/2004; 5/2011; 10/2012; 5/2015;

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

# STUDENT WITHDRAWAL FORM (C-6)

**Student Name ________________________ Withdrawal Date____________**

**Semester_____________________ Faculty Name ________________________**

**Reason for Withdrawal:**
**( ) Theory Failure Grade_______%** **( ) Clinical Failure**
**( ) Personal Reasons** **( ) Illness/Injury**

**Give brief description of incident(s) resulting in clinical failure:**

**Give brief description of illness/injury and need for withdrawal:**

**Recommendation for Readmission:**
**( ) Readmit Readmission Category______** *(Refer to Policy C-9)*
**( ) Do Not Readmit**

**Give brief description of reason(s) to readmit or not readmit:**

**Instructor Signature___________________________ Date______________**

**Director Signature** __________________________ **Date**_____________

*Original to Director for Signature then to Student File*

**C-8**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** Readmission into the Nursing Program

**PURPOSE:** To describe the readmission procedure for an RN student and/or an LVN to RN advanced placement student who withdraws during the semester or who fails either theory or clinical and who desires to be readmitted into the nursing program.

**DESCRIPTION:**
Withdrawal from the program may be based on theory failure, clinical failure or personal reasons such as an extended illness, an injury or a family emergency. In these instances, a student may apply for readmission by contacting the Director. Readmittance is determined on a space-available basis. A student who withdraws due to a theory and/or clinical failure will be allowed only one (1) readmittance.

Withdrawal Due to Theory and/or Clinical Failure
Theory failure is based on achieving a grade below 75%. Clinical failure is based on achieving less than minimum expectations as delineated by the Student Evaluation Record (SER). Clinical failure may also be a result of a serious, critical incident.

Withdrawal Due to Personal Reasons
A student who must leave the program due to personal reasons, such as an illness or family emergency, and cannot take an incomplete status can withdraw from the program.

Readmission Procedures

1. The student must notify the Director in writing of his/her desire to be readmitted by the 12th week of the semester in which the failure/withdrawal occurs.

2. If the student left the program for personal reasons, the student is responsible for notifying the Director in writing of his/her progress in resolving the issues and events which led to the withdrawal.

3. If any student has been absent from any program for more than one (1) year, he/she will be asked to enroll in the Student Success Program (SSP). Any student that returns after at least one (1) semester will be asked to enroll in the SSP.

4. The time limit for readmission to the nursing program is two (2) years from the original date of withdrawal from the COS Nursing Program or any other nursing program.

Prior to the first day of class, the student must demonstrate minimum competency on all starred skills on the SER. All starred skills from previous semesters must be verified. This is accomplished by enrolling in NURS 400 skills lab. Any exception can only be determined after the student submits a written petition for waiver to the Director and a signed skills check off list from previous program to the Director.

5. A student who fails clinically and is readmitted will meet with the 1st rotation clinical instructor during the first week of school. This instructor will review the Student Withdrawal Form, which was completed at the time the student left the program. Then the instructor will provide the student with an action plan for remediation designed to specifically address the reason(s) for the clinical failure and to support the student's success. The student must achieve the goals/objectives of the action plan AND meet all semester objectives listed on the SER as outlined by the determined date on the remediation action plan. A copy of the action plan will be given to the student and to other semester team members who will provide clinical instruction during the semester. The original remediation action plan will be signed by both student and instructor and will be placed in the student's file.

**REFERENCE**: Student Withdrawal Form
Readmission Priority and Advanced Placement Policy
Clinical Remediation Action Plan Form

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED:** 10/2000; 5/2004, 5/2007, 10/2012; 2/2013; 9/2013, 10/2014

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**CLINICAL REMEDIATION ACTION PLAN**
**For Re-entry Student**

**Student Name___________________ Course____________ Date_______________**

| **Brief Description of Reason(s) for clinical failure**: |
| --- |
| |

| **Remediation Action Plan:** | |
| --- | --- |
| **Areas of Concern** | **Goals & Specific Student Responsibilities** |
| | |

**Note: All areas of concern must be remediated AND SER must be in passing range by the date of the mid-term clinical evaluation in order for the student to continue in clinical.**

**Date_______ Instructor_____________________ Student_____________________**
*Signature* *Signature*

**C-9**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** Readmission Priority and Advanced Placement Decisions

**PURPOSE:** To describe the procedure for assigning priority for readmission into the nursing program for re-entry students and advanced placement students (LVN to RN students and transfer students).

**DESCRIPTION**:

In order to provide a fair and orderly process in the event of multiple eligible applicants, the following procedures will be followed:

1. Readmission positions will be decided after the semester is completed and the number of spaces available in the class of re-entry is determined.

2. At the time of a student's withdrawal or failure, the semester faculty team will assign the student to a category as listed below:

3. Transfer students who have failed once in any other RN program or combination of programs can only be admitted one time to the COS RN Program.

**Category I:** **A. Health/Personal Injury/Family Reasons for Withdrawal**

Should more than one (1) student be assigned to this category, readmission priority will be given to the student who has the earlier withdrawal date. If there is no space available in the desired class of re-entry, the student will be given priority for readmission for the following semester in which a space is available in class.

**Category I:** **B. Advanced Placement Candidates (LVNs returning to complete requirements OR transfer students)**

Advanced placement candidates will be placed in sequence on the waiting list once they are accepted into the program. Each student's date of acceptance into the program will be his/her priority date. If more than one candidate has the same priority date, a lottery will determine the order of priority.

**Category II:** **A. Failure/Withdrawal Due to Low Grades or Poor Performance**

These candidates will be second in priority to students in Category I. Should more students desire readmission than spaces available, date of withdrawal will determine order of readmission. If more than one candidate has the same withdrawal date, a **lottery** will determine the order of priority. Students who fit into this category and are not readmitted due to lack of class space in the desired class of re-entry will have first priority for readmission for the following semester behind students left over from Category I.

**Category II:** **B. Nursing 161 Withdrawal or Failure**

Students who fail or withdraw from N161 need special consideration since there are not likely to be available spaces in those classes. For the semester following the failure or withdrawal, candidates who fall into this category will be designated as Alternates for the desired class of re-entry. If they do not receive readmission as alternates, a space will be reserved for them at the following admission session.

**Category III: Failure to Meet Standards Specified by Handbook Policies**

For these students, there is NO automatic readmission. If the faculty agrees to readmit, readmission priority will be behind Category I and II applicants.

**REFERENCE:** Readmission Into the Nursing Program Policy
Student Withdrawal Form (Completed When Student Withdrew)

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED:** 3/2000; 10/2000; 5/2004; 11/2007; 2/2009; 11/2013

# Student Activities

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: STUDENT ACTIVITIES

**PURPOSE**:

This policy provides guidelines for a variety of student activities in which questions arise regarding standards.

**DESCRIPTION**:

**Student Activities**

Students who wish to do so are invited to join appropriate student nurse organizations. Students are encouraged to participate in both class and department activities. Opportunities exist for students to participate on Division Committees (see policy D-6) to provide input and gain information regarding the means by which the division develops guidelines in the maintenance of effective educational programs. Students are also encouraged to participate in college and community organizations, clubs, and activities as much as possible.

**Class Officers**

Each class may elect class officers. Class officers will coordinate class activities as desired by their classmates and represent their class at health care liaison meetings. These officers include president, treasurer/secretary, and historian. Officer responsibilities are as follows:

**President:**
- Officiate at class meetings
- Represent the class at Nursing division meetings
- Communicate information regarding activities and encourage class participation
- Plan and organize fund-raising activities
- Mentor president of following class

**Treasurer/Secretary:**
- Record minutes of class and officer meetings
- Collect monies for class fund-raisers, projects, cards, flowers, etc.
- Maintain records of all monies associated with class projects
- Represent class at Nursing division meetings
- Plan and organize fund-raising activities
- Mentor treasurer/secretary of following class

**Historian:**
- Maintain class history
- Obtain and maintain pictures for class
- Participate in developing class video presentation for pinning ceremony
- Mentor historian of following class

**Outside Activities**

Students are encouraged to limit outside jobs during the school year, and are responsible for

ensuring that the job does not interfere with their student responsibilities. Students who plan to work part time are encouraged to work in a health care setting for added experience. All students are strongly encouraged to seek health care employment in the summer time. ***A student may not work from 11:00 pm to 6:00 am or any portion of the shift on a night before a clinical assignment.*** A student's work hours must not interfere with required school attendance. No exceptions will be made.

Students who receive mandated legal summons (e.g., jury duty, subpoena) will not have the absence counted against them for having to appear for such summons. Should the legal summons event require prolonged absences from theory and/or clinical the student will meet with their instructor and Director of the program to discuss alternate assignments.

**Transportation**

Each student must have unlimited access to reliable transportation and possess a valid California drivers license. It may be necessary to drive to a clinical site several days per week. Car pooling is encouraged as much as possible, but clinical assignments cannot always be made according to convenient geographical locations.

**Student to Instructor Email and Text Messaging**

Instructors and students may wish to communicate via e-mail, and or text; however, students are encouraged to discuss their progress, problems or need for assistance by meeting face-to-face. E-mails and text messages to instructors containing jokes, chain letters, etc., are inappropriate.

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED**: 11/87; 12/98; 11/2001; 2/2004; 10/2011; 10/2017; 4/2021.

**B-14**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: GUIDELINES FOR PINNING CEREMONY

***-THIS POLICY IS SUBJECT TO CHANGE AT ANY TIME AT THE DISCRETION OF THE NURSING DIRECTOR/FACULTY-***

**PURPOSE:**
The purpose of the Pinning Ceremony is to recognize nursing students' successful completion of the requirements for the Associate of Science degree in Nursing and their qualifications as candidates to sit for the licensing exam as Registered Nurses. **This is a COS Division of Nursing and Allied Health** activity and it is meant to be a culminating experience for nursing students and their families and friends, as well as nursing faculty. **The College of the Sequoias Associate Degree Registered Nursing pinning ceremony is the faculty's and staff's gift to the graduating students**. This ceremony is in addition to the COS graduation exercise held every year in May.

**PLANNING:**
Some classes wish to add individual touches, and if students have new ideas they wish to incorporate, the faculty will consider them. NURS 164 class officers should schedule an initial planning meeting with the Director/Designee no later than the fifth week of the semester. Class officers are responsible for coordinating all student activities and serving as a liaison between the class and the Division of Nursing. The Director/Designee should be kept informed of all discussions and plans, either through formal meetings or written memos. A completed *Pinning Ceremony Approval Form* must be submitted to the Director/Designee by the twelfth week of the semester. Final class voting regarding all planning decisions must be attached. Plans cannot proceed until the Director has given written approval. NURS 164 class officers must have at least one final planning meeting with the Director no later than three weeks before the pinning ceremony.

**PROGRAM FORMAT**: *** Indicates content must be previewed by the Director**
The usual format for nursing pinning ceremonies is as follows:

| | |
|---|---|
| Processional | Students march in to "Pomp and Circumstance" |
| Opening | Student Speaker * |
| Welcome/Introductions | Director |
| Welcome | COS Administrator |
| Video Presentation | Optional Class Video Montage with Music * |
| Presentation of Awards | Director |
| Presentation of Diplomas | COS Administrator |
| Presentation of RN Pins | Nursing Faculty (rotating basis) |
| Nursing Pledge | Division Chair |
| Closing | Student Speaker * |
| Recessional | March out to musical selection (students may give |

input)

**SPEAKERS:**
Opening and closing remarks must not exceed 2 to 5 minutes each. Speeches can include topics such as the value of nursing education and the significant growth and enrichment achieved as a result of the college experience. It may not be religious in nature, other than in the very broadest sense. Since our students and/or college represent all religions, it must be acceptable to everyone. Speakers may use poems and famous quotations, citing the authors. Written speeches must be submitted to the Director/Designee **by the twelfth week of the semester.**

**VIDEO PRESENTATION:**
This is optional. Students may select photographs of their journey through nursing school to be set to music and put into a video montage. These may be serious and humorous, but discretion is advised. The presentation should reflect positively on the school's image. Please note that any photos of nursing faculty or clinical agency staff must have their prior written approval before inclusion. **NO** patients **and/or occupied patient room** may be depicted. The video presentation may be no longer than 5 minutes (100 pictures maximum), **and must be previewed by the Director/Designee or Division Chair at least three weeks before the pinning ceremony**. The COS Audio Visual Department will put together a video presentation for nursing students free of charge. Mr. Patrick Mitchell (737-4889) will assist students, or the class may have this done at their own expense by an outside source.

**VIDEOTAPING OF CEREMONY:**
Videotaping of the pinning ceremony is done at no cost to graduates. The students will be sent a link to the video of the pinning ceremony.

**INVITATIONS:**
Invitations are ordered through the COS Print Shop. The number of invitations ordered per student is based on the number of graduates. They will be distributed to each student and the Division of Nursing will be responsible for sending invitations to local hospitals, nursing staff, administrators, faculty, and other key members of the community. Once all dedicated invitations are given out, any remaining invitations will be made available to students who need additional sets.

**PRINTED PROGRAMS:**
The Division of Nursing will be responsible for printing the pinning ceremony programs. These are passed out to attendees as they enter the building and include the order of the ceremony, student names, faculty names, and the Nightingale Pledge. Other content may be added by the class with the Director's/Designee prior approval.

**DECORATIONS:**
If students wish to have extra decorations or carry flowers, they will be responsible for those arrangements and the costs incurred. Creativity and simplicity with decorations is encouraged, as students are responsible for putting up and taking down all decorations immediately following the pinning ceremony. Decorations must be approved by the Director/Designee.

**PROFESSIONAL ATTIRE:**
Only the COS student uniform will be worn for the pinning ceremony. Students will observe COS nursing dress code at all times. Uniforms are to be clean, pressed, and in good repair. Shoes are to be of white leather with rubber heels. No clogs, canvas tennis shoes, high tops, boots or shoes with open toes or heels are permitted. Hair should be clean, styled conservatively, and up off the collar. Please keep make-up, jewelry, and accessories professional. Gum chewing is not permitted. Use of cologne and scented cosmetics should be used sparingly. The scent of cigarette smoke should not be detectable on your person or uniform. These scents and odors can be offensive to those sitting in close proximity during the pinning ceremony.

**Noncompliance to the above may result in non-participation in the pinning ceremony.**

**CLASS PICTURE:**
This is an **optional** activity depending on class consensus. All costs of the picture are the responsibility of the students. The picture can be no larger than **25 X 21 (including the frame)**.

**FUNDRAISING/PINNING EXPENSES:**
All fundraising, collection of dues or any requests for money from students must be approved by the Director/Designee. Money collected as students of the COS/Nursing Program may only be used for costs associated directly with Pinning/Graduation and/or philanthropic goals.

**NOTE:** Pinning Ceremony Form can be obtained from the Director and a sample is on the following page.

***POLICY & PROCEDURE COMMITTEE***
**APPROVED/REVIEWED/REVISED:** 8/1999; 2/2004; 3/2005; 5/2006; 3/2008; 2/2009; 10/2011; 08/2016; 8/2017; 5/2021

College of the Sequoias
Division of Nursing and Health Science
**PINNING CEREMONY APPROVAL FORM**

Pinning Ceremony: Date____________ Time____________
Practice: Date____________ Time____________

Deadline for Director Approval is 12th week
***Attach Evidence of Class Vote!***

Date submitted_____________ Student Contact Person___________________

1. **Open Student Speaker:** Include speaker's name, estimated length of speech (no more than 5 minutes), and attach a copy of the speech to this form by **12th week:**___________

2. **Decorations**: Describe decorations, type, placement, etc.________________________________________________________________________
_____________________________________________________

   **Name of Student(s) in Charge**______________________________________

3. **Video/Slide Presentation: (**optional) Describe content, musical accompaniment, and estimated time needed (no longer than 10 minutes in length). The Director/Designee must preview presentation by the 14th week: ____________

4. **Closing Student Speaker: Class Speakers:** List the names of speaker, estimated length of each speech (no more than 5 minutes each) and attach copies of speech to this form by the 12th week: ____________

5. **Printed Programs:** Additions requested (attach materials). Please see details in the student handbook concerning Guidelines for Pinning.

**Director Comments:**

**Approved____ Disapproved____ Date_______ Director Signature____________**

**D6**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: Student Representatives on Nursing Committees

**PURPOSE**: To describe the process for selecting student representatives as members of the Division's standing committees and their role and responsibilities.

**DESCRIPTION**:
The process for selecting nursing students to serve as representatives on standing committees will be as follows:

1. Semester faculty will announce committee vacancies to their classes and request volunteers to serve on committees:

   Policy & Procedure Committee: 1 Student each from N154, N163 & N164
   Curriculum Committee: 1 Student each from N163 & N164
   Admission, Recruitment & Retention Committee: 1 Student each from N121 & N154

2. Nursing student representatives shall serve as advisory (non-voting) members on each standing committee.

3. Representatives shall serve for one semester.

4. Representatives will not participate in discussions/decisions related to sensitive and/or confidential student issues.

Roles and responsibilities of student representatives include the following:

1. Make a commitment to regularly attend and actively participate in committee meetings.

2. Obtain input from the student body and provide information to the student body related to committee activities.

3. Respective committee chairs will notify representatives of meeting dates/times and provide them with agenda packets and copies of minutes in a timely manner.

***Policy & Procedure Committee***
**APPROVED/REVIEWED/REVISED:** 11/1999; 5/2004; 3/2005; 5/2006, 5/2008; 10/2008; 11/2010; 5/2012; 10/2017; 06/2020

# Student Success

## Program Success

Registered Nursing is an exciting and fulfilling career, and the faculty and staff of the COS RN program are committed to providing you curriculum and clinical experiences necessary for you to become a licensed Registered Nurse. Your success will be equal to your commitment, and the more you know, the better your choices can be. Following are the best practices for the nursing students in their first semester:

1. **Do not work more than 20 hours a week,** and, if possible, not at all. Why? You are making a huge adjustment to the world of nursing. You will need more time than ever for study, on your own and with your classmates. Schedule at least 2 hours of study for each hour you are in class each week.
2. **Stay healthy.** Eat well, get some quality rest, and get some exercise in the fresh air every day.
   a. Fast food may be easy, but the lack of high quality nutrition will take its toll on your body.
   b. Make time for enough sleep and rest. In the middle of a busy nursing school schedule, sleep is often sacrificed first.
   c. Create and stick to a formal exercise plan; even if it is just parking in the farthest space from your class.
3. **Join a study group.** Why take part in a study group? Here are some reasons:
   a. **Get Questions Answered:** Your study group can be one of the best places to get your questions answered about confusing/difficult course material. Often, one member of the study group will understand some of the material, and others will find other elements easier to learn.
   b. **Build Confidence:** Taking turns in explaining the difficult parts helps build confidence in all the members. And when no one understands it, your group can all go together for help. The study group allows for a good course review, so even when you understand material it is good to review the material by explaining it to someone else.
   c. **Develop Self Discipline:** The study group decides on a meeting time and then everyone agrees to the schedule.
      i. You will have to prioritize and adapt to keep your commitment to study.
      ii. You support your team and become responsible for the group effort.
   d. **Learn Problem-solving Skills:** Everyone in a study group can improve his/her problem-solving abilities, by working together to solve difficult questions.
      i. Different people have individual ways to approach problems, conduct research, and reason out answers.
      ii. As your group works and spends more time together, everyone will learn the skills required to solve many types of problems.
   e. **Learn Teamwork Skills:** Being a good a good team member is a skill that can only be learned by doing. There are definitely challenges to working in a group, but the rewards outweigh these challenges.
4. **Use your syllabus.** The Syllabus contains information critical to your success.
   a. The Unit Objectives are the source of the quiz items.
   b. Be sure you understand what is being asked of you in each objective, and how you will be expected to display your mastery of the objective.
   c. Ask your instructor for examples if you are unsure of what is expected.

5. **Use your nursing instructor's office hours** for help with review, testing concerns, and clarification.
   a. Your instructor has five (5) office hours a week dedicated to helping you.
   b. Instructor office numbers are listed on Banner web and on instructor's doors.

6. **Be sure you understand your assignments**.
   a. What are the requirements?
   b. What are the expectations for format, grammar, font, etc?
   c. What is your instructor looking for?
   d. What feedback will you receive?
   e. What are you expected to do with that feedback?

7. **Study Effectively and Efficiently**.
   a. Reading complex textbooks is very different than recreational reading. Try this website: www.athabascau.ca/counselling/whats_in_it_for_me.php
   b. Use your personal learning preferences. Don't know them? Try this website: http://www.learning-styles-online.com/inventory/

8. **Use the open skills lab**. The psychomotor skills you learn in first semester will be the foundation you build on for the rest of your nursing career. Make it solid!
   a. The skills lab is open each week for your convenience. The schedule is posted on the door.
   b. The skills lab instructors are all registered nurses with a special knack to assist you in learning complex skills.
   c. Skills lab instructors will also help you with nursing math, care plans, and the application of theory from your lecture classes!
   d. Schedule skills lab time like study group time and sleep. Necessary and good for you!

**B-25**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE:** STUDENT SUCCESS PROGRAM (SSP)

**PURPOSE:** This policy describes the criteria and process utilized to support student success and retention in the COS Registered Nursing Program.

**DESCRIPTION:**
Students identified as being “at risk” for academic success and retention in the COS Registered Nursing program are eligible to participate in the Student Success Program (SSP). The SSP is a formalized and structured support service which partners the student with mentors, tutors, academic coaches and clinical preceptors. It also provides evidence-based learning and life resources which support and assist students to successfully manage the stress and demands of the nursing program and to eventually be successful in completing the program. <u>All returning nursing students will be referred to the SSP by their faculty of record.</u>

**PROCEDURE:**

<u>AT-RISK IDENTIFIERS</u>**:**
At-risk students will be identified and after instructor, consult will be considered for referral to the SSP. Identifiers fall into three (3) categories:

1. <u>Academic At-Risk Identifiers</u>
    a. Composite TEAS score <70%. Report provided by Director.
    b. Returning student
    c. LVN to RN Bridge or 30 Unit option students
    d. Excessive tardies/absences (See Policy B-19)
    e. Two (2) or more failed quizzes in a row
    f. Midterm theory grade <75% (See Early Alert process)
    g. Proctored ATI Content Mastery Assessment score < Level 1
    h. Faculty-identified concerns about theory knowledge
    i. First failure of any course
    j. Documentation of academic remediation plan
    k. Student with math comprehension challenges

2. <u>Clinical At-Risk Identifiers</u>
    a. Repeated difficulty meeting critical elements (Student Learning Outcomes) as documented in the Student Evaluation Tool (SER)
    b. Inability to maintain leveled progression of program content and outcomes (e.g. can’t apply concepts/skills from N161 while enrolled in N151 or N163)
    c. Student involvement in an adverse and/or critical clinical incident that causes or has the potential of causing serious harm to another person (patient, staff, visitor, other student, etc.)
    d. Student placed on clinical remediation plan

e. Student referred to Skills Lab > 2 times

3. <u>Psycho-Social At-Risk Identifiers</u>
   a. Employment > 20 hrs./week
   b. Lack of family, social or financial support system/network
   c. Childcare issues
   d. English language comprehension problems (e.g. poor verbal and/or written communication skills, ESL, heavy accent making it difficult to understand the student, etc.)
   e. Health issues
   f. Increased life-stressors (e.g. living with/caring for a chronically ill person, abuse)
   g. Test anxiety, performance anxiety

## REFERRAL PROCESS

1. A student may be referred to the SSP Coordinator at any time throughout the program/semester. The <u>earlier</u> in the semester a student is referred, the more effective the SSP interventions will be.

2. Sources of referral include the Nursing Director, nursing faculty and clinical staff at contracted health care agencies where students attend clinical laboratory practice.

3. Any student registered in the nursing program may self-refer.

4. Regardless of referral source, all referred students should be given the name, email address and phone number of the SSP Coordinator.

## ROLE OF THE SSP COORDINATOR

1. Once a student is identified and accepted into the SSP, the Coordinator will schedule a meeting with the student to initiate required documentation, perform an intake assessment, and develop a Student Success Plan.

2. The SSP Coordinator will act as a liaison between the student and the student's nursing instructors, providing on-going feedback, progress reports and recommendations.

3. The SSP Coordinator, with input and participation from the student's instructors, will make referrals to resource persons, provide resource materials and provide regularly scheduled counseling to the student.

4. The SSP Coordinator will meet with each SSP student as agreed upon.

5. The SSP Coordinator will maintain all SSP records/documentation and will provide reports as required by the nursing Director.

6. The SSP Coordinator will provide all nursing faculty with a brief status report, as part of the agenda (standing item) at monthly Nursing Division meetings.

## SSP RESOURCES

Resources include, but are not limited to, the following:

- Nursing Tutors (as available)
- Nursing Skills Lab Instructors
- Learning resource Center (LRC)
- COS Access and Ability Center (AAC)
- COS Student Health Care Center/Counseling
- ATI Practice Assessment and Tutorial on-line resources
- COS Student Services
  -Financial Aid
  -Tutorial Center
  -Veteran's Center
  -EOPS
  -CalWORKs
- Community Referrals

REFERENCE:

- SSP Intake Form and Success Plan

**Policy & Procedure Committee**
**DATE APPROVED/REVIEWED/REVISED:** 5/2010; 10/2012; 9/2013, 12/2014; 10/2016; 5/2018

DIVISION OF NURSING AND ALLIED HEALTH

STUDENT SUCCESS PROGRAM INTAKE FORM & SUCCESS PLAN

Student ___________________________ Semester _____ Referred by________________
Email _______________________________ Phone_____________________________

Instructor to initiate this form, then email to student and SSP coordinator**: Date emailed ________**

Reason for Referral: (Refer to "At-Risk Identifiers" as listed in the SSP policy as needed)
Narrative:

**Plan** (to be completed by SSP Coordinator)

Circle all COS resources that apply: Nursing tutors, skills lab, LRC, DRC, Health Center, Counseling Center, ATI, Seminars, Financial Aid, Tutorial Center, Veteran's Center, EOPS, CalWORKS, Community referrals, Other________________________________

Narrative:

Student Goal(s)

**Evaluation/Progress**

Narrative, or can add attachment

Goals met? _______________

Signatures: SSP Coord: ______________________ Student________________________
Date: ______________________ Date: ________________________

This form to be attached to students SER upon completion

Division of Nursing and Allied Health
Associate Degree Registered Nursing Program

# Understanding the NCLEX-RN

The **NCLEX-RN** (**N**ational **C**ouncil **L**icensure **E**xamination-**R**egistered **N**urse) is a computer-adaptive test designed to test the knowledge, skills and abilities essential to the safe and effective practice of nursing at the entry-level.
The test is given only in English, and the content of the items of the NCLEX exam is based on a practice analysis conducted every three years.

## Who Runs It?

The organization that oversees NCLEX and updates the test plan is the National Council of State Boards of Nursing (ncsbn.org). Please pay a visit to their web site. The latest information about NCLEX is available there. Bonus: ATI and your nursing faculty use the NCSBN test plan to write your exams!

## How Do They Decide How Much of Each Test Area?

The percentage of test questions assigned to each Client Needs category and subcategory of the NCLEX-RN Test Plan is based on the results of the Report of Findings from the 2005 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice (NCSBN, 2006) and expert judgment provided by members of the NCSBN Examination Committee.

| Client Needs | Percentage of Items from Each Category/Subcategory |
|---|---|
| Safe and Effective Care Environment | |
| Management of Care | 17-23% |
| Safety and Infection Control | 9-15% |
| Health Promotion and Maintenance | 6-12% |
| Psychosocial Integrity | 6-12% |
| Physiological Integrity | |
| Basic Care and Comfort | 6-12% |
| Pharmacological and Parenteral Therapies | 12-18% |
| Reduction of Risk Potential | 9-15% |
| Physiological Adaptation | 11-17% |

## NCLEX Question types

Most of the questions on the NCLEX-RN exam are multiple-choice questions. In recent years, however, the NCSBN has added broader types of questions. For example, some questions require:

- Identifying and selecting a particular area of a drawn body part pertaining to the question
- Selecting multiple correct answers (by checking the correct boxes)
- Calculating an answer for a mathematical question (usually for medication dosages) and inputting the answer
- Placing response items in the correct order by dragging and dropping

**And, the NCLEX Is All About You and Your Abilities…**

Your examination is unique because computer technology selects items to administer that match your ability level.

The items have been classified by test plan category and level of difficulty. After you answer an item, the computer calculates an ability estimate based on all of the previous answers you selected.

This means that if you answer the question correctly, the test increases in difficulty. Conversely, if you answer incorrectly, the test decreases in difficulty. This process is repeated for each item, creating an examination tailored to the knowledge and skills. The examination continues with items selected and administered in this way until a pass or fail decision is made.

**How Many Questions on the NCLEX RN?**

All registered nurse candidates must answer a minimum of 75 items, 15 of which are pretest items and will not count toward the exam score. The maximum number of items that you can answer is 265 during the allotted six-hour time period. Examination instructions and all rest breaks are included in the measurement of the time allowed for you to complete the examination.

**How Are Questions Written?**
The NCLEX consists of items that use Bloom's taxonomy as a basis for writing and coding items. Bloom was an educational psychologist who identified six levels of cognitive domains. Ranging from lowest level to the highest, the cognitive domains are classified as following: knowledge, understanding, application, analysis, synthesis, and evaluation.

Since the practice of nursing requires application of knowledge, skills and abilities, the majority of items are written at the application or higher levels of cognitive ability, which requires more complex thought processing.

**What is in it?**

According to the NCSBN, the NCLEX-RN test plan categories all address:

Client needs… Across the entire life span… In a variety of settings…

Under this broad topic, you will find four major categories of Client Needs that organize the content within the test plan. Two of the four categories are further divided into a total of six subcategories.

1. Safe and Effective Care
2. Health Promotion and Maintenance
3. Psychosocial Integrity
4. Physiological Integrity

## The NCLEX Test Plan (Short Version)

## NCLEX Category One: Safe and Effective Care Environment

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients, family/significant others and other health care personnel.

**Safe and Effective Care Environment Subcategory: Management of Care**- providing and directing nursing care that enhances the care delivery setting to protect clients, family/significant others and health care personnel. Related content includes but is not limited to:

- Advance Directives
- Advocacy
- Case Management
- Continuity of Care
- Client Rights
- Collaboration with Interdisciplinary Team
- Concepts of Management
- Confidentiality/Information Security
- Consultation
- Delegation
- Establishing Priorities
- Ethical Practice
- Informed Consent
- Information Technology
- Legal Rights and Responsibilities
- Performance Improvement (Quality Improvement)
- Referrals
- Resource Management
- Staff Education
- Supervision

**Safe and Effective Care Environment Subcategory: Safety and Infection Control**- protecting clients, family/significant others and health care personnel from health and environmental hazards. Related content includes but is not limited to:

- Accident Prevention
- Disaster Planning
- Emergency Response Plan
- Ergonomic Principles
- Error Prevention
- Handling Hazardous and Infectious Materials
- Home Safety
- Injury Prevention
- Medical and Surgical Asepsis
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Safe Use of Equipment
- Security Plan
- Standard/Transmission-Based/Other Precautions

- Use of Restraints/Safety Devices

## NCLEX Category Two: Health Promotion and Maintenance

The nurse provides and directs nursing care of the client, and family/significant others that incorporate the knowledge of expected growth and development principles; prevention and/or early detection of health problems, and strategies to achieve optimal health. Related content includes but is not limited to:

| | |
|---|---|
| • Aging Process<br>• Ante/Intra/Postpartum and Newborn Care<br>• Developmental Stages and Transitions<br>• Disease Prevention<br>• Expected Body Image Changes<br>• Family Planning<br>• Family Systems<br>• Growth and Development<br>• Health and Wellness | • Health Promotion Programs<br>• Health Screening<br>• High Risk Behaviors<br>• Human Sexuality<br>• Immunizations<br>• Lifestyle Choices<br>• Principles of Teaching/Learning<br>• Self-Care<br>• Techniques of Physical Assessment |

## NCLEX Category Three: Psychosocial Integrity

The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client and family/significant others experiencing stressful events, as well as clients with acute or chronic mental illness. Related content includes but is not limited to:

- Abuse/Neglect
- Behavioral Interventions
- Chemical and Other Dependencies
- Coping Mechanisms
- Crisis Intervention
- Cultural Diversity
- End of Life Care
- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Psychopathology
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress Management
- Support Systems
- Therapeutic Communications
- Therapeutic Environment
- Unexpected Body Changes

## NCLEX Category Four: Physiological Integrity

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients, family/significant others and other health care personnel.

Physiological Integrity Sub-category: Basic Care and Comfort- providing comfort and assistance in the performance of activities of daily living. Related content includes but is not limited to:

- Assistive Devices
- Complementary and Alternative Therapies
- Elimination
- Mobility/Immobility
- Nutrition and Oral Hydration
- Palliative/Comfort Care
- Personal Hygiene
- Rest and Sleep
- Non-Pharmacological Comfort Interventions

**Physiological Integrity Sub-category: Pharmacological and Parenteral Therapies**- providing care related to the administration of medications and Parenteral therapies. Related content includes but is not limited to:

- Adverse Effects/Contraindications
- Blood and Blood Products
- Central Venous Access Devices
- Dosage Calculation
- Expected Effects/Outcomes
- Medication Administration
- Parenteral/Intravenous Therapies
- Pharmacological Agents/Actions
- Pharmacological Interactions
- Pharmacological Pain Management
- Total Parenteral Nutrition

**Physiological Integrity Sub-category: Reduction of Risk Potential**- Reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures. Related content includes but is not limited to:

- Diagnostic Tests
- Laboratory Values
- Monitoring Conscious Sedation
- Potential for Alterations in Body Systems
- Potential for Complications of Diagnostic Tests, Treatments, Procedures
- Potential for Complications from Surgical Procedures and Health Alterations
- System Specific Assessments
- Therapeutic Procedures
- Vital Sign

**Physiological Integrity Sub-category: Physiological Adaptation**- managing and providing care for clients with acute, chronic or life threatening physical health conditions. Related content include but is not limited to:

- Alterations in Body Systems
- Fluid and Electrolyte Imbalances
- Hemodynamics
- Illness Management
- Infectious Diseases
- Medical Emergencies
- Pathophysiology
- Radiation Therapy
- Unexpected Response to Therapies

## And, Those Areas All Fit As…

Integrated Processes: The following processes are fundamental to the practice of nursing and are integrated throughout the Client Needs categories and subcategories:

- Nursing Process- a scientific problem-solving approach to client care that includes assessment, analysis, planning, implementation and evaluation.
- Caring - interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.
- Communication and Documentation - verbal and nonverbal interactions between the nurse and the client, the client's significant others and other members of the health care team. Events and activities associated with client care are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.
- Teaching/Learning - facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.

# General Assessment Information

## Assessment Technologies Institute, LLC

ATI's nursing assessments follow the most current NCLEX® Detailed Test Plans and are similar in content and in format to the licensure examination. They reflect content that is taught in MOST nursing programs nationwide. Because of the differences in school and program philosophy, objectives, student body, and curricula, it is not possible for these assessments to cover all material offered in every program.
ATI's assessments provide data about the student's knowledge base in a particular area. Each piece of data is one bit of information about a student's overall knowledge and should be used in conjunction with other methods of evaluation when making a judgment about the student's abilities, competence, knowledge, and safety.

Criteria for the interpretation of ATI assessment scores are the sole responsibility of the institution. ATI encourages the use of multiple sources of information when making decisions about individuals.

## Licensing Exam Preparation

The final phase of Assessment-Driven Review provides two-stage preparation for the NCLEX.

## Comprehensive Predictor

The proctored RN Comprehensive Predictor is 96% predictive for outcomes of the NCLEX. Scores are included for content, nursing process, critical thinking, and knowledge level. The exam report includes NCLEX correlation and a study guide.

## Preparing for the NCLEX- RN and Preparing for the NCLEX- PN

This preparatory guide features strategies for improving performance on the NCLEX.

**A-19**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: NURSING SKILLS LAB

**PURPOSE**:

To describe the resources available to students for clinical practice and the process for coordinating these resources. The goal of the Nursing Skills Lab is to provide the student with an opportunity to become competent with nursing skills and thereby become a safe practitioner while working towards excellence in nursing.

**DESCRIPTION**:

1. The RN program maintains a clinical practice laboratory which is open to students and instructors, and which has the following functions:

    A. Enhances the nursing curriculum by providing learning activities which reinforce clinical objectives,
    B. Provides an environment within which students can practice clinical skills prior to performing these skills in actual patient-care settings,
    C. Provides a mechanism for the remediation of clinical skills when students need extra training opportunities, and
    D. Assists students in achieving clinical objectives/outcomes when they don't have opportunities to do so in actual clinical settings.

2. The skills lab provides the following resources for students and instructors:

    A. Simulated patient care stations with practice manikins (e.g., Sim Man, Sim Baby, Vital Sim Anne, Vital Sim Child, and infant dolls).
    B. Audio-visual equipment for viewing clinical media
    C. Clinical equipment and supplies for practicing procedures (i.e. foley catheter kits, IV sets, BP cuffs, dressing supplies, injection supplies, etc.)
    D. Anatomical and clinically-focused models, charts, and diagrams
    E. Computer-assisted instruction (CAI) programs, instructional videos and DVDs, and resource library.
    F. Skills lab instructors to provide one-on-one and group instruction and tutoring during scheduled hours.

3. Skills lab activities, equipment, and supplies are coordinated by the Nursing Skills Lab Personnel.

4. General Guidelines for Handling Syringes and Other Sharps:

    A. All sharps should be disposed of via the red sharps containers that COS provides.
    B. Sharps should never be disposed of in the regular trash. This places

an unfair risk of needle puncture on other students as well as staff.

5. Discard a Sharps Container
   A. Stop using a sharps container when 2/3 full or filled to FULL LINE.
   B. Close sharps container as instructed on label of sharps container.
   C. Contact the Administrative Assistant for the Science Division (559) 730-3774.
   D. Science Division Assistant will pick up the sealed sharps container and transport it to the designated Hazardous Waste Container here on campus.
   E. Open a new sharps container and place today's date on the lid with a Sharpie.

**REFERENCE**: Nursing Skills Lab Guidelines
Skills Lab Referral Form

***Policy & Procedure Committee***
**DATE APPROVED/REVIEWED/REVISED:** 4/2004; 11/2010; 2/2015, 4/2019, 5/6/19, 6/2020

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

# NURSING SKILLS LAB GUIDELINES

The Nursing Skills Lab is an extension of the students' clinical and academic programs. Therefore, all the same requirements for maintaining professional behaviors in both Clinical and Academic settings apply (i.e., dress and professional behavior, etc.). Students should wear their **student ID** and **lab jacket or vest** at all times while in the lab.

1. **NO FOOD OR DRINK** in the Skills Lab (Bottled water only).
2. **CELL PHONES turned off or placed on vibrate before entering the lab.**
3. **NO CHILDREN ALLOWED.**
4. Students are not allowed in the lab without a faculty or skills lab instructor present.
5. If you are aware that you have a **latex allergy**, **or suspect** that you do, it is your responsibility to notify skills lab personnel. Non-latex gloves are available upon request.
6. Sign in and out of the lab at all times for both practice and testing.
7. Review and check lab schedules for open and closed times (Posted on Website & Outside Lab).
8. Space, Equipment (manikins, simulators, IV pumps) and Lab Personnel are limited during high usage times (e.g., right before and during testing times). Access is on a first-come first-served basis. Consider using off times to practice. The highest demand for use of space and equipment is right after class.
9. Prior to practicing or being signed-off for any skill in the skills lab, students must study each designated skill in the required textbook. Each procedure/skill is performed by the student to demonstrate competence, safety, and appropriate infection-control measures.
10. No inappropriate language and/or inappropriate behavior.
11. Please be courteous of other students who are testing.
12. Student-purchased lab-skills kits are for practice and skills check-off for NURS 161. Students need to keep supplies in their lab-skills kit well maintained for the entire length of the program. Students must bring their lab-skills kit to every skills check-off session. Failure to do so will result in automatic remediation of the skill.
13. If you notice a broken or damaged part/piece of equipment /supplies – please notify the instructor immediately.
14. Students are required to return equipment to its proper place after use.
15. Use **beds** for practice and testing purposed only.
16. Individuals serving as patients are to remove their shoes when lying on the beds.
17. Skills lab resource manuals/reference materials are available for reference. Please **DO NOT** remove from lab.
18. Lab videos/DVDs may be used during open lab hours only. Please **DO NOT** remove from the lab.
19. **Manikins:**
    a. **Wash hands** before touching any patient/manikin.

b. **NO INK OR BETADINE** around manikins. Pencils only.
c. **Use gloves** when handling all manikins and parts.
d. **DO NOT MOVE MANIKINS OR MANIKIN PARTS WITHOUT THE HELP OF SKILLS LAB PERSONNEL.**
e. **DO NOT use** betadine on manikins. Use soap as lubricant for tubes.
f. Clean manikin surfaces with soap & water, leave to air dry.
g. Articulating parts will benefit from a light application of talcum powder prior to training sessions.
h. Ask for assistance for use of Vital Sim units (BP, assessments, etc.).

**Ending Skills Lab Time:**

1. Please pick up and throw away your trash!
2. Return all equipment and supplies to appropriate place.
3. If bed linen is in disarray, please straighten or re-make the simulator/manikin bed(s).
4. Return bed to the lowest position.
5. Maintain supply room in a neat and orderly fashion.
6. Return all tables and chairs to their appropriate place.
7. Turn off all simulators/equipment/remotes prior to leaving skills lab.
8. Please sign-out of skills lab session.

**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

# SKILLS LAB REFERRAL

**Student Name**________________________ **Course**____________ **Date**_______________

**Required Clinical Remediation** (Skills Practice, Skill Check-Off, Tutoring, etc.)
***(Completed by Student's Clinical Instructor)***

***Instructor Signature***________________________

**Remediation Activities** (Describe specific learning activities)
***(Completed by Skills Lab Instructor)***

**( ) The student achieved competency in the area(s) requiring remediation**
**( ) The student could not achieve competency**

***Skills Lab Instructor Signature***_________________________ ***Date***____________

***Original to Skills Lab Instructor then Student File; Copy to Student***

**A-23**
**COLLEGE OF THE SEQUOIAS**
**DIVISION OF NURSING AND ALLIED HEALTH**

**TITLE**: ASSESSMENT TECHNOLOGIES INSTITUTE TESTING

**PURPOSE:** To describe the types of Assessment Technology Institute (ATI) testing, the responsibilities for ATI testing for staff and faculty in each testing type, ATI resource utilization, and the incorporation of ATI resources within each course, including grade weight.

**DESCRIPTION:**
**ATI TESTING TYPES:**

1. **ADMISSION TESTING**: All ATI testing taken by students prior to entry into the COS RN Program is admission testing.
    a. Admission Testing utilizes the ATI Test of Academic Skills (TEAS). This test has been approved by the California Community College Chancellor's Office (CCCCO) for evaluating student preparedness for nursing program curriculum and as a predictor of their success in the program, based on their individual scores.
    b. Students are required to achieve the CCCCO approved cut score on the current version of the TEAS in order to be eligible to apply to the COS RN Program.
    c. The current TEAS version and required minimum cut score is available on the website of the COS RN program.
    d. Students who do not achieve the minimum cut score in their first attempt are allowed one additional attempt to achieve the required score.
    e. Students who do not achieve the minimum score in their first two attempts become ineligible for program acceptance.
    f. Students who take the TEAS at COS must provide a copy of their TEAS results with their application packet.
    g. Students who do not take the TEAS at COS must provide a copy of their TEAS results with their application packet and must purchase an electronic transcript from ATI and have it sent to the COS RN Program.
    h. ADMISSION TESTING RESPONSIBILITIES
        i. Program Director Designee
            1. Initiates and maintains agreements with ATI for testing dates and reimbursements.
            2. Schedules testing sessions and locations.
            3. Proctors TEAS sessions.
            4. Completes required TEAS reporting to CCCCO.

2. **ATI CURRICULUM RESOURCES AND TESTING:** Curriculum resources and testing include all those ATI resources utilized after students are formally accepted into the COS RN Program. ATI curriculum resources include tutorials, practice assessments, proctored assessments, and books/eBooks, Real Life Scenarios, or other resources as assigned by instructor.
    a. ATI curriculum responsibilities are as follows:

**Program Director Designee**

1. Informs incoming students as to ordering all the ATI testing resources for all four semesters, as needed**.**

2. Orients students each semester to the use of ATI resources. This orientation may be conducted in groups or individually.
3. Orients faculty each semester to ATI resources and testing processes. Provides additional technical support as needed.

**Nursing Faculty:**

1. First semester faculty distribute ATI resources to students as needed, including course specific assessment codes.
2. Determine assignments from ATI resources and (Optimal Package) and integrates those assignments into their course syllabi.
    a. Faculty may choose from books/eBooks, assessments, or tutorials, e.g., skills modules, RN Learning System 2, Nurse Logic, or any other ATI resource that supports Student Learning Outcomes.
3. Selects proctored test dates.
4. Reserves the nursing computer lab for identified dates and times.
5. Proctors course assessment in the computer lab.
6. Notifies appropriate student(s) of the make-up day and time for the proctored assessment.
7. Identifies students who are required to complete remediation based on proctored assessment results.
8. Discusses with student the ATI results and assigned remediation plan.
9. Reviews completed remediation plan and assigns a retake date and time for students scoring at Level 1 or Below Level 1. Retakes will be assigned per instructor preference.
10. Coordinates with the semester team to ensure student compliance with ATI remediation plan.

**Proctored Assessment Delivery Model**

- The ATI recommended delivery model for proctored assessments provides that students take the course proctored assessment when 90% of course content has been delivered.
- Practice assessments may be taken at any time, and are designed to guide students' study in the course content.
- Following this model, the COS RN program will provide proctored assessments at the following intervals (the week intervals may vary depending on room availability):

| **Course** | **Weeks 3-4** | **Weeks 7-9 (midterm)** | **Weeks 15-17 (finals)** |
|---|---|---|---|
| NURS 164<br>Targeted Review Practice Neurological & Musculoskeletal<br>Targeted Review Practice Perioperative | | **To Match Syllabus** | |
| NURS 164<br>Comprehensive Predictor Practice A<br>Maternal Newborn Practice B<br>Nursing Care of Children Practice B<br>Mental Health Practice B | | <br>**X**<br>**X**<br>**X**<br>**X** | |
| NURS 164 Comprehensive Predictor Practice B<br>**NURS 164 Proctored Comprehensive Predictor** | | <br>**(week 11)** | **X**<br><br>**X** |
| NURS 166 Leadership Practice A<br>NURS 166 Community Health Practice A | | | **X**<br>**X** |

| NURS166 Leadership Practice B<br>NURS 166 Community Health Practice B | | | X<br>X |
|---|---|---|---|
| **NURS 166 Proctored Leadership**<br>**NURS 166 Community Health Proctored** | | | **X**<br>**X** |

**Proctored Assessment Remediation Plan:**
The goal of a remediation plan is to direct students to the content areas in which questions were missed during the proctored course assessment, and to have students study that specific content.

**Formal Remediation Plans**
All students scoring a Level 1 or a Below Level 1 on proctored course assessments will be required to complete a formal remediation plan. The formal remediation plan for students earning a Level 1 or Below Level 1 on the first attempt of a proctored course assessment will consist of the following:

1. The course instructor will notify the student of the remediation due date.
2. The student will create a focused review of the proctored course assessment.
3. The student will complete the appropriate remediation template for each area listed on the focused review. Templates may be completed electronically and printed, or printed and completed by hand.
    a. The active learning templates are found on the home page, under Resources.
    b. The remediation templates are categorized by subject:
        i. Basic Concept
        ii. Growth and Development
        iii. Diagnostic Procedure
        iv. Nursing Skill
        v. Medication
        vi. Therapeutic Procedure
        vii. Systems Disorder
4. The student will report to their faculty member with the completed remediation templates.
5. The faculty member will review the remediation plan and per instructor preference provide the student the date, time, and location of the proctored assessment retake.

6. The formal remediation plan will be completed upon instructor approval of the formal remediation plan. Or, per instructor preference, the student may be required to submit the formal remediation plan AND retake the proctored course assessment, thereby completing the formal remediation plan.

**Informal Review Plans**
All students scoring a Level 2 or Level 3 on the first attempt of a proctored course assessment will be encouraged to complete an informal review plan. The informal review plan will consist of the following:

1. The student will create a focused review of the proctored course assessment.
2. The student will complete the appropriate remediation template for each area listed on the focused review. Templates may be completed electronically and printed, or printed and completed by hand.
    a. The active learning templates are found on the home page, under Resources.
    b. The remediation templates categorized by subject:
        i. Basic Concept

ii. Growth and Development
iii. Diagnostic Procedure
iv. Nursing Skill
v. Medication
vi. Therapeutic Procedure
vii. Systems Disorder

3. The student will not be required to report to their faculty member.

**Grade Weight**

1. Each course will attach course value to the completion of assigned ATI activities.
    a. All ATI assignments and their course weight will be included in course syllabi.
    b. The ATI course weight will be at least 10%, and will not exceed 20% of the course grade.

## Policy & Procedure Committee

**DATE APPROVED/REVIEWED/REVISED:** 2/2007; 5/2007; 5/2011; 2/2012; 11/2012, 04/2014; 09/2014; 10/2016; 2/2017, 6/2020, **12/2020, 5/2021.**

Division of Nursing and Allied Health
Associate Degree Registered Nursing Program

# Board of Registered Nursing Documents

Students must be familiar with important policies, standards, and statements by the California Board of Registered Nursing (BRN), which affect their nursing practice. Copies of some of these documents are located in this Appendix and should be regularly reviewed. Students are accountable for knowing and abiding by these and other BRN policies. Students are encouraged to visit the BRN website at **www.rn.ca.gov**.

The following are additional important BRN policies/standards/statements the student should be familiar with:

Scope of Regulation **§2725** An Explanation of the Scope of RN Practice Including Standardized Procedures

Standards of Competent Performance

Policy Statement on Denial of Licensure

Statement on Delivery of Health Care

Abuse Reporting Requirements

Abandonment of Patients

# BACKGROUND CHECKS FOR STUDENT CLINICAL PLACEMENT

During the past the Board of Registered Nursing (BRN) has received numerous questions regarding the issue of background checks on registered nursing students prior to clinical placement. The Board has been asked to assist programs with meeting this requirement.

The use of background checks on individuals working in clinical settings is one of the means agencies use to help protect their clients/patients. While obtaining background checks on employees is not new for clinical agencies, the Joint Commission has added to their Human Resources standards (HR.1.20) a section related to criminal background checks. The Joint Commission standard requires agencies to include nursing students in criminal background checks *when required by state law, regulation or hospital policy*. (www.jointcommission.org)

The BRN does not require prelicensure nursing programs to screen potential students for a history of convictions prior to acceptance into their program. The BRN only requires background checks on criminal convictions at the time of application for licensure. Furthermore, BRN staff reviews all applications with prior convictions on an individual case-by-case basis before issuing or denying licensure. The criteria used by the Board in evaluating an applicant's present eligibility for licensure are found in the California Code of Regulations (CCR) Section 1445. (www.rn.ca.gov)

Clinical agencies have the right to establish criteria that would exclude a student from placement at their facility. Those clinical agencies that have a policy that include student nurses in their requirement for criminal background checks will need to comply with their own policy to be compliant with the Joint Commission Standard HR 1.20. On the other hand agencies may use different criteria for students than are used for employees or exempt them entirely and still meet Joint Commission Standards.

Nursing programs should establish a written policy describing the process for obtaining background checks for those clinical agencies that require them. The Board recommends that the policy on background checks, like all program policies, be published in documents that are available to applicants and students. Examples include admission packets and school catalogs and/or nursing student handbooks.

The written policies should include the following:

- Who will perform the search (the college, the agency or an independent service);

- Who will pay for the process;
- Where and by whom the results will be maintained and protected (student confidentiality);
- What criteria will be used to exclude a student from a particular clinical placement; and
- What alternatives if any will be available in the event a student is denied a clinical placement.

The Board encourages clinical agencies and nursing programs to work collaboratively in establishing standardized policies that are the least restrictive possible while also protecting the rights of consumers. A process that allows for a case-by-case review of students with prior convictions is encouraged. However, the burden of proof lies with the student to demonstrate evidence of rehabilitation that is acceptable to the clinical agencies and the nursing program. (See the document "Prior Convictions and Disciplinary Actions" on the Board's Website.)

**Frequently Asked Questions Related to Background Checks:**

***Question: Does the BRN require student nurses to undergo criminal background checks prior to admission in a prelicensure school of nursing?***
No. The Board has no authority to request a criminal background check except at the time of application for licensure.

**Question: Does the Joint Commission require that student nurses in California have criminal background checks done prior to the students participating in a clinical rotation in a Joint Commission approved facility?**
No. The Joint Commission requires that clinical agencies follow state law/regulation and their own organization's policy regarding background checks on students. (See Joint Commission website www.jointcommission.org) There is no state law in California that mandates background checks be completed on nursing students. Some clinical agencies have included student nurses in the category of individuals that need to be screened, therefore, the Joint Commission would also require that nursing students need background checks done.

**Question: If a clinical agency denies a student with a prior conviction from being placed at their facility does the BRN <u>require</u> that the student be dropped from that course or from the program?**
No. The program is encouraged to evaluate such students, in collaboration with their clinical agencies, to find possible alternatives for the student to complete the objectives of the course. All students are expected to meet course objectives as defined by the course syllabi and program policy.
**Question: If students have had a criminal background check done as part of clinical placement can they use that information as part of their application packet for licensure?**

No. The Board requires a background check on all applicants for licensure by the Department of Justice. As a health care licensing Board, the background check conducted on applicants is more extensive than most employers obtain.

**Question: If a student is denied access to a clinical site due to a positive criminal background check does the nursing program have to find an alternative site for the student to meet course requirements?**
No. The Board encourages programs and agencies to work collaboratively to review students with a prior conviction on an individual basis since the specific conviction may not prevent the student from ultimately being licensed. While the BRN encourages alternative placement ultimately the program would need to follow their published policy regarding the options available to the student in this situation. (See the attached Criteria for Rehabilitation, CCR 1445.)

**Question: Can the college or university request the Department of Justice to perform a criminal background check on their nursing students in order to meet clinical agency requirements for placement?**
No. Only authorized agencies may request the Department of Justice to perform criminal background checks. The nursing program or the agency may utilize private companies that provide background checks for a fee. The Board does not require the use of such a service nor does it endorse any specific company.

**Question: Should results of criminal background checks be placed in the student's academic file?**
The self-disclosed student information and the results of a background check are confidential information. The nursing program must develop in consultation with their administration and clinical agencies a means to safeguard this information. It is recommended that the process, maintenance and security of student background checks should be described in the program's contract with those agencies requiring screening of nursing students and in policies provided to students and applicants.

**Question: Do students need to have a background check done every time they go to a new clinical agency?**
The Board encourages nursing programs to work collaboratively with other nursing programs in their geographical area to develop a standardized policy with all clinical agencies requiring background checks on nursing students. Since there is no state law or regulation that mandates background checks on nursing students, individual agency policy is the source of this requirement. Working collaboratively within a geographic area is probably the most efficient way to coordinate requirements in the least disruptive manner.

**Question: Can a clinical agency refuse to allow a student to do a clinical course at their agency as a result of a prior conviction?**

Yes. The Board would encourage the nursing program to work with the agency to clearly identify the types of prior convictions that would exclude a student from clinical rotation. The BRN suggests using CCR 1445 as a guide.

**Question: Can a nursing program require students to meet clear background checks prior to admission or as a requirement for progression in the program?**

Admission and progression policies are the purview of the program & the institution. The nursing program should seek guidance from their institutions legal counsel. The Board regulations require that all policies affecting students be written, available to students, and applicants.

**Attachment:**

**TITLE 16, CALIFORNIA CODE OF REGULATIONS:**
**1445. Criteria for Rehabilitation**

(a) When considering the denial of a license under Section 480 of the code, the board, in evaluating the rehabilitation of the applicant and his/her present eligibility for a license will consider the following criteria:
(1) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.
(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480 of the code.
(3) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (1) or (2).
(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.
(5) Evidence, if any, of rehabilitation submitted by the applicant.

(b) When considering the suspension or revocation of a license on the grounds that a registered nurse has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his/her eligibility for a license will consider the following criteria:
(1) Nature and severity of the act(s) or offense(s).
(2) Total criminal record.
(3) The time that has elapsed since commission of the act(s) or offense(s).
(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.
(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.
(6) Evidence, if any, of rehabilitation submitted by the licensee.

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# STANDARDS OF COMPETENT PERFORMANCE

**Website:** http://www.rn.ca.gov/regulations/title16.shtml#1443.5

## 1443.5. STANDARDS OF COMPETENT PERFORMANCE

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

## Registered Nurse Scope of Practice
## Business and Professional Code Section 2725

1. The Registered Nursing Business and Professional Code is the set of laws that provide clear legal authority regarding the commonly accepted functions and procedures of Registered Nursing.
2. The Registered Nursing Business and Professional Code was created and is governed by the California State Legislature.
3. I, as a Registered Nursing Student and as a Registered Nurse am required to comply with all sections of the RN Scope of Practice as outlined in the California Business and Professional Code, section 2725.
4. Section 2725 includes the following:

**Section (b)**

**The Practice of Nursing includes…basic health care that:**

1. Helps people cope with difficulties in daily living that are associated with their actual or potential health or illness problems, or
2. Are the treatment for actual or potential health or illness problems, and
3. That require a substantial amount of scientific knowledge or technical skill, including all of the following:
   - A. All patient care services that ensure the safety, comfort, personal hygiene, and protection of patients.
   - B. The performance of disease prevention and restorative measures.
   - C. All patient care services, including, but not limited to:
     - Administering medications and therapeutic agents, necessary to implement a treatment, and/or disease prevention.
     - Conducting a rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
     - Performing skin tests and immunization techniques.
     - Withdrawing human blood from veins and arteries.
     - Observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition.
     - Determining if the signs, symptoms, reactions, behavior, or general appearance of patients show abnormal characteristics.

- Appropriate reporting, referral, or undertaking **standard procedures**, **standard** changes in treatment, or starting emergency procedures if your observations indicate abnormalities.

## What Are Standardized Procedures?

1. Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

2. Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

The policies and protocols of Registered Nursing are subject to any guidelines for **standardized procedures** that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly establish.

**The guidelines are administered by the Board of Registered Nursing.**

## I Am Responsible For Knowing

- A Registered Nurse may dispense drugs or devices upon an order by a licensed physician and surgeon if the nurse is functioning within a licensed clinic.
- No clinic may employ a registered nurse to perform dispensing duties exclusively.
- No registered nurse shall dispense drugs in a pharmacy; keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons.
- No registered nurse shall compound drugs.
- No registered nurse may dispense drugs (except a certified nurse-midwife or a nurse practitioner) included in the California Uniform Controlled Substances Act.

For More Information:

**http://www.rn.ca.gov/regulations/bpc.shtml**

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# IMPAIRED NURSING STUDENTS

## GUIDELINES FOR SCHOOLS OF NURSING IN HANDLING NURSING STUDENTS IMPAIRED BY CHEMICAL DEPENDENCY OR MENTAL ILLNESS

### BOARD STATEMENT:

The Board of Registered Nursing considers the student use of controlled substances, dangerous drugs or devices or alcoholic beverages to an extent or in a manner injurious to self or others to constitute unprofessional conduct. The conviction of a criminal offense involving the prescription, consumption or self-administration of the above substances is conclusive evidence thereof. (B&P 2762).

Nursing students showing signs of mental illness or chemical dependency should be directed to a health care provider for diagnosis and treatment of the illness. Chemical dependency and mental illness are diseases and should be treated as such. The Board has established a diversion program for impaired registered nurses as a voluntary alternative to traditional Board disciplinary actions. (B&P 2770)

### NURSING PROGRAMS ARE EXPECTED TO:

- Have a policy for students who are impaired by or demonstrate characteristics of chemical dependency or mental illness which directs the student to seek appropriate assistance through a health care provider and provide the nursing program with proof of treatment.
- Provide instructors with the authority and responsibility to take immediate corrective action with regard to the impaired student's conduct and performance in the clinical setting. This includes removing the impaired student from the patient care area until the student is deemed medically safe to return to patient care activities.
- Provide this information to incoming students in their nursing program handbooks along with factual material related to chemical dependency and mental illness among nursing students.
- Handle the matter confidentially.

### STUDENTS ARE EXPECTED TO:

- Voluntarily seek diagnosis and treatment for chemical dependency or mental illness and provide evidence of treatment and fitness for practice to the nursing program.
- Show evidence of rehabilitation when submitting their application for licensure.