The purpose of the Henderson Community College Associate Nursing Degree Handbook is to present guidelines and policies for the students. It is given to each student at nursing orientation. However, the policies are subject to change without notice with each semester and therefore may not remain the same throughout a student’s entire nursing education career.

HENDERSON COMMUNITY COLLEGE VISION, MISSION, VALUES, AND INSTITUTIONAL GOALS STATEMENT

Vision:
To be the area’s educational leader providing opportunities for personal growth, professional training, and cultural enrichment.

Mission:
The mission of Henderson Community College is to partner with the community in assessing and providing educational, economic, workforce development, civic and cultural programs that
• Provide high-quality general education curriculum for the first two years of a baccalaureate program (Associate in Arts and Associate in Science degrees).
• Provide high-quality technical programs to prepare students for immediate employment (certificates, diplomas, or Associate in Applied Science degrees).
• Provide continuing education, adult education, and customized training to prepare a competitive workforce.
• Provide personal enrichment and cultural opportunities.

Values:
• Academic freedom, honesty and integrity
• Accountability
• Community and collaboration
• Diversity and cultural awareness
• Innovation, access and opportunity
• Student success
• Trust, respect, and open communication

Institutional Goals:
• Increase Student Access and Success
• Promote Excellence in Teaching and Learning
• Foster Diversity and Global Awareness
• Enhance the Economic Development of Communities and the Commonwealth
• Promote the Recognition and Value of Henderson Community College

TABLE OF CONTENTS
Dear Nursing Student,

Welcome to Henderson Community College Associate Degree Nursing Program. If you are a new student in Nursing, you are beginning an exciting, challenging and rewarding experience. If you are a returning student, you are aware of the demanding but satisfying course you have chosen. The faculty and staff wish you the best in fulfilling your goal.
This handbook along with the Kentucky Community College and Technical System Code of Student Conduct will provide you with invaluable information for successful completion of the program. Retain this booklet throughout the semesters as a handy resource.

You are encouraged to seek help from the faculty and staff whenever it is needed. We are here to help you. We want you to feel free to stop in and visit us in our offices. Regular office hours are posted on each door and unless at a clinical site, there is almost always someone here to help you.
**HENDERSON COMMUNITY COLLEGE**

**HISTORY**

Henderson Community College accepted the first class of seventeen Nursing Students in the Fall of 1963. Funded by a Kellogg Grant through the University Of Kentucky College Of Nursing, Henderson holds the distinction of having the first Associate Degree Nursing Program in the state of Kentucky.
In February of 1987 the Program completed a self-study and was visited by the National League for Nursing Accrediting Commission (NLNAC)*. Initial accreditation was granted for eight years. Re-accreditation was granted in the Spring of 1996 and Spring of 2005. In the Spring 2013 the program was re-accredited by the Accreditation Commission for education in Nursing, Inc. (formerly known as NLNAC). The Program has full approval from the Kentucky Board of Nursing and the College is accredited by the Southern Association of Colleges.

Due to the shortage of registered nurses and with financial support of the two local hospitals in Owensboro, an Extension of the Henderson Community College Program was opened at Owensboro Community College in the Spring of 1991. In the Spring of 1999, Owensboro separated and became an independent Nursing Program.

Through the history of the Program, the results of State Board Examination, now called the NCLEX-RN, have varied. In the past ten years, the results have been above the national and state average with several classes achieving 100% on the first attempt.

* Accreditation Commission for Education in Nursing, Inc.
3343 Peachtree Road NE, Suite 850
Atlanta, Georgia 30326
www.acenursing.org

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
ASSOCIATE DEGREE NURSING
PHILOSOPHY

The philosophy of the Associate Degree Nursing (A.D.N.) program is congruent with the Kentucky Community and Technical College System (KCTCS) mission statement and is supported by the works of Marjory Gordon and the National League for Nursing. The faculty believes that:
Each individual is a unique, holistic being with bio-psychosocial, cultural and spiritual dimensions in constant interaction with the environment. All human beings have in common certain functional patterns that contribute to their health, quality of life, and achievement of human potential;

The dynamic process of mastering core competencies is essential to the practice of contemporary and futuristic nursing. This process illustrates the personal, progressive, and lifelong professional development of the nurse through the accumulation, analysis, and synthesis of knowledge, scientific findings and human experience. The components of this A.D.N. conceptual model include: core values, integrating concepts, program outcomes and nursing practice;

Learning is an individual and lifelong process evidenced by changed behavior resulting from the acquisition of knowledge, practice and ethical comportment. Knowledge encompasses the realms of science and theory. Practice includes the ability to engage in a thoughtful, deliberate, and informed way. Ethical comportment involves the individual’s formation within a set of recognized responsibilities; it includes the notions of “good practice” and “boundaries of practice.” Learning in an educational setting is enhanced by a teacher/student relationship in which the teacher’s responsibility is to structure and facilitate optimal conditions for critical thinking and learning through clearly defined student learning outcomes. The student brings to this relationship the willingness to learn and is accountable for his/her education. Recognizing that both the rate and style of learning differ with individuals, various strategies are utilized to facilitate the achievement of student learning outcomes, attainment of maximum potential, and promotion of continued learning;

The A.D.N. graduate, having achieved the graduate outcomes, is prepared to practice in a variety of settings within the parameters of individual knowledge and experience according to the standards of practice. The role of the A.D.N. graduate includes human flourishing, nursing judgment, professional identity, and spirit of inquiry. Encompassed within these roles are the core components of context and environment, knowledge and science, personal/professional development, quality and safety, relationship-centered care, and teamwork.

References:

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
ASSOCIATE DEGREE NURSING
CONCEPTUAL FRAMEWORK

The conceptual framework of the Associate Degree Nursing (A.D.N.) program as developed and valued by the faculty is based upon constructs of the nursing paradigm and related concepts.

The framework relates the philosophy to the curriculum and provides focus for the program. It organizes and defines nursing practice, explaining the relationships between the concepts of the
philosophy and depicting the seven core values with their six integrated concepts and eleven functional health patterns.

The faculty members believe that nursing practice includes human flourishing, nursing judgment, professional identity, and spirit of inquiry that are based on the National League for Nursing educational program outcomes for A.D.N. graduates and Marjory Gordon’s functional health pattern framework.

Fundamental to the framework are the seven core values of caring, diversity, ethics, excellence, holism, integrity, and patient centeredness. The six integrating concepts of nursing practice are: context and environment, knowledge and science, personal/professional development, quality and safety, relationship-centered care, and teamwork. The core values and integrating concepts are introduced, developed, and built upon throughout the curriculum.

The client’s functional health patterns are: health perception/health management, nutrition/metabolism, elimination, activity/exercise, sleep/rest, cognitive/perceptual, self-perception/self-concept, role/relationships, sexuality/reproduction, coping/stress tolerance, and value/belief. These patterns are influenced by the client’s culture, age/development, and state of health/illness and serve as a unifying structure for the organization of the curriculum.

The conceptual model is a visual representation of the relationships among the concepts of the philosophy and depicts all components inherent in nursing practice and the eleven functional patterns inherent in the client.

References:


KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
ASSOCIATE DEGREE NURSING
OPERATIONAL DEFINITIONS

Core Values are those elements of Associate Degree Nursing that are essential to entry level registered nursing practice and are inherent in the four roles of nursing practice: human flourishing, human judgment, professional identity, and spirit of inquiry. The core values include caring, diversity, ethics, excellence, holism, integrity, and patient-centeredness and are defined as:

- **Caring**: “promoting health, healing and hope in response to the human condition” (NLN, 2010, p.11). ‘A culture of caring, as a fundamental part of the nursing profession, characterizes our concern and consideration for the whole person, our commitment to the common good, and our outreach to those who are vulnerable.’ (NLN, 2007).

- **Diversity**: recognizing differences among “Persons, ideas, values, and ethnicities,” while affirming the uniqueness of each (NLN, 2010). “A culture of diversity embraces acceptance and respect. We understand that each individual is unique and recognize individual differences, which can be along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. A culture of diversity is about understanding ourselves and each other and moving beyond simple tolerance to embracing and celebrating the richness of each individual. While diversity can be about individual differences, it also encompasses institutional and system-wide behavior patterns.” (NLN 2007).

- **Ethics**: involves reflective consideration of personal, societal and professional values, principles, and codes that shape nursing practice. Ethical decision-making requires applying an inclusive, holistic, systematic process for identifying and synthesizing moral issues in health care and nursing practice, and for acting as moral agents in caring for patients, families, communities, societies, populations, and organizations. Ethics in nursing integrates knowledge with human caring and compassion, while respecting the dignity, self-determination, and work of all persons. (NLN, 2010, p.13).

- **Excellence**: “… reflects a commitment to continuous growth, improvement, and understanding. It is a culture where transformation is embraced, and the status quo and mediocrity are not tolerated” (NLN, 2007).
• Holism: the culture of human caring in nursing and health care that affirms the human person as the synergy of unique and complex attributes, values, and behaviors, influenced by that individual’s environment, social norms, cultural values, physical characteristics, experiences, religious beliefs and practices, and moral and ethical constructs, within the context of a wellness-illness continuum (NLN, 2010, p.14).

• Integrity: “respecting the dignity and moral wholeness of every person without conditions or limitations.” Integrity within nursing practice…recognizes with humility, the human dignity of each individual patient, fellow nurse, and others whom we encounter in the course of our work. It means accepting accountability for our actions while being fully committed to the betterment of patient care while advocating for patients in a consistently professional and ethical manner (NLN, 2010, p.13).

• Patient-Centeredness: an orientation to care that incorporates and reflects the uniqueness of an individual patient’s background, personal preferences, culture, values, traditions, and family. A patient-centered approach supports optimal health outcomes by involving patients and those close to them in decisions about their clinical care (NLN, 2010, p.14).

Emerging from core values are six integrating concepts. These concepts are defined as:

• Context and Environment: “…the conditions or social system within which the organization’s members act to achieve specific goals. In health care, context and environment encompass organizational structure, leadership styles, patient characteristics, safety climate, ethical climate, teamwork, continuous quality improvement, and effectiveness.” (NLN, 2010, p.16)

• Knowledge and Science: “…the foundations that serve as a basis for nursing practice, which, in turn, deepen, extend and help generate new knowledge and new theories that continue to build the science and further the practice. These foundations include (a) understanding and integrating knowledge from a variety of disciplines outside nursing that provide insight into the physical, psychological, social, spiritual, and cultural functioning of human beings; (b) understanding and integrating knowledge from nursing science to design and implement plans of patient-centered care for individuals, families, and communities; (c) understanding how knowledge and science develop; (d) understanding how all members of a discipline have responsibility for contributing to the development of that discipline’s evolving science; and (e) understanding the nature of evidence-based practice.” (NLN, 2010, p.20)

• Personal/Professional Development: “…a lifelong process of learning, refining, and integrating values and behaviors that (a) are consistent with the profession’s history, goals, and codes of ethics; (b) serve to distinguish the practice of nurses from that of other health care providers; and (c) give nurses the courage needed to continually improve the care of patients, families, and communities and to ensure the profession’s ongoing viability.” (NLN, 2010, p.23)
• Quality and Safety: “…the degree to which health care services are 1) are provided in a way consistent with current professional knowledge; 2) minimized the risk of harm to individuals, populations, and providers; 3) increase the likelihood of desired health outcomes; and 4) are operationalized from an individual unit and systems perspective.” (NLN, 2010, p.25)

• Relationship-Centered Care: “positions (a) caring; (b) therapeutic relationships with patients, families, and communities; and (c) professional relationships with members of the health care team at the core of nursing practice. It integrates and reflects respect for the dignity and uniqueness of others, valuing diversity, integrity, humility, mutual trust, self-determination, empathy, civility, the capacity for grace, and empowerment.” (NLN, 2010, p.27)

• Teamwork: to function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve quality patient care.” (NLN, 2010, p.30)

Goals of nursing education for entry into nursing practice are defined as:

• Human Flourishing: “…an effort to achieve self-actualization and fulfillment within the context of a larger community of individuals, each with the right to pursue his or her own such efforts. ...Human flourishing encompasses the uniqueness, dignity, diversity, freedom, happiness, and holistic well-being of the individual within the larger family, community, and population.” (NLN, 2010, p.33)

• Nursing Judgment: encompassing “…critical thinking, clinical judgment, and integration of best evidence into practice. Nurses must employ these processes as they make decisions about clinical care, the development and application of research and the broader dissemination of insights and research findings to the community, and management and resource allocation.” (NLN, 2010, p.34) This process is driven by Maslow’s hierarchy of needs to assist in the prioritization of patient-centered care.

• Professional Identity: “…the internalization of core values and perspectives recognized as integral to the art and science of nursing. The nurse embraces these fundamental values in every aspect of practice while working to improve patient outcomes and promote the ideal of the nursing profession.” (NLN, 2010, p.35)

• Spirit of Inquiry: “…a persistent sense of curiosity that informs both learning and practice. A nurse infused by a spirit of inquiry will raise questions, challenge traditional and existing practices, and seek creative approaches to problems.” (NLN, 2010, p.36)

Functional Health Patterns are ways of living that include a configuration of behaviors that occur across time. The patterns are interrelated, interactive and independent. Functional and dysfunctional patterns determine client strengths and/or nursing diagnoses. There are eleven (11) functional health patterns that include: health perception/health management, nutrition/metabolism, elimination, activity/exercise, self-perception/self-concept, role/relationships, sexuality/reproduction, coping/stress/tolerance, and value/belief and are defined as:
• Health Perception-Health Management: the client’s perceived pattern of health and wellbeing and how health is managed. It includes the client’s perception of his/her own health status, the general level of health care behaviors, and adherence to health practices.

• Nutritional-Metabolic: the client’s pattern of food and fluid consumption relative to metabolic need and pattern indicators of nutrient supply. It includes skin integrity, nutritional intake, nutrient supply to tissues, and metabolic needs.

• Elimination: patterns of excretory function (bowel, bladder, and skin). It includes the client’s perceived excretory functions, changes or disturbances in function, devices used to control excretion, and family/community disposal patterns.

• Activity-Exercise: patterns of exercise, activity, leisure, and recreation. It includes activities of daily living requiring energy expenditure, type and quality of exercise, and factors that interfere with the expected pattern (neuromuscular deficits, musculoskeletal abnormalities, and cardio-pulmonary insufficiencies).

• Sleep-Rest: patterns of sleep, rest, and relaxation. It includes the perception of quality and quantity of sleep, rest-relaxation, and energy levels.

• Cognitive-Perceptual: patterns of sensory-perceptual and cognitive patterns. It includes adequacy of vision, hearing, taste, touch, smell, language, memory, judgment, and decision-making.

• Self-Perception-Self-Concept: the client’s self-concept pattern and perception of self (self-conception/worth, body image which includes attitudes of self, perception of abilities (cognitive, affective, or physical) image, identity, worth, and emotional patterns.

• Role-Relationship: the client’s pattern of role engagements and relationships. It includes the client’s perception of his/her major roles, responsibilities, and relationships in current life situations.

• Sexuality-Reproductive: the client’s patterns of satisfaction and dissatisfaction with sexuality pattern. It includes reproductive patterns, satisfaction with sexual relationships and sexuality patterns.

• Coping-Stress-Intolerance: the client’s general coping pattern and effectiveness of the pattern in terms of stress tolerance. It includes the capacity to resist challenges to self-integrity, modes of handling stress, support systems, and ability to control or manage situations.

• Value-Belief: patterns of values, beliefs (including spiritual) and goals that guide the client’s choice of decisions. It includes perceptions of what is important in life, and conflicts in values, beliefs or expectations that are health related.
References:


KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
ASSOCIATE DEGREE NURSING
GRADUATE OUTCOMES

Upon completion of this program, the Associate Degree Nursing graduate can:

1. Advocate for patients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings (human flourishing);
   a. Develop, implement and evaluate individualized plans of care focusing on services and activities that promote independence, maintain or restore health, or support a peaceful death;
   b. Advocate for the access to and quality of care for patients;
   c. Use teaching/learning processes to facilitate the patients in informed decision-making to achieve positive outcomes and support the client’s functional patterns;
   d. Provide culturally competent care that demonstrates respect for diverse patients;

2. Make judgments in practice, substantiated with evidence, that integrate nursing science in the provision of safe, quality-care and promote the health of patients within a family and community context (nursing judgment);
   a. Utilize the nursing process while incorporating Gordon’s functional health patterns as a basis for clinical judgment to optimize outcomes of care for the patient, family, and community;
   b. Perform essential nursing skills as identified by the critical criteria;
   c. Collaborate with the patient, family, significant others and members of the health care team in the management of care;
   d. Establish and maintain effective/therapeutic communication with patients, families, significant others, and members of the health care team;
   e. Manage the direct provision of nursing care through effective organizational skills, appropriate delegation, and supervision within the scope of practice;
   f. Employ principles of quality and safety, healthcare policy, and cost effectiveness to improve healthcare outcomes;

3. Implement one’s role as a nurse in ways that reflect integrity, responsibility, ethical practice and an evolving identity as a nurse committed to evidence-based practice, caring, advocacy, and safe, quality care for diverse patients within a family and community context (professional identity);
   a. Recognize situations beyond one’s knowledge and experience, and seek consultation from appropriate resources in a changing healthcare environment;
b. Integrate caring behaviors in managing care;
c. Exhibit professional behaviors/practice as defined by the ethical, legal, and regulatory frameworks of nursing;
d. Use information and technology to communicate, manage knowledge, mitigate error and support decision making;

4. Examine the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and offer new insights to improve the quality of care for patients, families, and communities (spirit of inquiry);
   a. Recognize and examine evidence-based literature/research for use in nursing practice;
   b. Value continuous learning within the nursing profession;

Adopted: Fall 2012

Nursing – Associate Degree

Degrees:
AAS Nursing
Track: Modular 62-66

Description:
The Associate Degree Nursing program prepares graduates to use their skill and knowledge to fulfill the role of the nurse: enhance human flourishing, demonstrate sound nursing judgment, continually develop professional identity, and possess a spirit of inquiry to improve the quality of patient care. Encompassed within these roles are the core components of context and environment, knowledge and science, personal/professional development, quality and safety, relationship-centered care, and teamwork. These core components are introduced, developed and built upon through the curriculum. Graduates are eligible to take the National Council Licensure Examination for Registered Nurses (NCLEX-RN). The Associate Degree Nursing curriculum is organized around a clearly defined conceptual framework and combines general education and nursing courses. The nursing courses correlate classroom and clinical instruction in a variety of community agencies. *

Acceptance into the Associate Degree Nursing program is based on a selective admissions process. In order to be considered for admission, applicants must comply with college and program admission requirements prior to March 1 for admission to a fall NSG 101 course (July 1 for admission to a spring NSG 101 course).

Progression in the Associate Degree Nursing program is contingent upon achievement of a grade of “C” or better in each biological science, nursing and mathematics course and maintenance of a 2.0 cumulative grade point average or better (on a 4.0 scale).

CPR requirements must be successfully completed prior to enrolling in the first nursing course and must be kept current throughout the program. Documentation of successful completion of a minimum 75-hour nursing assistant course, or its equivalent, and documentation of computer literacy as defined by KCTCS is required prior to enrolling in the first nursing course.

*Transportation to the community agencies is the responsibility of each student.

Note: The Kentucky Board of Nursing may deny a nursing graduate admission to the NCLEX-RN Exam if an individual has been convicted of a misdemeanor or felony which involves acts that bear directly on the qualifications of the graduate to practice nursing.
The following Associate Degree Nursing programs are accredited by the Accreditation Commission for Nursing in Education, 3343 Peachtree Rd. NE, Suite 850, Atlanta, GA 30326, www.acenursng.org, telephone: (404) 975-5000:

Implementation: Fall 2018

Competencies:

Nursing – Associate Degree
Upon completion of this program, the graduate can:

Program Title: Nursing Associate Degree
Upon completion of this program, the graduate can:

General Education Competencies:
Students should prepare for twenty-first century challenges by gaining:

A. Knowledge of human cultures and the physical and natural worlds through study in the sciences and mathematics, social sciences, humanities, histories, languages, and the arts.

B. Intellectual and practical skills, including
   • inquiry and analysis
   • critical and creative thinking
   • written and oral communication
   • quantitative literacy
   • information literacy
   • teamwork and problem solving

C. Personal and social responsibility, including
   • civic knowledge and engagement (local and global)
   • intercultural knowledge and competence
   • ethical reasoning and action
   • foundations and skills for lifelong learning

D. Integrative and applied learning, including synthesis and advanced accomplishment across general and specialized skills.

Technical Competencies: Associate Degree in Nursing
Upon completion of this program, the graduate can:
1. Advocate for patients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings (human flourishing).
   a. Incorporate culturally competent, individualized plans of care focusing on services and activities that promote independence, maintain or restore health, or support a peaceful death and advocate for access and quality of care for patients.
   b. Formulate teaching/learning processes to facilitate the patients in informed decision-making to achieve positive outcomes and support the client’s functional patterns that demonstrates respect for diverse patients.
2. Formulate judgments in practice, substantiated with evidence, that integrate nursing science in the provision of safe, quality-care and promote the health of patients within a family and community context (nursing judgment).
   a. Utilize the nursing process while incorporating Gordon’s functional health patterns as a basis for clinical judgment to optimize outcomes of care for the patient, family, and community.
   b. Establish and maintain effective/therapeutic communication in collaboration with patients, families, significant others, and members of the health care team.
   c. Manage the direct provision of nursing care through effective organizational skills, appropriate delegation, and supervision within the scope of practice.
3. Develop one’s role as a nurse in ways that reflect integrity, responsibility, ethical practice and an evolving identity as a nurse committed to evidence-based practice, caring, advocacy, and safe, quality care for diverse patients within a family and community context (professional identity).
   a. Employ principles of advocacy, quality and safety, healthcare policy, and cost effectiveness to improve healthcare outcomes.
   b. Exhibit professional behaviors/practice as defined by the ethical, legal, and regulatory frameworks of nursing.
   c. Incorporate the ability to ethically and responsibly integrate technology to skillfully locate, evaluate, use, create and communicate information to improve the quality and safety of patient care and the life and employability of graduates.
4. Consider the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and offer new insights to improve the quality of care for patients, families, and communities (spirit of inquiry).
   a. Interpret evidence-based literature/research for use in nursing practice.
   b. Value continuous learning within the nursing profession.

Outline:

**Program Title:** AAS in Nursing – Modular Track

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<td>NSG 230</td>
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**Subtotal** | **38-42** |
**TOTAL CREDITS** | **62-66**

**Taken by Licensed Practical Nurses who meet specific program requirements.**

***Credit may be awarded to Licensed Practical Nurses who meet specific program requirements.**

**NOTE:** CPR requirements must be successfully completed prior to enrolling in the first nursing course and must be kept current throughout the program. Documentation of successful completion of a minimum 75-hour nursing assistant course, or its equivalent, and documentation of computer literacy as defined by KCTCS is required prior to enrolling the first nursing course.
Students in need of assessment, testing or accommodation must contact (preferably at the beginning of or prior to each semester):

Pamela Franklin Buchanan MPA
Coordinator of Assessment/Testing
Henderson Community College
STC 227
2660 S. Green Street
Henderson, KY 42420
P-270-831-9783
F-270-831-9843
pam.buchanan@kctcs.edu

Accommodations are not transferred from one college to another, one course to another or one semester to the next. Students must inform their instructor that they wish to utilize their accommodations. Students in the nursing program with accommodations will take examinations in the Testing Center under the direction of Ms. Buchanan.
HENDERSON COMMUNITY COLLEGE  
KCTCS  
Associate Degree Nursing Program 
Guidelines for Re-Admission to the Associate Degree Nursing Program

1. A student who withdraws from or earns lower than a grade of C in a nursing course, the biological science courses, the mathematics course or has a cumulative grade point average below 2.0 will be dropped from the Associate Degree Nursing Program.

2. Applicants who wish to apply for re-admission should do so prior to March 1 or July 1 if planning to enroll for the subsequent semester in Nursing I. Otherwise applicants should apply at least two months prior to expected date of enrollment. It is recommended that a student wait one semester before taking a nursing course for the second time.

3. Re-admission to the Nursing Program will be dependent upon available resources.

4. In order to be considered for re-admission by the Nursing Admissions Committee the applicant must:
   a) Submit a written request using the Readmission Form to the Nursing Director/Admissions Committee.
   b) Request in writing evaluation and recommendation for re-admission from two nursing faculty members. Letters must be from course faculty to be repeated. (See Appendix)
   c) Meet current guidelines for admission.

5. If more than three years have elapsed since initial enrollment in any RN Program, the applicant must successfully complete available special examinations in the Community College System, or repeat the entire program.

6. A student may be re-admitted to the Associate Degree Nursing Program one time. The Nursing Admissions Committee may recommend re-admission a second time,
if a student furnishes sufficient evidence of remedial study, additional preparation, or resolution of factors contributing to unsuccessful course completion.

7. Students seeking readmission to NSG 210, 220 or 230 (and relative practicing corresponding courses) will be required to establish retained competency and the student will be required to take the previous Medical-Surgical course’s Comprehensive Final Exam and earn at least a 78%.

8. Students may be required to readmit into the program beginning with the first nursing course (NSG 101). In this situation the student is considered a new student and must take all nursing courses in succession, regardless of past success.

9. When a student readmits into courses (with the exception of NSG 225 or NSG 213), but is not required to restart in NSG 101, they will only be required to retake the course(s) in which they were unsuccessful. If a student is not successful in NSG 225 and / or NSG 213, the student must also retake NSG 230, regardless of past success in the course.

(Revised KCTCS Modular Curriculum 2009)

**NSG 101 Nursing Practice I 9 Credits**

**Description:**
Covers nursing practice using functional health patterns within the context of the contemporary health care delivery system. Emphasizes foundation knowledge of nursing practice, skills acquisition, and the care of patients with health perception-health management, value-belief, and rest-sleep dysfunctional health patterns.

**Components:** Lecture: 5 credit hours (75 contact hours). Laboratory: 4 credit hours (180 contact hours).

**Pre-requisite:** Admission to the Associate Degree Nursing program. (BIO 137 and MAT 110 or (MAT 150 or higher) with a grade of “C” or better), PSY 110 and Computer Literacy.

**Pre- or Co-requisite:** BIO 139 with a grade of “C” or better and PSY 223.

**Implementation:** Fall 2012

**Competencies:**
Upon completion of this course the student can:
1. Use Gordon’s functional health patterns as a basis for assessment with emphasis on the adult and gerontologic patient;
2. Perform identified foundational nursing skills according to critical criteria;
3. Identify and apply at a beginning level, the nursing process to clinical judgment and the management of care for one patient experiencing dysfunctional health patterns;
4. Utilize basic communication techniques with patients and members of the health care team;
5. Recognize caring behaviors in self and others;
6. Demonstrate a beginning knowledge of professional behaviors as identified by the standards of nursing practice;
7. Identify and respond to situations that require basic knowledge of teaching and learning strategies; and
8. Recognize and report situations that require collaboration with the patient and other members of the health care team.

Outline:
I. Context of Nursing Practice
   A. The Nursing Profession as a Context for Practice
   B. Health Care Delivery System as a Context for Practice
II. Framework for Nursing Practice
   A. Developing a Framework for Practice
   B. Critical Thinking and Clinical Judgment
   C. Physical Assessment Techniques
   D. Nursing Process
   E. 
III. The Tools of Practice
   A. Communication
   B. Patient Teaching and Learning
   C. Caring Interventions
   D. Managing Care of a Patient
IV. The Adult Patient
A. The Well Adult
B. The Well Older Adult

V. Nursing Care for Functional Health
   A. Health Perception-Health Management Pattern
   B. Nutritional-Metabolic Pattern
   C. Elimination Pattern
   D. Activity/Exercise Pattern
   E. Sleep & Rest Pattern
   F. Cognitive/Perceptual Pattern
   G. Self-Perception-Self Concept Pattern
   H. Role/Relationship Pattern
   I. Sexuality/Reproduction Pattern
   J. Coping/Stress Pattern
   K. Value/Belief Pattern

VI. Managing Care for Patient with Risk for/Actual Health Pattern Dysfunctions
   A. Nursing Management of Value/Belief Dysfunction
   B. Nursing Management of Rest/Sleep Dysfunction
   C. Nursing Management of Health/Perception-Health Management Dysfunction

Experiments/Activities:
* Safety Practices (overriding)
* Standard Precautions (overriding)
  * Physical Assessment -
  * Administration of Medications
    oral
topical (eye, ear, cutaneous, inhalation, rectal, vaginal)
subcutaneous
intramuscular injection intradermal injection
*Teaching – Learning
  Breast Self-Examination
  Testicular Self-Examination
  Peri-operative Concepts
*Surgical Asepsis
  Dressing
  Catheterization
Heat/Cold
Protective Barriers
*IV. Maintenance
1. Assessment
2. Termination
  Oxygen Administration
  Glucose Monitoring
  Enemas
  Neurological Assessment
  Glasgow Coma Scale
*Management of Care of One Patient
*Requires individual faculty check off

Dates of Actions:
Approved: April 1965
NSG 210  Medical Surgical Nursing I   6 Credits

Description:
Focuses on the application of the core components of nursing to adult patients experiencing dysfunctional health patterns. Emphasizes the care of patients with nutritional-metabolic and elimination dysfunctional health patterns.

Components: Lecture: 3 credit hours (45 contact hours). Lab/Clinical: 3 credits (135 contact hours).

Pre-requisite: (NSG 101 and BIO 139) with a grade of “C” or better and PSY 223.

Pre- or Co-requisite: (NSG 212 and NSG 215) with a grade of “C” or better, ENG 101 and Oral Communications.

Implementation: Fall 2012

Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment with emphasis on adult patients with nutritional-metabolic and elimination dysfunctional health patterns.
2. Provide safe nursing care while maintaining previously learned skills and acquiring additional essential skills that adhere to critical criteria.
3. Apply the nursing process to clinical judgment and the management of care for a minimum of two patients with multiple dysfunctional health patterns.
4. Communicate effectively with patients, families, significant others and members of the health care team.
5. Translate caring behaviors into nursing practice.
6. Demonstrate professional behaviors according to the standards of nursing practice in the delivery of patient care.
7. Implement understanding of the teaching-learning processes.
8. Demonstrate collaboration with the patient, family, significant others and members of the health care team.

Outline:
I. Managing Care for Patients with Risk for/Actual Dysfunctions Related to Nutritional-Metabolic Health Patterns.
A. Nursing management of nutritional dysfunctions  
B. Nursing management of upper and lower gastrointestinal dysfunctions  
C. Nursing management of liver, biliary tract, and pancreatic dysfunctions  
D. Nursing management of endocrine dysfunctions

II. Managing Care for Patients with risk for/Actual Dysfunctions Related to the Elimination Patterns  
A. Nursing management of urinary dysfunction  
B. Nursing management of bowel dysfunction  
C. Nursing management of integumentary dysfunctions

Experiments/Activities:  
*Safety Practices (overriding)  
*Standard Precautions (overriding)  
*Intravenous Therapy (fluids and medications)  
  Venipuncture  
    a. initiation  
    b. IV medications  
    c. infusion devices  
*Suctioning  
  1. Nasogastric  
*Nasogastric Intubation  
  1. Gavage  
  2. Lavage  
*Teaching Learning  
  1. Ostomy Care  
  2. Chronic Disease Self Care  
*Management of Care for two clients

*Requires individual faculty check

Dates of Actions:  
Approved: May 2008  
Revised: October 2011
NSG 212 Behavioral Health Nursing 3 Credits

Focuses on the application of the nursing care to patients experiencing a dysfunctional health pattern. Emphasizes the care of patients with Coping-Stress-Tolerance and Altered Role Relationship health patterns.

Components: Lecture: 2 credit hours (30 contact hours). Laboratory: 1 credit hour (45 contact hours).

Pre-requisite: (NSG 101 and BIO 139) with a grade of “C” or higher and PSY 223.

Pre- or Co-requisite: (NSG 210 and NSG 215) with a grade of “C” or higher, ENG 101 and Oral Communications
Implementation: Fall 2012

Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment with emphasis on adult patients with dysfunctional behavioral health patterns.
2. Provide safe nursing care while demonstrating competency with previously learned skills and acquiring additional essential skills that adhere to critical criteria.
3. Apply the nursing process to clinical judgment and the management of care of patients with dysfunctional behavioral health patterns.
4. Utilize therapeutic communication techniques with patients, families, significant others and members of the health care team.
5. Translate caring by exhibiting spontaneous caring behaviors in nursing practice.
6. Incorporate professional behaviors according to the standards of nursing practice in the delivery of patient care and self-improvement.
8. Participate in a collaborative team approach to provide holistic patient-centered care.

Outline:
I. Introduction to Behavioral Health Nursing
   A. Legal/ethical issues
   B. Theorists
   C. Therapeutic communication
II. Managing Care for Clients with Risk for/Actual Dysfunctions Related to Coping-Stress-
Tolerance Pattern
A. Nursing management of stress
B. Nursing management of anxiety dysfunctions
C. Nursing management of somatoform/dissociative/non-dissociative dysfunction

III. Managing Care for Clients with Altered Role-Relationship Functional Patterns
A. Nursing management of altered role-relationship dysfunctions
B. Nursing management of adult clients experiencing personal/family violence
C. Nursing management of personality disorders
D. Nursing management of affective disorders
E. Nursing management of cognitive impairment
F. Nursing management of schizophrenic dysfunction
G. Nursing management of clients experiencing self-destructive behaviors
H. Nursing management of sexual dysfunction

Experiment/Activities:
*Safety Practices (overriding)
*Standard Precautions (overriding)
*Therapeutic Communication

*Requires individual faculty check off

Dates of Actions:
Approved: May 2008
Revised: October 2011
NSG 215  Pharmacology I  1 Credit

Focuses on common drugs, their classification and effects on functional and dysfunctional health patterns (value/belief, rest/sleep, health perception/health management, nutritional/metabolic and elimination health patterns). Emphasizes nursing responsibility, accountability, and application of the nursing process regarding drug therapy.

Components: Lecture: 1 credit hour (15 contact hours).

Pre-requisite: (NSG 101 and BIO 139) with a grade of “C” or higher and PSY 223.

Pre- or Co-requisite: (NSG 210 and NSG 212) with a grade of “C” or higher, ENG 101 and Oral Communication.

Implementation: Fall 2012

Course Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Identify the indications, modes of action, and effects of drugs in response to functional and dysfunctional health patterns of value/belief, rest/sleep, health perception/health management, nutritional/metabolic and elimination health patterns.
2. Apply the nursing process as related to drug therapy.
3. Identify drug classifications and common representative drugs with related nursing implications.
4. Describe legal/ethical parameters of drug therapy as related to nursing practices.
5. Identify the influence of cultural and psychosocial factors on client compliance with drug therapy.

Outline:
I. Principles of Pharmacology
   A. Pharmaceutics
   B. Pharmacokinetics
   C. Pharmacodynamics
II. Nurse’s Role in Drug Therapy
A. Nursing process
B. Legal/ethical responsibilities
C. Cultural, psychosocial and life span factors

III. Relationship of Pharmacological Agents to Functional and Dysfunctional Health Patterns Across the Life Span
   A. Drugs affecting the value/belief health pattern
   B. Drugs affecting the rest/sleep health pattern
   C. Drugs affecting the health perception/health management health pattern
   D. Drugs affecting the nutritional/metabolic health pattern
   E. Drugs affecting the elimination health pattern

NSG 197 Transition to ADN 3 Credits

Builds upon the basic nursing skills and concepts learned in the LVN/LPN experience. Assists the Practical Nurse to make the beginning transition to the RN role. Includes the role of the Associate Degree Nurse and application of the course components of nursing practice to patients experiencing the dysfunctional health patterns of nutritional-metabolic and elimination. Upon successful completion of all components of the course, the student will be admitted to NSG 220 and will have earned by advanced standing, 15 credit hours in nursing.

Components: Lecture: 2.5 credit hours (37.5 contact hours). Lab/Clinical: 0.5 credit hours (22.5 contact hours).

Pre-requisite: Admission to the Associate Degree Nursing Program and (BIO 137 and BIO 139 and (MAT 110 or MAT 150 or higher) with a grade of “C” or better), PSY 110, PSY 223, ENG 101, Oral Communications and Digital Literacy.

Pre- or Co-requisite: NSG 215 and NSG 212 with a grade of “C” or better.

Implementation: Fall 2013

Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment with emphasis on adult patients with nutritional-metabolic and elimination dysfunctional health patterns.
2. Provide safe nursing care while maintaining previously learned skills and acquiring additional essential skills that adhere to critical criteria.
3. Apply the nursing process to clinical judgment and the management of care for a minimum of two patients with multiple dysfunctional health patterns.
4. Communicate effectively with patients, families, significant others and members of the health care team.
5. Translate caring behaviors into nursing practice.
6. Demonstrate professional behaviors according to the standards of nursing practice in the delivery of patient care.
7. Implement understanding of the teaching-learning processes.
8. Demonstrate collaboration with the patient, family, significant others and members of the health care team.
9. Exhibit behaviors that indicate transition from the practical nurse role to the registered nurse role.

Outline:
I. A Framework for Nursing Practice
   A. Role development and role transition
      1. Program philosophy, conceptual framework
      2. Core components of nursing practice
      3. Critical thinking and clinical judgment
   B. Nursing skills competency validation
II. Managing Care for Patients with Risk for/Actual Dysfunctions Related to Nutritional-Metabolic Health Patterns
    A. Nursing management of nutritional dysfunctions
       A. Nursing management of upper gastrointestinal dysfunctions
       B. Nursing management of liver, biliary tract, and pancreatic dysfunctions
       C. Nursing management of endocrine dysfunctions
    B. Nursing management of urinary dysfunction
    C. Nursing management of bowel dysfunctions
    D. Nursing management of integumentary dysfunctions

Experiments/Activities:
Standard Precautions (overriding)
* Physical Assessment
  Administration of Medication
1. Topical
2. Subcutaneous
3. Intra-muscular Injection
4. Intra-dermal Injection
5. Oral
*Teaching – Learning
1. Breast Self-Examination
2. Testicular Self-Examination
3. Perioperative Concepts
4. Chronic Disease Self-care
5. Ostomy Care
*Surgical Asepsis
1. Dressing
2. Catheterization
Heat/Cold
Protective Isolation

*Intravenous Therapy
1. Venipuncture
   a. Assessment
   b. Termination
   c. Initiation
2. IV Medications administration
   a. Infusion Devices
   b. Central Line Dressing
*Nasogastric Intubation
1. Gavage
2. Lavage (suctioning)

Oxygen Administration

Glucose Monitoring

Enemas

*Management of care for two clients

*Requires individual faculty check off

**Dates of Actions:**

**Approved:** May 2008

**Revised:** March 2009, October 2011, December 2012
NSG 220  Medical Surgical Nursing II    6 Credits

Description:
Focuses on the application of the core components of nursing to adult patients experiencing dysfunctional health patterns. Emphasizes the care of patients with activity-exercise dysfunctional health patterns (cardiac, respiratory and musculoskeletal).

Components: Lecture: 3 credit hours (45 contact hours). Lab/Clinical: 3 credit hours (135 contact hours).

Pre-requisite: (NSG 210, NSG 215 and NSG 212) with a grade of “C” or higher and ENG 101 and Oral Communications.

Pre – or Co-requisite: (NSG 211 and BIO 225) with a grade of “C” or higher and ENG 102.

Implementation: Fall 2012

Course Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment with emphasis on adult patients with activity-exercise dysfunctional health patterns.
2. Illustrate safe nursing care while maintaining previously learned skills and acquiring additional essential skills that adhere to critical criteria.
3. Apply the nursing process to clinical judgment and the management of care for a minimum of three patients with activity-exercise dysfunctional health patterns.
4. Demonstrate effective communication with patients, families, significant others and members of the health care team.
5. Integrate caring behaviors into nursing practice.
6. Employ professional behaviors according to the standards of nursing practice in the delivery of patient care.
7. Model understanding of the teaching-learning processes.
8. Participate in collaboration with the patient, family, significant others and members of the health care team.
Outline:

I. Managing Care for Patients with Risk for/Actual Dysfunctional Related to Activity-Exercise Health Patterns – Cardiovascular
   A. Nursing management of hematological dysfunctions
   B. Nursing management of blood pressure dysfunctions
   C. Nursing management of coronary artery dysfunctions
   D. Nursing management of cardiac dysfunctions
   E. Nursing management of vascular dysfunctions

II. Managing Care for Patients with Risk for/Actual Dysfunctional Related to Activity-Exercise Health Patterns - Respiratory
   A. Nursing management of upper respiratory dysfunctions
   B. Nursing management of lower respiratory dysfunctions
   C. Nursing management of obstructive pulmonary dysfunctions
   D. Nursing management of total respiratory dysfunction

III. Managing Care for Patients with Risk for/Actual Dysfunctional Related to Activity-Exercise Health Patterns - Musculoskeletal
   A. Nursing management of musculoskeletal dysfunctions
   B. Nursing management of arthritis and connective tissue dysfunctions

Experiments/Activities:
1. *Body Substance Isolation (overriding)
2. *Standard precautions (overriding)
3. *Tracheostomy Care
4. *EKG Strips
5. *Suctioning
   a. Oropharyngeal
   b. Nasotracheal
   c. Tracheobronchial
6. *Central Lines / Implanted Port
   a. Accessing Central Line / Implanted Port
b. De-accessing Central Line / Implanted Port
c. Obtaining Blood Sample
d. Medications
e. Central Line Dressing
7. *Blood and Blood Products Administration
8. *Management of Care for three clients
9. Teaching – Learning
   a. Maintenance of Traction
   b. Cast Care
   c. Crutch Walking
d. Walkers
*Requires individual faculty check off

Dates of Actions:
Approved: May 2008 Revised: October 2011

NSG 211  Maternal Newborn Nursing  3 Credits

Description:
Focuses on the application of the core components of nursing to the care of childbearing families experiencing functional and dysfunctional health patterns.

Components: Lecture: 2 credit hours (30 contact hours). Lab/Clinical: 1 credit hour (45 contact hours).

Pre-requisite: (NSG 210, NSG 212 and NSG 215), with a grade of “C” or higher, ENG 101 and Oral Communications.

Pre- or Co-requisite: NSG 220 with a grade of “C” or higher, ENG 102, and BIO 225.

Implementation: Fall 2012

Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment of childbearing families.
2. Illustrate safe nursing care while demonstrating competency with previously learned skills and acquiring additional essential skills that are unique to childbearing families and that adhere to critical criteria.
3. Apply the nursing process to clinical judgment and the management of care for childbearing families.
4. Demonstrate effective therapeutic communication techniques to the care of childbearing families.
5. Exhibit caring behaviors in the care of childbearing families.
6. Employ professional behaviors according to the standards of nursing practice in the care of childbearing families.
7. Model the teaching-learning process in the care of childbearing families.
8. Participate in a collaborative team approach to provide holistic patient-centered care with an emphasis on childbearing families.

Outline:
I. Managing Care for Patients for Functional Health related to the Sexuality and Reproduction Pattern
   A. Introduction to family nursing
   B. Maternal/newborn care
II. Managing Care for Patients with Risk for/Actual Dysfunctional Sexuality and Reproduction Patterns
   A. Nursing management of reproductive dysfunctions
   B. Nursing management of pregestational dysfunctions
   C. Nursing management of childbearing dysfunctions
   D. Nursing management of newborn health dysfunctions

Experiments/Activities:
*Safety Practices (overriding)
*Standard Precautions (overriding)
*Timing Contractions (including electronic fetal monitoring)
*Fetal Heart Rate (including fetal monitoring)
*Immediate Care of the Newborn
*Postpartum Assessment

*Teaching – Learning
1. Breastfeeding/Bottlefeeding
2. Bathing newborn
3. Breathing/Relaxation
4. Infant Safety

*Requires individual faculty check-off.

**Dates of Actions:**
**Approved:** May 2008  
**Revised:** October 2011
Focuses on common drugs, their classification and effects on functional and dysfunctional health patterns (activity-exercise, coping/stress/tolerance, role/relationship, altered self-perception/self-concept, and cognitive perceptual). Emphasizes nursing responsibility, accountability and application of the nursing process regarding drug therapy. (Unsuccessful completion of NSG 225 will require mandatory withdrawal from NSG 230; 201 KAR 20:320).

**Components:** Lecture: 1 credit hour (15 contact hours).

**Pre-requisite:** (NSG 220 and NSG 211 and BIO 225) with a grade of “C” or higher and ENG 102.

**Co-requisite:** NSG 230 or Consent of Instructor.

**Pre- or Co-requisites:** Heritage/Humanities/Foreign Language and NSG 213.

**Implementation:** Fall 2012

**Course Competencies/Student Outcomes:**
Upon completion of this course, the student can:

2. Formulate a plan utilizing the nursing process as related to drug therapy.
3. Categorize drug classifications and common representative drugs with related nursing implications.
4. Evaluate legal/ethical parameters of drug therapy as related to nursing practices.
5. Examine the influence of cultural and psychosocial factors on patient compliance with drug therapy.

**Outline:**

I. Nurse’s Role in Drug Therapy
   A. Nursing process
   B. Legal/ethical responsibilities
   C. Cultural, psychosocial and life span factors

II. Relationship of Pharmacological Agents to Functional and Dysfunctional Health Patterns Across the Life Span
   A. Drugs affecting the activity/exercise health pattern
   B. Drugs affecting the coping/stress/tolerance health pattern
   C. Drugs affecting the role/relationship health pattern
   D. Drugs affecting the self-perception/self-concept health pattern
   E. Drugs affecting the cognitive/perceptual health pattern
**Dates of Actions:**
Approved: May 2008  Revised:  October 2011

**NSG 230  Medical Surgical Nursing III  6 Credits**

**Description:**
Focuses on the application of the core components of nursing to adult patients experiencing dysfunctional health patterns. Emphasizes the care of patients with cognitive/perceptual, altered self-perception/self-concept, management of patients with dysfunctional health patterns: neurological, eyes/ears, immune/cancer, multiple systems organ failure, and disaster planning. Role transition is addressed and emphasizes leadership, management of care, skill development and professionalism. NSG 230 is the capstone course and must be successfully completed in the final semester of the associate degree nursing program enrollment. (201 KAR 20: 320).

**Components:** Lecture: 3 credit hours (45 contact hours). Lab/Clinical: 3 credit hours (135 contact hours).

**Pre-requisite:** (NSG 220 and NSG 211 and BIO 225) with a grade of “C” or higher and ENG 102.

**Pre- or Co-requisite:** NSG 213, NSG 225, Heritage/Humanities/Foreign Language.

**Implementation:**  Fall 2012

**Course Competencies/Student Outcomes:**
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment in the management of care for a group of patients.
2. Demonstrate competency in all essential skills and adhere to critical criteria.
3. Apply the nursing process to clinical judgment and the management of care for a group of patients.
4. Employ and adapt therapeutic communication techniques with a group of patients, significant others and members of the health care team.
5. Synthesize caring behaviors into the management of care for a group of patients.
6. Incorporate professional behaviors into nursing practice when making decisions and taking actions that are consistent with the standards of nursing practice, self-development and a commitment to professional nursing.
7. Evaluate and modify teaching - learning processes to assure achievement of positive patient outcomes.
8. Facilitate a collaborative team approach to provide holistic patient-centered care while managing a group of patients.

**Outline:**
I. Tools for Managing Care for Multiple Patients with Dysfunctional Health Patterns
   A. Clinical judgment
B.  Nursing process

II.  Managing Care for Patients with Risk for/Actual Dysfunctions Related to Altered Self-Perception-Self-Concept Patterns
   A.  Nursing management of altered immune response
   B.  Nursing management of the client with cancer
   C.  Nursing management of clients with multiple organ systems dysfunction

III. Managing Care for Patients with Risk for/Actual Dysfunction of Cognitive-Perceptual Patterns
    A.  Nursing management of visual dysfunction
    B.  Nursing management of auditory dysfunction
    C.  Nursing management of acute neurologic dysfunction
    D.  Nursing management of chronic neurologic dysfunction
    E.  Nursing management of peripheral nerve and spinal cord dysfunction

IV.  Human Flourishing
    A.  Client advocacy
    B.  Nursing process
    C.  Teaching/learning
    D.  Cultural competency

V.    Nursing Judgment
    A.  Clinical reasoning
    B.  Health care delivery and economics
    C.  Communication
    D.  Essentials of managing care

VI.  Professional Identity
    A.  The Kentucky Nursing Laws
    B.  Professional behaviors (legal/ethical)
    C.  Changing roles: student to graduate
    D.  Informatics

VII. Spirit of Inquiry
     A.  Nursing research
     B.  Continuous learning

VIII. Trauma/Emergency/Disaster Planning
     A.  Community
     B.  Facility-based

Experiments/Activities:
*Neurological Evaluation
*Management of care for a group of clients
*Requires individual faculty check off

Dates of Actions:
Approved: May 2008
Revised: October 2011

NSG 213  Pediatric Nursing  3 Credits

Description:
Focuses on the application of the core components of nursing to the care of the child and family experiencing functional and dysfunctional health patterns.  (Unsuccessful completion of NSG 213 will require mandatory withdrawal from NSG 230; 201 KAR 20:320)

Components: Lecture: 2 credit hours (30 contact hours).  Lab/Clinical: 1 credit hour (45 contact hours).

Pre-requisite: (NSG 220 and NSG 211 and BIO 225) with a grade of “C” or better, ENG 102.

Co-requisite: NSG 230 or Consent of Instructor.

Pre- or Co-requisite: NSG 225 with a grade of “C” or better, and Heritage/Humanities.

Implementation: Fall 2013

Course Competencies/Student Outcomes:
Upon completion of this course, the student can:
1. Use Gordon’s functional health patterns as a basis for assessment of the child and family.
2. Demonstrate safe and competent nursing care using previously learned skills and acquiring additional essential skills that are unique to the child and family and that adhere to critical criteria.
3. Formulate a plan, utilizing the nursing process, to apply clinical judgment and the management of care for the child and family.
4. Employ and adapt therapeutic communication techniques to the care of the child and family.
5. Synthesize caring behaviors into the care of the child and family.
6. Incorporate professional behaviors, according to the standards of nursing practice, into the care of the child and family.
7. Evaluate and adapt the teaching- learning process in the care of the child and family.
8. Facilitate a collaborative team approach to provide holistic patient-centered care with an emphasis on the child and family.

Outline:
I. Managing Family-Centered Care for Children for Functional Health Perception – Health Management Patterns
   A. Philosophy of pediatric care
   B. Role of the pediatric nurse
   C. Growth and development
   D. Communication and health assessment of the child and family
II. Managing Family-Centered Care for Children with Risk for/Actual Dysfunctional Health Patterns
   A. Nutritional-metabolic pattern
   B. Elimination pattern
   C. Activity-exercise pattern
   D. Sleep & rest pattern
   E. Cognitive/perceptual pattern
   F. Self-perception-self-concept pattern
   G. Role-relationship pattern
   H. Sexuality-reproduction pattern
   I. Coping-stress-tolerance pattern
   J. Value/belief pattern

Experiments/Activities:
*Safety Practices (overriding)
*Body Substance Isolation (overriding)
*Administration of Pediatric Medications
1. Oral  
2. Topical (Eye, Ear, Inhalation, Cutaneous, Rectal, Vaginal)  
3. Subcutaneous  
4. Intramuscular Injection  
5. Intradermal Injection  
6. Intravenous Medication  
7. Infusion Devices  
*Physical Assessment  
*Diversional Activities (Pediatric)  

*Requires individual faculty check off  

Dates of Actions:  
Approved: May 2008  
Revised: October 2011, December 2012
NURSING ASSISTANT

In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

General Principles

1. Body substance isolation precautions must be utilized and appropriate asepsis must be maintained.
2. Correct supplies/equipment must be assembled and organized.
3. Client instruction must be provided.
4. The client must not be placed in physical jeopardy.
5. The client must not be placed in emotional jeopardy.
6. Pertinent information must be reported and/or documented.

Safety Practices

2. Washes hands before and after performing any client care or gathering supplies.
3. Verifies facility policy for procedure and assembles appropriate equipment or supplies.
4. Identifies client and notes overall condition.
5. Explains procedure to client.
6. Elevates bed to appropriate working level.
8. Lowers bed, applies side rails according to plan of care and places call system within reach.
9. Retakes any abnormal reading and if still abnormal, reports and records immediately.

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature and other appropriate data. Any action or inaction on the part of the student, which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

Standard Precautions (Body Substance Isolation)

Handwashing

1. Removes all jewelry with the exception of a plain band.
2. Uses soap and running water to cleanse wrists and hands.
3. Keeps hands level with or lower than elbow.
4. Washes all areas of wrists, hands, fingers and nails using interlacing and circular motions.
5. Cleans fingernails.
6. Washes hands for a minimum of 15 seconds.
7. Dries hands from fingers to wrist and discards paper towels.
8. Uses dry paper towel to turn off manually controlled faucet and discard.

Vital signs - Temperature

Electronic Thermometer
1. Selects appropriate thermometer.
2. Inserts probe into a plastic disposable cover.
   Orally
   a. Waits 20 minutes since documented time client last ingested hot or cold food or fluid, or smoked.
   b. Places covered probe in posterior sublingual pocket.

Axillary
   a. Pats axilla dry.
   b. Places covered probe in axilla.
   c. Positions arm.

Rectally
   a. Positions client.
   b. Inserts lubricated covered probe into rectum 0.5 inch for infants, 1.0 inch for children,
      1.5 inches for adult (unless manufacturer specifies otherwise).

Tympanic
   a. Places probe in external ear canal at angle toward tympanic membrane.
   b. Depresses scan button.

3. Leaves in place until signal indicates a final reading.
4. Discards probe cover in designated receptacle.
5. Documents.
6. Returns thermometer to appropriate place.
Vital signs - Pulse

1. Places client at rest.
   Peripheral
   a. Locates radial artery.
   b. Uses fingers to palpate pulsation.
   Apical
   a. Places stethoscope over apex of heart.
2. Counts regular pulse for 30 seconds and multiplies by two, counts irregular pulse for 60 seconds within 4 beats of accuracy.
3. Documents rate and rhythm.

Vital Signs - Respiration

1. Places client at rest.
2. Counts regular respirations for 30 seconds and multiplies by two, counts irregular respirations for 60 seconds within 2 breaths of accuracy.
3. Documents rate and regularity.

Vital Signs – Blood Pressure

1. Places client at rest.
2. Selects appropriate cuff size.
3. Positions equipment and self properly (i.e. to read at eye level).
4. Maintains pulse site at heart level.
5. Applies cuff smoothly and securely.
7. Raises the gauge reading of the manometer 20-30 mm Hg above the anticipated systolic pressure
8. Decreases cuff pressure gradually and smoothly, noting on the manometer the point at which the first sound is heard.
9. Notes on the manometer when the last distinct sound is heard.
10. If recheck is necessary, waits 30-60 seconds.
11. Reads and documents systolic and diastolic readings within 4 mm Hg of accuracy.
12. Repositions and retakes according to client needs.
Weight/Height

Weight
1. Chooses appropriate scale.
   a. Platform scale with balance beam
   b. Electronic scale
   c. Bed scale
   d. Small platform scale
      1) Covers scale (protective barrier when appropriate).
      2) Balances scale.
      3) Positions individual in center of scale.
      4) Protects individual.
         a) Adult/Child - assures stable posture.
         b) Infant - holds hand immediately over, but not touching.
2. Documents weight within one (1) pound of accuracy.
3. Disinfects scale after use when appropriate.

Height
1. Standing
   a. Has client remove shoes and stand straight.
   b. Has client face away from scale.
   c. Places measuring device on crown of head.
   d. Documents height within one (1) inch of accuracy.

2. Lying Down
   a. Places client in dorsal recumbent position with crown of head touching head of bed or flat surface.
   b. Extends legs parallel to bed.
   c. Measures distance from crown to heel.
   d. Documents height within one (1) inch of accuracy

Bedmaking
1. Carries linen away from uniform.
2. Keeps linen off floor. 3. Does not shake linen.
4. Confines dirty linen in suitable container.

Unoccupied
Places and secures bottom sheet on mattress, tucking to prevent wrinkles; if using a flat sheet, tucks under head of mattress and miters corners.

Occupied
a. Utilizes side rails to position client.
b. Assists client into lateral position.
c. Rolls dirty linen with contaminated side in underneath client.
d. Places clean, wrinkle free linen on bed and tucks underneath client.
e. Rolls client onto clean linen.

5. Makes certain any protective or turning linens are free of wrinkles.
6. Places top linen on bed, tucks under foot of mattress and miters corners.
7. Inserts pillow in case and places on bed.

Hygienic Care

Bath
1. Removes top bed linen and gown while keeping client covered.
2. Bathes in appropriate sequence.
3. Protects client from chilling.
5. Changes water as necessary.
6. Assists with or provides care of nails and hair.

Perineal
1. Female
   a. Cleanses perineal area with soap and water. Rinses and dries.
   b. Separates labia, cleanses.
c. Cleanses from anterior to posterior, and rinses cloth between each stroke, rinses and dries.
d. Turns client on side and cleanses rectal area with soap and water. Rinses and dries.

2. Male
   a. Cleanses penis (gently retracts foreskin of uncircumcised male, replaces after cleansing), scrotum and perineum with soap and water. Rinses and dries.
   b. Turns client on side and cleanses rectal area with soap and water. Rinses and dries.

Oral
1. Provides for cleansing of teeth/dentures, gums, and mucous membranes.
2. Uses appropriate method (brushing, swabbing, flossing).

Back Massage
1. Places client in appropriate position, prone if possible.
2. Exposes back.
3. Lubricates hands.
4. Stimulates circulation, using long, slow, rhythmic strokes, beginning at sacrum.
5. Removes excessive lubricant.

Application of Soft Restraints
1. Verifies order for restraints.
2. Consults facility policies.
5. Applies restraints and pads as needed.
7. Assesses for impaired circulation/respiration every 30 minutes to an hour.
8. Releases restraint(s) every 2-4 hours.
9. Documents reasons for restraint, type, location and client response.

Measuring Intake and Output
1. Assembles appropriate measuring container(s).
2. Measures amount of fluid intake in appropriate unit of measurement.
3. Measures amount of fluid output in appropriate unit of measurement.
4. Documents data.

**Assisting/Feeding Clients**

1. Prepar[es client and environment.
2. Verifies food on tray with prescribed diet.
3. Assists client as necessary.
4. Documents intake.

**Mobility**

**Positioning Client**

1. Demonstrates principles of body mechanics.
2. Handles extremities at joints, using palm of hand rather than fingers.
3. Places individual in functional anatomical body alignment (Fowler's, Lateral, Sims and Prone positions).
4. Uses supportive devices as necessary.

**Range of Motion**

1. Supports dependent joints.
2. Moves body parts smoothly, slowly and rhythmically.
3. Stops at point of pain, resistance or fatigue.
4. Identifies and demonstrates exercises appropriate for specific body joints (flexion, extension, hyperextension, abduction, adduction, circumduction, opposition, internal and external rotation).

**Assisting Client In and Out of Bed**

1. Stabilizes bed in lowest position and obtains foot stool, if necessary.
2. Elevates head of bed.
3. Assists client to sit on side of bed.
4. Checks pulse, respiration, and appearance of client.
5. Assists client with robe and slippers/shoes.
6. Assists client to standing position.
7. Provides support.
8. Assists client to sitting position on side of bed, and removes robe and slippers / shoes.
9. Assists client to reclining position.

Approved 2001; Revised 2008; Revised Fall 2011; Revised Fall 2013

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM
ASSOCIATE DEGREE NURSING – MODULAR TRACK

ESSENTIAL SKILLS - CRITICAL CRITERIA
NURSING 101 – NURSING PRACTICE I

In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

*General Principles
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

*Safety Practices
1. Verifies care/order for client
2. Performs hand hygiene before and after performing any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature, and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

*Standard Precautions*
1. Standard Precautions: Tier One: to be used with all clients
   a) Verifies rationale for standard precaution: Tier 1
   b) Identifies, dons, & doffs the appropriate PPE
   c) Performs hand hygiene prior to don and doff PPE
   d) Documents and reports pertinent observations and findings

2. Standard Precautions: Tier Two Transmission Based Precautions: Precautions used with specific types of clients (airborne, droplet, contact)
   a) Verifies rationale for standard precaution: Tier 2
   b) Identifies, dons, & doffs the appropriate PPE for each type of Tier 2 precaution
   c) Performs hand hygiene prior to don and doff PPE
   d) Documents and reports pertinent observations and findings

*Physical Assessment*

Health History
1. Demographics – Name, address, sex, age, birth date, marital status or significant other, religion, race, education, occupation, hobbies, and significant life events
2. Health History - Smoking, heart disease, alcohol use, drug use or abuse, surgeries, injuries, childhood diseases, immunizations, hypertension, diabetes, arthritis, seizures, cancer, emotional problems, transfusions, drug/food allergies, perception of health/illness, lifestyle, hygiene, eating habits, health practices

3. Family Medical History - Includes history of heart disease, substance abuse, diabetes, arthritis, cancer, emotional problems

4. Current Situation - Chief complaint, reason for seeking help

5. History of the Present Illness – Location and duration of the present problem, aggravating/alleviating factors, associated symptoms, effect on lifestyle, coping measures, review of body systems

6. Medications - Prescribed, occasional, over the counter, and herbals

Vital Sign Evaluation
1. Verbalizes factors affecting vital signs of the older adult
2. Verbalizes effects of ethnicity, activity/exercise, and body structure on the vital signs of an adult
3. Verbalizes situations when vital signs are to be measured
4. Identifies which elements of the vital signs that can be delegated to the UAP and when the licensed nurse needs to perform the vital signs

Temperature
1. Verbalizes normal range/s of temperature for the adult client
2. Determines route of temperature measurement based on client condition
3. Demonstrates temperature measurement using a variety of devices: electronic thermometer: axillary, rectally, tympanic, temporal artery
4. Verbalizes general physiological processes that create heat production or heat loss which result in temperature variations
5. Identifies independent nursing interventions that affect thermoregulation
6. Documents temperature measurement including additional collaborative assessment data if present (flushing, warm skin, diaphoresis, etc.)

Peripheral Pulse
1. Verbalizes normal range/s of pulses for the adult client
2. Obtains heart rate (pulse) based on assessment needs including rate, rhythm, strength and equality; temporal, carotid, apical, brachial, radial, ulnar, femoral, popliteal, posterior tibial, dorsal pedis
3. Verbalizes factors influencing pulse rate
4. Verbalizes alterations in pulse rate (for example: bradycardia, tachycardia)
5. Verbalizes that in the event of a dysrhythmia (regularly irregular or irregularly irregular), the student would reassess the pulse by performing an apical pulse
6. Reports any unanticipated irregularities immediately
7. Documents findings utilizing descriptive medical terminology (for example, bounding, thready, 0–4 scale, and equality)

Vital Signs - Respiration
1. Assesses respiration as to rate, depth, and rhythm
2. Identifies alterations in breathing patterns (bradypnea, tachypnea, hyperpnea, apnea, dyspnea, hyperventilation, hypoventilation, Cheyne-Stokes, Kussmaul’s, Biot’s)
3. Verbalizes acceptable ranges of respiratory rate
4. Verbalizes factors that may affect character of respirations
5. Documents findings utilizing descriptive medical terminology

**Vital Signs – Blood Pressure**
1. Identifies preferred method of obtaining blood pressure based on client condition (i.e. manual or electronic)
2. Selects appropriate cuff size for the area to be utilized (upper arm, forearm, thigh, etc.) and states rationale for adequate cuff measurement and placement
3. Selects site of blood pressure measurement as determined by the client’s condition and the rationale for the blood pressure measurement (i.e. B/P abnormalities, presence of casts, etc.)
4. After positioning client and placing cuff, locates pulsation of artery and places bell/diaphragm of stethoscope on the pulse
5. While inflating the cuff, raises the gauge reading of the manometer 30 mm Hg above the anticipated systolic pressure
6. Decreases cuff pressure gradually and smoothly, noting on the manometer the point at which the first sound is heard
7. Recognizes the muffling of sound if present
8. Notes on the manometer when the last distinct sound is heard
9. Verbalizes presence of Korotkoff sounds during auscultation of the blood pressure if distinct
10. If recheck is necessary, waits 30-60 seconds
11. Repositions and retakes according to client needs
12. Documents blood pressure measurement and reports any unexpected readings immediately

**Pulse Oximetry**
1. Identifies situations when pulse oximetry is indicated
2. Demonstrates or verbalizes sites to measure pulse oximetry (forehead, earlobe, bridge of the nose, digits)
3. Uses appropriate probe to obtain reading
4. Documents pulse oximetry with any collaborating assessment features, if present, such as cyanosis of the lips and mucous membrane.

**Functional Assessment (Inspection, Auscultation, & Light Palpation)**
1. Appearance - Stage of growth and development, general health, striking features, height, weight, vital signs, behavior, posture, grooming, hygiene, communication
2. Skin – Color, consistency, temperature, turgor, integrity, texture, lesions, mucous membranes
3. Hair – Color, texture, amount, distribution, presence or absence of parasites
4. Nails – Color, texture, shape, size
5. Neurologic – Pupil reaction and size, gait and balance
6. Musculoskeletal – Range of Motion, gait, tone, posture
7. Cardiovascular – Heart rate and rhythm, central and peripheral pulses, temperature, edema
8. Respiratory – Rate, rhythm, depth, effort quality, expansion, cough, breath sounds, sputum, nasal patency
9. Gastrointestinal – Abdominal contour, bowel sounds, nausea, vomiting, ostomy type and care, fecal frequency, consistency, presence of blood
10. Genitourinary – Urine color, character, amount, odor, consistency, ostomy, external genitalia, appearance and patency of the anus
11. Reproductive – Last menstrual period, menopause, breast exam, pap & pelvic, prostate exam, testicular exam

*Administration of Medications*
1. Verifies healthcare provider’s written order for medications
2. Prepares medication based on six rights: right drug, right dose, right time, right route, right client (uses two identifiers), right documentation.
3. Provides adjunctive assessment and interventions as indicated; including but not limited to verifying allergies, clinical indications, etc.
4. Administers medication according to six rights, including electronic bedside verification where available
5. Documents time, medication, dose, and route
6. Evaluates drug response and effectiveness

**Oral**
1. Does not alter extended released or enteric coated medications
2. Remains with client until medication is taken
3. Examines for pocketing prior to leaving the client

**Topical**
1. Prepares area for medication
2. Applies with applicator or with gloved finger as indicated
3. Covers with dressing as indicated
4. Maintains anatomical position to allow absorption or distribution

**Injections**
1. Uses sterile technique
2. Positions or restrains as indicated
3. Using anatomical landmarks, locates and names acceptable sites for injection
4. Selects and cleanses site for injection
5. Maintains skin contact with selected site with non-dominant hand
6. Inserts needle with bevel up if indicated, at the correct angle: 90 degree angle for intramuscular, 45 to 90 degree angle as indicated for subcutaneous, 15 degree angle for intradermal
7. Stabilizes syringe
8. Injects medication slowly and at an even rate of speed
9. Uses Z-Track method, if indicated, for IM injections
10. Withdraws needle quickly
11. Applies pressure or bandage to site unless contraindicated

**Intramuscular Sites**
1. Ventrogluteal
2. Vastus lateralis
3. Deltoid

**Subcutaneous Sites**
1. Outer aspect of upper arm
2. Anterior thigh
3. Abdomen two inches at or below the umbilicus

Note: Unless otherwise indicated by the medication’s manufacturer recommendation

**Intradermal Sites**
1. Inner forearm
2. Scapular region for allergy testing

**Teaching – Learning**
1. Assesses client's knowledge of subject and readiness to learn
2. Reviews goals of session with client
3. Assembles materials and prepares the environment
4. Implements teaching plan, using appropriate content
5. Obtains evaluative feedback from client (summarizes content taught)
6. Evaluates effectiveness of session and documents

**Breast Self-Examination**
1. Explains best time to perform breast self-exam
2. Demonstrates visual inspection of breast before mirror
3. Demonstrates breast examination (standing and lying down)
4. Checks nipples and palpates axillae (circular, vertical, and wedge method)
5. Provides instructions for follow up with health care provider to clients with abnormal findings
Testicular Self-Examination
1. States time for examination
2. Demonstrates palpation technique
3. Identifies testes and epididymis
4. Provides instructions for follow up with health care provider to clients with abnormal findings

Perioperative Concepts
1. Documents client's understanding of surgical procedure and expected outcome
2. Explains legal forms and procedures to be completed prior to surgery
3. States reasons for and demonstrates to client how to move, perform leg exercises, and Coughing/deep breathing exercises
4. Clarifies clients' concerns related to postoperative pain and its control
5. Explains and completes preoperative assessment
6. Explains and conducts postoperative assessment
7. Evaluates achievement of identified outcomes

*Surgical Asepsis
1. Prevents anything that is not sterile from coming in contact with that which is sterile
2. Prepares a sterile field maintaining visual contact at all times
3. Avoids reaching across the sterile field with unsterile objects
4. Dons sterile gloves avoiding contamination

Dressings
1. Uses clean gloves to remove and discard soiled dressing
2. Assesses wound and/or dressing for appearance, drains, drainage, and odor
3. Uses sterile technique, cleanses wound from area of least to most contamination, using one swab for each stroke
4. Applies and secures dry sterile dressing

Catheterization
1. Cleanses perineal area
2. Determines comfortable position and drapes for exposure
3. Opens catheter kit and applies sterile drape if appropriate
4. Organizes supplies using sterile technique
5. Cleanses urinary meatus: Female - Maintains exposure, uses anterior/posterior strokes; Male - Exposes meatus and straightens urethra, cleanses using circular motion from meatus downward
6. Uses the uncontaminated hand, inserts lubricated catheter into the urethra and obtains urine
7. Replaces foreskin over glans for the male client
8. Inflates balloon completely if using Foley catheter
9. Stabilizes tubing according to facility policy and procedure

**Heat Application**
1. Gathers specific equipment for type of dry/moist heat application as ordered
2. Selects proper temperature (100-115°F) or uses appropriate distance above area exposed (18-24 inches)
3. Provides protective covering when applicable
4. Applies to specific area and checks frequently

NOTE: If using commercial devices, follows the manufacturer’s instructions for use

**Cold Application**
1. Fills container 1/2 to 2/3 capacity with chipped or cracked ice
2. Expels air and closes securely
3. Dries bag and tests for leakage
4. Provides protective covering
5. Applies to specified area and checks frequently

NOTE: If using commercial devices, follows the manufacturer’s instruction for use

*I.V. Maintenance and Termination*

**Assessment**
Verifies order for I.V. fluids and prescribed rate
1. Assesses site for patency and complications (infection, phlebitis, infiltration), reporting abnormalities
2. Documents findings

**Termination**
1. Stops flow
2. Removes intravenous device
3. Assesses site. Inspects and assures device is intact
4. Applies pressure and applicable dressing

**Oxygen Administration**
1. Removes articles which can produce a spark or open flame
2. Places “Oxygen in Use” signs in view according to facility policy and procedure
3. Provides for humidification of oxygen (per facility policy and procedure)
4. Sets, adjusts and maintains oxygen flow at prescribed rate
5. Secures and maintains integrity of devices used for flow of oxygen
6. Observes skin condition under delivery device frequently to prevent pressure injuries to skin

**Glucose Monitoring**
1. Assembles equipment and supplies
2. Calibrates equipment and performs control per facility policy and procedure
3. Selects and prepares puncture site
4. Obtains blood specimen on reagent strip
5. Processes strip according to manufacturer's instructions
6. Verbalizes expected peripheral glucose levels for adult
7. Follows facility protocol for critical values
8. Measures and documents blood glucose

**Enemas**
1. Verifies order for enema
2. Selects appropriate equipment for client
3. Prepares correct amount of solution assuring correct temperature
4. Drapes and positions client
5. Expels air from tubing
6. Lubricates tip
7. Inserts colon tube appropriate distance into rectum: Adult 3-4 inches (7-10 cm)
8. Holds container no higher than 12-18 inches (30-45 cm) above anus and releases clamp
9. Observes client during procedure
10. Assists client to toilet or places on bedpan
11. Documents type of enema, amount, return, and client response

NOTE: If using commercially prepared enema, follows manufacturer's instructions for use

**Basic Care and Comfort**
1. Evaluates environmental comfort: (room temperature, cleanliness and orderliness, bed/linens, environmental stimulation)

**Therapeutic communication**
1. Employs various communication techniques in communicating with consideration to lifespan, culture, sociocultural influences
2. Uses elements of professional communication
Rest and sleep
1. Assesses environment for rest & sleep according to the client’s preferences
2. Implements nursing interventions conducive to rest and sleep

Pain Management
1. Assesses pain including scale, description and effective relief measures
2. Verbalizes independent nursing interventions to address pain
3. Evaluates interventions
4. Provides adjunctive pain medication measures (pharmaceuticals), when indicated

Activity & Mobility
1. Assesses ability to perform ADLs and implement measures to maintain mobility
2. Assesses for use of assistive devices and implement measures to compensate for impairment
3. Identifies safety issues that impair activity and/or mobility

Application of Soft/Medical Physical Restraints
1. Verbalizes that restraints are only employed to ensure the safety of the client or other clients when less restrictive interventions have proven to be are ineffective, only on the written order of a qualified provider.
2. Verbalizes alternative methods that can be utilized to avoid restraints (weight and motion sensors, alarms on doors, etc.)
3. Reviews provider’s order for type of restraint including type, purpose, location and tie or duration of restraint
4. Implements and applies according facility policy and in accordance with regulatory agencies
5. Verbalizes safety checks and interventions for restraints: belt, extremity (ankle or wrist), mitten, elbow
6. Assesses for proper placement including skin integrity, pulses, skin temperature, color, and sensation of restrained body part
7. Identifies which elements of soft restraints can be delegated to the UAP
8. Removes restraint at least every 2 hours or more frequently or according to facility policy
9. Documents behaviors before restraint was applied, reasons for restraint, type, location, client understanding of restraint, prior attempts to use alternatives methods of behavior modification, evaluation time, interventions during the restraint episode, and client response

Measuring & Evaluating Intake and Output
1. Assembles appropriate measuring container(s)
2. Measures amount of fluid intake in appropriate unit of measurement
3. Measures amount of fluid output in appropriate unit of measurement
4. Verbalizes normal intake and output for the average adult client
5. Verbalizes various routes and sources of intake
6. Verbalizes various routes and sources of output
7. Identifies which elements of I & O tasks can be delegated to the UAP
8. Reports inappropriate intake and output
9. Develops a 24-hour intake plan to ensure accurate and sufficient quantity of fluid for the average adult
10. Documents intake and output data including client preferences according to facility policy

**Assessing, Evaluating, and Facilitating Nutrition Needs**
1. Assesses client’s ability to chew and swallow and collaborates findings to the health care team
2. Prioritizes safety needs and assignment of personnel to feed client based on assessment
3. Identifies which clients can be fed by the UAP and which clients need to be fed by licensed staff
4. Prepares client and environment
5. Verifies food on tray with prescribed diet
6. Assists client as necessary
7. Documents food and fluid intake including any special occurrences, and client response

**Management of Care**
1. Provides care for one client experiencing dysfunctional health patterns
2. Documents assessment of individual needs and establishes nursing care priorities based on individual needs
3. Constructs a plan to implement nursing care to meet individual needs of the assigned client
4. Utilizes professional communications skills with verbal, non-verbal and written communications and ISBARR appropriate to the situation
5. Evaluates effectiveness of nursing care of assigned client

**REFERENCE**


In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time.
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

**Safety Practices**
1. Verifies care/order for client
2. Performs hand hygiene before and after preforming any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature, and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.
**Focused Abdominal Assessment**

1. Inquire about current bowel and bladder habits, previous history, and recent changes
2. Obtains vital signs and reviews health history
3. Places client in the supine position
4. Inspects the abdomen for contour, symmetry, condition of the skin, abnormal pulsations or movement, and notes the position, shape, and color of the umbilicus
5. Auscultates the abdomen before palpation to assess bowel and vascular sounds in all four quadrants
6. Using light palpation, palpate all four quadrants of the abdomen, assessing for tenderness, distention, masses, and aortic pulsation
7. Document and report pertinent findings

**Focused Integumentary Assessment**

1. Inquires about current skin condition, previous history, and recent changes
2. Obtains vital signs and reviews health history
3. Places the client in a sitting or supine position
4. Assesses all visible aspects of the skin noting the color, moisture, temperature, texture, turgor, and vascularity
5. Assesses for lesions or masses on the skin
6. Assesses the scalp and hair for general condition, distribution, presence or absence of parasites
7. Assesses nails for color, condition, hygiene, while palpating for any tenderness in the nail bed or nail structure
8. Assesses mucous membranes for color, moisture, and general health
9. Documents and reports pertinent findings

**Standard Precautions**

1. Standard Precautions: Tier One: to be used with all clients
   a) Verifies rationale for standard precaution: Tier 1
   b) Identifies, dons, & doffs the appropriate PPE
      c) Performs hand hygiene prior to don and doff PPE
   d) Documents and reports pertinent observations and findings

2. Standard Precautions: Tier Two Transmission Based Precautions: Precautions used with specific types of clients (Airborne, Droplet, Contact)
   a) Verifies rationale for standard precaution: Tier 2
   b) Identifies, dons, & doffs the appropriate PPE for each type of Tier 2 precaution
   c) Performs hand hygiene prior to don and doff PPE
d) Documents and reports pertinent observations and findings

*Physical Assessment*

**Health History**
1. Demographics – Name, address, sex, age, birth date, marital status or significant other, religion, race, education, occupation, hobbies, and significant life events
2. Health History - Smoking, heart disease, alcohol use, drug use or abuse, surgeries, injuries, childhood diseases, immunizations, hypertension, diabetes, arthritis, seizures, cancer, emotional problems, transfusions, drug/food allergies, perception of health/illness, lifestyle, hygiene, eating habits, health practices
3. Family Medical History - Includes history of heart disease, substance abuse, diabetes, arthritis, cancer, emotional problems
4. Current Situation - Chief complaint, reason for seeking help
5. History of the Present Illness – Location and duration of the present problem, aggravating/alleviating factors, associated symptoms, effect on lifestyle, coping measures, review of body systems
6. Medications - Prescribed, occasional, over the counter, and herbals

**Vital Sign Evaluation**
1. Verbalizes factors affecting vital signs of the older adult
2. Verbalizes effects of ethnicity, activity/exercise, and body structure on the vital signs of an adult
3. Verbalizes situations when vital signs are to be measured
4. Identifies which elements of the vital signs that can be delegated to the UAP and when the licensed nurse needs to perform the vital signs

**Temperature**
1. Verbalizes normal range/s of temperature for the adult client
2. Determines route of temperature measurement based on client condition:
   electronic thermometer: axillary, rectally, tympanic, temporal artery
3. Demonstrates temperature measurement using a variety of devices
4. Verbalizes general physiological processes that create heat production or heat loss which result in temperature variations
5. Identifies independent nursing interventions that affect thermoregulation
6. Documents temperature measurement including additional collaborative assessment data if present (flushing, warm skin, diaphoresis, etc.)

**Peripheral Pulse**
1. Verbalizes normal range/s of pulses for the adult client
2. Obtains heart rate (pulse) based on assessment needs including rate, rhythm, strength and equality; temporal, carotid, apical, brachial, radial, ulnar, femoral, popliteal, posterior tibial, dorsal pedis
3. Verbalizes factors influencing pulse rate
4. Verbalizes alterations in pulse rate (for example: bradycardia, tachycardia)
5. Verbalizes that in the event of a dysrhythmia (regularly irregular or irregularly irregular), the student would reassess the pulse by performing an apical pulse
6. Reports any unanticipated irregularities immediately
7. Documents findings utilizing descriptive medical terminology (for example, bounding, thready, 0–4 scale, and equality)

**Vital Signs - Respiration**
1. Assesses respiration as to rate, depth, and rhythm
2. Identifies alterations in breathing patterns (bradypnea, tachypnea, hyperpnea, apnea, dyspnea, hyperventilation, hypoventilation, Cheyne-Stokes, Kussmaul’s, Biot’s)
3. Verbalizes acceptable ranges of respiratory rate
4. Verbalizes factors that may affect character of respirations
5. Documents findings utilizing descriptive medical terminology

**Vital Signs – Blood Pressure**
1. Identifies preferred method of obtaining blood pressure based on client condition (i.e. manual or electronic)
2. Selects appropriate cuff size for the area to be utilized (upper arm, forearm, thigh, etc.) and states rationale for adequate cuff measurement and placement
3. Selects site of blood pressure measurement as determined by the client’s condition and the rationale for the blood pressure measurement (i.e. B/P abnormalities presence of casts, etc.)
4. After positioning client and placing cuff, locates pulsation of artery and places bell/diaphragm of stethoscope on the pulse
5. While inflating the cuff, raises the gauge reading of the manometer 30 mm Hg above the anticipated systolic pressure
6. Decreases cuff pressure gradually and smoothly, noting on the manometer the point at which the first sound is heard
7. Recognizes the muffling of sound if present
8. Notes on the manometer when the last distinct sound is heard
9. Verbalizes presence of Korotkoff sounds during auscultation of the blood pressure if distinct
10. If recheck is necessary, waits 30–60 seconds
11. Repositions and retakes according to client needs
12. Documents blood pressure measurement and reports any unexpected readings immediately

**Pulse Oximetry**
1. Identifies situations when pulse oximetry is indicated
2. Demonstrates or verbalizes sites to measure pulse oximetry (forehead, earlobe, bridge of the nose, digits)
3. Uses appropriate probe to obtain reading
4. Documents pulse oximetry with any collaborating assessment features if present such as cyanosis of the lips and mucous membrane

**Functional Assessment (Inspection, Auscultation, & Light Palpation)**
1. Appearance - Stage of growth and development, general health, striking features, height, weight, vital signs, behavior, posture, grooming, hygiene, communication
2. Skin – Color, consistency, temperature, turgor, integrity, texture, lesions, mucous membranes
3. Hair – Color, texture, amount, distribution, presence or absence of parasites
4. Nails – Color, texture, shape, size
5. Neurologic – Pupil reaction and size, gait and balance
6. Musculoskeletal – Range of Motion, gait, tone, posture
7. Cardiovascular – Heart rate and Rhythm, central and peripheral pulses, temperature, edema
8. Respiratory – Rate, rhythm, depth, effort quality, expansion, cough, breath sounds, sputum, nasal patency
9. Gastrointestinal – Abdominal contour, bowel sounds, nausea, vomiting, ostomy type and care, fecal frequency, consistency, presence of blood
10. Genitourinary – Urine color, character, amount, odor, consistency, ostomy, external genitalia, appearance and patency of the anus
11. Reproductive – Last menstrual period, menopause, breast exam, pap & pelvic, prostate exam, testicular exam

*Administration of Medications*
1. Verifies healthcare provider’s written order for medications
2. Prepares medication based on six rights: right drug, right dose, right time, right route, right client (uses two identifiers), right documentation
3. Provides adjunctive assessment and interventions as indicated, including but not limited to verifying allergies, clinical indications, etc.
4. Administers medication according to six rights, including electronic bedside verification where available
5. Documents time, medication, dose, and route
6. Evaluates drug response and effectiveness

**Oral**
1. Does not alter extended released or enteric coated medications
2. Remains with client until medication is taken
3. Examines for pocketing prior to leaving the client

**Topical**
1. Prepares area for medication
2. Applies with applicator or with gloved finger as indicated
3. Covers with dressing as indicated
4. Maintains anatomical position to allow absorption or distribution

**Injections**
1. Uses sterile technique
2. Positions or restrains as indicated
3. Using anatomical landmarks, locates and names acceptable sites for injection
4. Selects and cleanses site for injection
5. Maintains skin contact with selected site with non-dominant hand
6. Inserts needle with bevel up if indicated, at the correct angle: 90 degree angle for intramuscular, 45 to 90 degree angle as indicated for subcutaneous, 15 degree angle for intradermal
7. Stabilizes syringe
8. Injects medication slowly and at an even rate of speed
9. Uses Z-Track method, if indicated, for IM injections
10. Withdraws needle quickly
11. Applies pressure or bandage to site unless contraindicated

**Intramuscular Sites**
1. Ventrogluteal
2. Vastus lateralis
3. Deltoid

**Subcutaneous Sites**
1. Outer aspect of upper arm
2. Anterior thigh
3. Abdomen two inches at or below the umbilicus

Note: Unless otherwise indicated by the medication’s manufacturer recommendation

**Intradermal Sites**
1. Inner forearm
2. Scapular region for allergy testing

*Teaching – Learning*
1. Assesses client's knowledge of subject and readiness to learn
2. Reviews goals of session with client
3. Assembles materials and prepares the environment
4. Implements teaching plan, using appropriate content
5. Obtains evaluative feedback from client (summarizes content taught)
6. Evaluates effectiveness of session and documents

**Breast Self-Examination**
1. Explains best time to perform breast self-exam
2. Demonstrates visual inspection of breast before mirror
3. Demonstrates breast examination (standing and lying down)
4. Checks nipples and palpates axillae (circular, vertical, and wedge method)
5. Provides instructions for follow up with health care provider to clients with abnormal findings

**Testicular Self-Examination**
1. States time for examination
2. Demonstrates palpation technique
3. Identifies testes and epididymis
4. Provides instructions for follow up with health care provider to clients with abnormal findings

**Perioperative Concepts**
1. Documents client's understanding of surgical procedure and expected outcome
2. Explains legal forms and procedures to be completed prior to surgery
3. States reasons for and demonstrates to client how to move, perform leg exercises, and coughing/deep breathing exercises
4. Clarifies clients' concerns related to postoperative pain and its control
5. Explains and completes preoperative assessment
6. Explains and conducts postoperative assessment
7. Evaluates achievement of identified outcomes

**Surgical Asepsis**
1. Prevents anything that is not sterile from coming in contact with that which is sterile
2. Prepares a sterile field maintaining visual contact at all times
3. Avoids reaching across the sterile field with unsterile objects
4. Dons sterile gloves avoiding contamination
Dressings
1. Uses clean gloves to remove and discard soiled dressing
2. Assesses wound and/or dressing for appearance, drains, drainage, and odor
3. Uses sterile technique, cleanses wound from area of least to most contamination, using one swab for each stroke
4. Applies and secures dry sterile dressing

Catheterization
1. Cleanses perineal area
2. Determines comfortable position and drapes for exposure
3. Opens catheter kit and applies sterile drape if appropriate
4. Organizes supplies using sterile technique
5. Cleanses urinary meatus: Female - maintains exposure, uses anterior/posterior strokes; Male - exposes meatus and straightens urethra, cleanses using circular motion from meatus downward
6. Uses the uncontaminated hand, inserts lubricated catheter into the urethra and obtains urine
7. Replaces foreskin over glans for the male client
8. Inflates balloon completely if using Foley catheter
9. Stabilizes tubing according to facility policy and procedure

Heat Application
1. Gathers specific equipment for type of dry/moist heat application as ordered
2. Selects proper temperature (100-115° F) or uses appropriate distance above area exposed (18-24 inches)
3. Provides protective covering when applicable
4. Applies to specific area and checks frequently

NOTE: If using commercial devices, follows the manufacturer's instructions for use

Cold Application
1. Fills container 1/2 to 2/3 capacity with chipped or cracked ice
2. Expels air and closes securely
3. Dries bag and tests for leakage
4. Provides protective covering
5. Applies to specified area and checks frequently

NOTE: If using commercial devices, follows the manufacturer's instruction for use
*I.V. Maintenance and Termination*

**Assessment**
Verifies order for I.V. fluids and prescribed rate
1. Assesses site for patency and complications (infection, phlebitis, infiltration) reporting abnormalities
2.Documents findings

**Termination**
1. Stops flow
2. Removes intravenous device
3. Assesses site; inspects and assures device is intact
4. Applies pressure and applicable dressing

**Oxygen Administration**
1. Removes articles which can produce a spark or open flame
2. Places “Oxygen in Use” signs in view according to facility policy and procedure
3. Provides for humidification of oxygen (per facility policy and procedure).
4. Sets, adjusts, and maintains oxygen flow at prescribed rate
5. Secures and maintains integrity of devices used for flow of oxygen
6. Observes skin condition under delivery device frequently to prevent pressure injuries to skin

**Glucose Monitoring**
1. Assembles equipment and supplies
2. Calibrates equipment and performs control per facility policy and procedure
3. Selects and prepares puncture site
4. Obtains blood specimen on reagent strip
5. Processes strip according to manufacturer’s instructions
6. Verbalizes expected peripheral glucose levels for adult
7. Follows facility protocol for critical values
8. Measures and documents blood glucose

**Enemas**
1. Verifies order for enema
2. Selects appropriate equipment for client
3. Prepares correct amount of solution assuring correct temperature
4. Drapes and positions client
5. Expels air from tubing
6. Lubricates tip
7. Inserts colon tube appropriate distance into rectum: Adult 3-4 inches (7-10 cm)
8. Holds container no higher than 12-18 inches (30-45 cm) above anus and releases clamp
9. Observes client during procedure
10. Assists client to toilet or places on bedpan
11. Documents type of enema, amount, return, and client response

NOTE: If using commercially prepared enema, follows manufacturer's instructions for use

**Basic Care and Comfort**
1. Evaluates environmental comfort: (room temperature, cleanliness and orderliness, bed/linens, environmental stimulation)

**Therapeutic communication**
1. Employs various communication techniques in communicating with consideration to lifespan, culture, sociocultural influences
2. Uses elements of professional communication

**Rest and sleep**
1. Assesses environment for rest & sleep according to the client’s preferences
2. Implements nursing interventions conducive to rest and sleep

**Pain Management**
1. Assesses pain including scale, description and effective relief measures
2. Verbalizes independent nursing interventions to address pain
3. Evaluates interventions
4. Provides adjunctive pain medication measures (pharmaceuticals) when indicated

**Activity & Mobility**
1. Assesses ability to perform ADLs and implement measures to maintain mobility
2. Assesses for use of assistive devices and implement measures to compensate for impairment
3. Identifies safety issues that impair activity and/or mobility

**Application of Soft/Medical Physical Restraints**
1. Verbalizes that restraints are only employed to ensure the safety of the client or other clients when less restrictive interventions have proven to be are ineffective, only on the written order of a qualified provider
2. Verbalizes alternative methods that can be utilized to avoid restraints (weight and motion sensors, alarms on doors, etc.)
3. Reviews provider’s order for type of restraint including type, purpose, location, tie, or duration of restraint
4. Implemented and applied according facility policy and in accordance with regulatory agencies
5. Verbalizes safety checks and interventions for restraints: (belt, extremity, mitten, elbow)
6. Assess for proper placement including skin integrity, pulses, skin temperature, color, and sensation of restrained body part
7. Identifies which elements of soft restraints can be delegated to the UAP
8. Removes restraint at least every 2 hours or more frequently or according to facility policy
9. Documents behaviors before restraint was applied, reasons for restraint, type, location, client understanding of restraint, prior attempts to use alternatives methods of behavior modification, evaluation time, interventions during the restraint episode, and client response

**Measuring & Evaluating Intake and Output**

1. Assembles appropriate measuring container(s)
2. Measures amount of fluid intake in appropriate unit of measurement
3. Measures amount of fluid output in appropriate unit of measurement
4. Verbalizes normal intake and output for the average adult client
5. Verbalizes various routes and sources of intake
6. Verbalizes various routes and sources of output
7. Identifies which elements of I & O tasks can be delegated to the UAP
8. Reports inappropriate intake and output
9. Develops a 24-hour intake plan to ensure accurate and sufficient quantity of fluid for the average adult
10. Documents intake and output data including client preferences according to facility policy

**Assessing, Evaluating, and Facilitating Nutrition Needs**

1. Assesses client’s ability to chew and swallow and collaborates findings to the health care team
2. Prioritizes safety needs and assignment of personnel to feed client based on assessment
3. Identifies which clients can be fed by the UAP and which clients need to be fed by licensed staff
4. Prepares client and environment
5. Verifies food on tray with prescribed diet
6. Assists client as necessary
7. Documents food and fluid intake including any special occurrences, and client response

*Intravenous Therapy - IV (Fluids and Medications)*

**Initiation**

1. Correctly assembles intravenous system
2. Expels air from tubing
3. Applies tourniquet when appropriate
4. Selects appropriate vein
5. Releases tourniquet
6. Prepares site
7. Reapplies tourniquet when appropriate and distends vein
8. Inserts needle/catheter in vein
9. Releases tourniquet
10. Removes stylet using safety feature
11. Connects tubing to intravenous device, while stabilizing catheter
12. Initiates IV flow to maintain patency of line
13. Secures intravenous device to skin
14. Applies sterile dressing
15. Regulates and maintains intravenous flow at prescribed rate
16. Documents procedure

**Obtaining Blood Specimens via Peripheral IV (Performed only upon initiation of IV Site)**
1. Verifies the order and amount of specimen needed
2. Selects appropriate collection devices
3. Correctly initiates IV Access and withdraws blood from catheter, amount required for specimen
4. Connects Saline Lock Device
5. Flushes IV System with Normal Saline
6. Initiates infusion if continuous I.V.F. is ordered
7. Applies sterile transparent dressing to site
8. Correctly labels and prepares specimens for transport to the lab
9. Correctly documents procedure
10. Provides on-going monitoring

**Intravenous Medication**
1. Prepares medication based on six rights
2. Verifies pharmacological compatibility
3. Assesses site; verifies patency and placement of intravenous device
4. Administers intravenous medication at appropriate rate (I.V. piggyback/additives, I.V.
5. push medications
6. Provides adjunctive assessment and interventions as indicated
7. Maintains patency of intravenous device
8. Documents medications given
Infusion Devices
1. Set up infusion
2. Inserts IV tubing into infusion device
3. Sets required rate
4. Initiates infusion
5. Monitors infusion and documents

Central Line Dressing
1. Wears mask and instructs client on head position (or places a mask on the client)
2. Uses clean gloves to remove the soiled dressing toward catheter insertion
3. Discards soiled dressing
4. Assesses site and/or dressing for appearance and drainage
5. Cleans site in circular motion from catheter site to outer areas
6. Applies and secures air occlusive sterile dressing per facility policy and procedure
7. Follows the manufacturer's instructions for use of products

*Gastrointestinal Intubation
1. Positions client appropriately
2. Performs focused abdominal assessment
3. Measures tube for placement in stomach
4. Inserts lubricated tube into oral or nasal orifice
5. Advances tube to pre-determine distance and stabilizes
6. Verifies placement of tube in stomach per facility policy and procedure (check pH or obtains X-Ray)
7. Secures tube

Gavage
1. Positions client appropriately
2. Verifies placement of tube per facility policy and procedure
3. Assesses gastric residual
4. Instills prescribed feeding and administer prescribed flush
5. Clamps tube appropriately

Lavage
1. Positions client appropriately  
2. Verifies placement of tube per facility policy and procedure  
3. Instills solution  
4. Aspirates fluid  
5. Measures and assesses return

*Suctioning (Gastric)*  
1. Verifies placement per facility policy and procedure  
2. Connects tubing to appropriate suctioning device  
3. Selects correct vacuum setting  
4. Measures and assesses return

*Teaching – Learning*  
1. Assesses client’s knowledge of subject and readiness to learn  
2. Reviews goals of session with client  
3. Assembles materials and prepares the environment  
4. Implements teaching plan, using appropriate content  
5. Obtains evaluative feedback from client  
6. Summarizes content taught  
7. Evaluates effectiveness of session and documents

**Chronic Disease Self Care**  
1. Recognizes strengths and weaknesses  
2. Encourages verbalization of anxiety and concerns  
3. Identifies support systems  
4. Identifies community resources  
5. Verbalizes importance of adherence to medical regime

**Ostomy Care**  
1. Demonstrates proper appliance, maintenance, and removal  
2. Maintains skin and stoma integrity  
3. Demonstrates proper irrigation technique when applicable

*Management of Care*  
1. Applies the nursing process to clinical decision-making and the management of care for a minimum of two clients
2. Documents assessment of individual needs and establishes nursing care priorities based on the individual needs of a minimum of two clients
3. Constructs a plan and implements nursing care to meet individual needs of assigned clients
4. Utilizes inter-professional communications skills with verbal, non-verbal and written communications, ISBARRR appropriate to the situation
5. Evaluates effectiveness of nursing care of assigned clients

REFERENCE


In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time.
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

*Safety Practices*
1. Verifies care/order for client
2. Performs hand hygiene before and after performing any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature, and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

**Focused Abdominal Assessment**
1. Inquires about current bowel and bladder habits, previous history, and recent changes
2. Obtains vital signs and reviews health history
3. Places client in the supine position
4. Inspects the abdomen for contour, symmetry, condition of the skin, abnormal pulsations or movement, and notes the position, shape, and color of the umbilicus
5. Auscultates the abdomen before palpation to assess bowel and vascular sounds in all four quadrants
6. Using light palpation, palpates all four quadrants of the abdomen, assessing for tenderness, distention, masses, and aortic pulsation
7. Documents and reports pertinent findings

**Focused Integumentary Assessment**
1. Inquires about current skin condition, previous history and recent changes
2. Obtains vital signs and reviews health history
3. Places the client in a sitting or supine position
4. Assesses all visible aspects of the skin noting the color, moisture, temperature, texture, turgor, and vascularity
5. Assesses for lesions or masses on the skin
6. Assesses the scalp and hair for general condition, distribution, presence or absence of parasites
7. Assesses nails for color, condition, hygiene, while palpating for any tenderness in the nail bed or nail structure
8. Assesses mucous membranes for color, moisture, and general health
9. Documents and reports pertinent findings

*Intravenous Therapy - IV (Fluids and Medications)

Initiation
1. Correctly assembles intravenous system
2. Expels air from tubing
3. Applies tourniquet when appropriate
4. Selects appropriate vein
5. Releases tourniquet
6. Prepares site
7. Reapplies tourniquet when appropriate and distends vein
8. Inserts needle/catheter in vein
9. Releases tourniquet
10. Removes stylet using safety feature
11. Connects tubing to intravenous device, while stabilizing catheter
12. Initiates IV flow to maintain patency of line
13. Secures intravenous device to skin
14. Applies sterile dressing
15. Regulates and maintains intravenous flow at prescribed rate
16. Documents procedure

Obtaining Blood Specimens via Peripheral IV (Performed only upon initiation of IV Site)
*Please note this is not to be included in required faculty check-off
1. Verifies the order and amount of specimen needed
2. Selects appropriate collection devices
3. Correctly initiates IV access and withdraws blood from catheter, amount required for specimen
4. Connects saline lock device
5. Flushes IV system with normal saline
6. Initiates infusion if continuous I.V.F. is ordered
7. Applies sterile transparent dressing to site
8. Correctly labels and prepares specimens for transport to the lab
9. Correctly documents procedure
10. Provides on-going monitoring

**Intravenous Medication**
1. Prepares medication based on six rights
2. Verifies pharmacological compatibility
3. Assesses site; verifies patency and placement of intravenous device
4. Administers intravenous medication at appropriate rate (I.V. piggyback/additives, I.V. push medications)
5. Provides adjunctive assessment and interventions as indicated
6. Maintains patency of intravenous device
7. Documents medications given

**Infusion Devices**
1. Sets up infusion
2. Inserts IV tubing into infusion device
3. Sets required rate
4. Initiates infusion
5. Monitors infusion and documents

**Central Line Dressing**
1. Wears mask and instructs client on head position (or places a mask on the client)
2. Uses clean gloves to remove the soiled dressing toward catheter insertion
3. Discards soiled dressing
4. Assesses site and/or dressing for appearance and drainage
5. Cleans site in circular motion from catheter site to outer areas
6. Applies and secures air occlusive sterile dressing per facility policy and procedure
7. Follows the manufacturer's instructions for use of products
**Gastrointestinal Intubation**
1. Positions client appropriately
2. Performs focused abdominal assessment
3. Measures tube for placement in stomach
4. Inserts lubricated tube into oral or nasal orifice
5. Advances tube to pre-determine distance and stabilizes
6. Verifies placement of tube in stomach per facility policy and procedure (check pH or obtains X-Ray)
7. Secures tube

**Gavage**
1. Positions client appropriately
2. Verifies placement of tube per facility policy and procedure
3. Assesses gastric residual
4. Instills prescribed feeding and administer prescribed flush
5. Clamps tube appropriately

**Lavage**
1. Positions client appropriately
2. Verifies placement of tube per facility policy and procedure
3. Instills solution
4. Aspirates fluid
5. Measures and assesses return

**Suctioning (Gastric)**
1. Verifies placement per facility policy and procedure
2. Connects tubing to appropriate suctioning device
3. Selects correct vacuum setting
4. Measures and assesses return

**Teaching – Learning**
1. Assesses client's knowledge of subject and readiness to learn
2. Reviews goals of session with client
3. Assembles materials and prepares the environment
4. Implements teaching plan, using appropriate content
5. Obtains evaluative feedback from client
6. Summarizes content taught
7. Evaluates effectiveness of session and documents

Chronic Disease Self Care
1. Recognizes strengths and weaknesses
2. Encourages verbalization of anxiety and concerns
3. Identifies support systems
4. Identifies community resources
5. Verbalizes importance of adherence to medical regime

Ostomy Care
1. Demonstrates proper appliance, maintenance, and removal
2. Maintains skin and stoma integrity
3. Demonstrates proper irrigation technique when applicable

*Management of Care
1. Applies the nursing process to clinical decision-making and the management of care for a minimum of two clients
2. Documents assessment of individual needs and establishes nursing care priorities based on the individual needs of a minimum of two clients
3. Constructs a plan and implements nursing care to meet individual needs of assigned clients
4. Utilizes inter-professional communications skills with verbal, non-verbal and written communications, ISBARR appropriate to the situation
5. Evaluates effectiveness of nursing care of assigned clients

REFERENCE


**ESSENTIAL SKILLS - CRITICAL CRITERIA**

**NURSING 211 – MATERNAL NEWBORN NURSING**

In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:
*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time.
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

**Safety Practices**
1. Verifies care/order for client
2. Performs hand hygiene before and after preforming any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature, and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

**Postpartum Assessment**
1. Assesses the Breasts: Lactation status, breast support, condition of the nipples, engorgement, avoids stimulating the breasts, discomfort level
2. Assesses the Uterus: Empties the bladder, immobilizes the uterus and palpates the fundus, ascertain height, position, and tone of the fundus
3. Assesses the Bladder: Palpates for presence of distention, assess for any urinary difficulties
4. Assesses the Bowel: Assess for presence of abdominal distention, assess for any bowel difficulties
5. Assesses Lochia: Turns client to the side, remove perineal pad from anterior to posterior, assess amount, color, consistency and correlate to the status of the uterus, Instructs and monitors cleansing with peri-bottle
6. Assesses Episiotomy: Assess appearance of perineum, edema, discoloration, approximation
7. Assesses Hemorrhoids: Assess appearance of the rectal area (pain, edema, discoloration, hemorrhoids), applies clean perineal pad from anterior to posterior
8. Assesses Extremities: Assess indication of developing thrombus, edema
9. Assesses Emotions and Bonding: Emotional status of the mother and new family, assess infant bonding
10. Documents and reports pertinent data and observations

*Timing Contractions*

Palpation Method
1. Assesses by palpation
2. Frequency - time from beginning of one contraction to the beginning of next
3. Duration - beginning of increment to completion of decrement
4. Intensity - mild, moderate to strong during acme
5. Documents frequency, duration and intensity of contraction

Electronic Monitoring (if available)
1. Places tocotransducer snugly on fundus (apex) of uterus and attaches lead to monitor
2. Assesses frequency and duration on printout

*Fetal Heart Rate*
1. Positions client
2. Locates fetal heart tone at point of maximum intensity (PMI)

Auscultory assessment using Doppler (if available)
1. Places lubricated Doppler at PMI
2. Counts for 60 seconds, (within -2 or +2 of accuracy)
3. Assesses rhythm for increase or decrease following contractions and documents
Electronic Monitoring (FHR)
1. Attaches transducer leads to monitor
2. Places lubricated ultrasound transducer at PMI
3. Read rate indicated on printout
4. Identifies accelerations and decelerations in FHR
   a. Early
   b. Late
   c. Variable
5. Documents position changes and removal of transducer

*Immediate Care of the Newborn*
1. Prevents hypoxia: Positions to facilitate drainage, uses bulb syringe, stimulates crying
2. Prevents cold stress: Dries infant, wraps and/or uses warmer, implements Kangaroo Care
3. Assesses Apgar score: Heart rate, respiratory effort, muscle tone, reflex irritability, color
4. Assesses cord: Checks bleeding, number of vessels
5. Identifies mother and baby with bracelet and obtains required prints before maternal separation
6. Provides eye prophylaxis: Cleanses the eyelid and instills medication in lower conjunctival sac of each eye
7. Administers appropriate medication, if applicable
8. Documents and reports pertinent findings

*Teaching – Learning*
1. Clarifies desired outcome
2. Assesses level of understanding
3. Utilizes accurate, current content
4. Utilizes varied teaching methods
5. Allows for feedback
6. Provides positive reinforcement
7. Evaluates the effectiveness of the session

Breathing/Relaxation
1. Utilizes various breathing/relaxation techniques appropriately for stage of labor
Infant Feeding: Breast/Bottle

**Breast**
1. Performs hygienic care of breasts and hands
2. Expresses milk onto nipple
3. Positions self for comfort and accessibility of nipple/areola
4. Positions infant to prevent obstruction of nose
5. Ascertains suckling process
6. Breaks suction prior to removing infant from breast
7. Burps infant as indicated
8. Positions infant after feeding to prevent aspiration

**Bottle**
1. Obtains specified feeding as ordered
2. Holds infant with head higher than stomach
3. Holds bottle so that nipple remains full and on top of tongue
4. Ascertains suckling process
5. Burps infant after 1/2 - 1 ounce taken, at the end of feeding, and/or as necessary
6. Positions infant after feeding to prevent aspiration

**Bathing Newborn**
1. Maintains warmth
2. Cleanses eyes from inner canthus outward with warm water using a clean part of the cloth for each stroke
3. Washes with warm water and dries newborn paying special attention to head and body creases
4. Cleanses genitalia
5. Assesses cord for bleeding, foul smelling drainage and normal atrophy
6. Keeps cord clean and dry
7. Dresses infant to maintain warmth

**Client Infant Safety**
1. Assesses family functioning in relation to child safety in context of family environment
2. Assesses family knowledge
3. Provides anticipatory guidance and teaches to promote safety and health
4. Refers report to appropriate agency if necessary
5. Addresses car seat safety
REFERENCE


ESSENTIAL SKILLS - CRITICAL CRITERIA
NURSING 212 – BEHAVIORAL HEALTH NURSING

In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

**Safety Practices**
1. Verifies care/order for client
2. Performs hand hygiene before and after preforming any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

**Focused Psychosocial Assessment**
1. Establishes rapport
2. Obtains understanding of chief complaint
3. Reviews physical status and baseline vital signs
4. Obtains historical and current review of body systems, obtains vital signs, current medications, and documents allergies
5. Reviews pertinent laboratory data
6. Performs mental status examination (MSE)
7. Assesses history of violent, suicidal, or self-mutilation tendencies
8. Assesses alcohol and substance abuse history
9. Assesses family psychiatric history
10. Assesses current stressors and coping mechanisms
11. Assesses quality of activities of daily living
12. Assesses personal and social background to include support systems
13. Assesses strengths, weaknesses, and goals of therapy
14. Assesses racial, ethnic, and cultural beliefs and practices
15. Assesses spiritual beliefs and religious practices
16. Documents and report pertinent findings

*Therapeutic Communication*
1. Identifies dynamics of coping behavior/defense mechanisms in clients and self
2. Identifies manifestations of behavioral deviations
3. Identifies therapeutic techniques
4. Identifies non-therapeutic techniques
5. Utilizes interpersonal communication techniques in individual and/or group settings
6. Evaluates the effectiveness of one’s own communication with clients, colleagues, etc.

**De-Escalation Techniques**
1. Assesses the client for aggressive, escalating behavior
2. Demonstrates a calm demeanor and non-threatening posture
3. Provides safe personal space between self and client
4. Identifies presence of or indicators for precipitating stressors
5. Responds in a timely manner using a calm, clear, assertive tone of voice
6. Employs therapeutic communication techniques and empathic listening
7. Demonstrates honesty and genuineness in communication
8. Models controlled communication with the client, setting clear, reasonable limits
9. Gives reasonable choices/options when applicable
10. Avoids argumentative language and power struggles
11. Helps the client identify their feelings and needs
12. Identifies a goal for the intervention
13. Offers quiet area with decreased stimulation and noise
14. Offers pharmacological interventions as available or indicated

**Emergency Behavioral Interventions**

**Seclusion**
1. Utilizes seclusion only after all other less restrictive means of behavioral interventions have been utilized and ONLY with the provider’s order; per facility policy and procedure
2. Ensures that there is no existing safety issue which could result in self-harm (pocket contents, belts, etc.)
3. Monitors client continuously during the seclusion episode
4. Offers food and fluids every 30-60 minutes
5. Completes a face to face assessment by the registered nurse
6. Offers client the opportunity to meet elimination needs a minimum of every 2 hours
7. Obtains vital signs a minimum of every 2 hours
8. Provides for dignity needs during the intervention
9. Documentation:
   a. Assessment including a full description of behavior leading up to the seclusion/restraint episode
   b. A description of non-physical alternatives and other less restrictive interventions attempted, including the client response, before seclusion was implemented
   c. Essential nursing interventions including physiological, emotional, nutritional, and hygienic needs during the seclusion episode
   d. Interventions to expedite release and the client’s response
   e. Description of effective communication interventions
   f. Time and medications given with resulting effects of administration
   g. Time of release from seclusion
   h. Client’s response to the seclusion intervention
10. Participates in debriefing
Psychiatric Physical Restraint
1. Utilizes psychiatric restraints only after all other less restrictive means of behavioral interventions have been utilized and ONLY with the provider’s order
2. Monitors client continuously while in restraints
3. Completes a face to face assessment by the registered nurse
4. Offers food and fluids every 30-60 minutes
5. Offers client the opportunity to meet elimination needs a minimum of every 2 hours
6. Obtains vital signs a minimum of every 2 hours
7. Provides for dignity needs during the intervention
8. Documentation:
   a. Assessment including a full description of behavior leading up to the restraint episode.
   b. A description of non-physical alternatives and other less restrictive interventions attempted, including the client response, before restraint was implemented.
   c. Essential nursing interventions including physiological, emotional, nutritional, and hygienic needs during the restraint episode
   d. Interventions to expedite release and the client’s response.
   e. Description of effective communication interventions.
   f. Time and medications given with resulting effects of administration
   g. Time of release from restraint
   h. Client’s response to the restraint intervention
9. Participates in debriefing

REFERENCE


In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

**Safety Practices**
1. Verifies care/order for client
2. Performs hand hygiene before and after preforming any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

**Physical Assessment**
1. Collects data in a systematic manner utilizing inspection, auscultation, light palpation, and percussion
2. Determines developmental stage
3. Conducts general survey; general appearance, state of wellness, communication (age appropriate)
4. Skin: color, texture, turgor, edema, birth marks, pigmentations (jaundice, pigmented nevi, Mongolian spots), infectious lesions, infestations, trauma, temperature, moisture, integrity, nails, hair distribution
5. Head: hair, scalp, shape, symmetry, head circumference (under 2 yrs. old), fontanels (age appropriate), head control (age appropriate), features
6. Ears: external, position (in relation to outer canthus of the eye), hearing (response to speech), startle reflex
7. Eyes: placement and symmetry, eyelids, conjunctiva, sclera, pupils and iris, vision (age appropriate)
8. Nose: patency of nares, septum (deviation), structure variations
9. Mouth and pharynx: oral mucosa, gums, teeth, tongue, palate, tonsils
10. Neck: appearance, control (age appropriate), clavicle (age appropriate), lymph nodes, movement
11. Thorax and lungs: shape, symmetry, posture, breath sounds
12. Breasts and axillae: shape, symmetry, nipples (Tanner stages), masses
13. Heart and peripheral vascular: heart sounds, cardiac landmarks, rate, rhythm, murmurs
14. Abdomen: contour, peristalsis, skin (color, veins), umbilicus, tenderness, rigidity, hernias, masses, liver, spleen, kidneys, bladder, response to light palpation
15. Musculoskeletal: alignment, strength/weakness, symmetry, posture, spinal symmetry, and hip abduction and symmetry (age appropriate), gait (age appropriate), joints (ROM)
16. Neurological: mental status, appearance, behavior cooperation, LOC, language, emotional status, social response, attention span, motor response, verbal response, age appropriate reflexes (blink, root, suck, extrusion, Moro, palmer, Babinski), pupil size and reactivity to light, sensory response to tactile stimuli
17. Genitourinary and anus: external genitalia, symmetry/masses, appearance and patency of anus, appearance of feces and urine
18. Documents and report pertinent findings and observations

**Administration of Pediatric Medications**
1. Verifies order for medication
2. Prepares medication based on six rights: Right drug, right dose, right time, right route, right client (double identifiers), right documentation
3. Provides adjunctive assessment and interventions as indicated.
4. Incorporates the CDC Recommendations for Childhood Immunization and proper site administration
5. Administers medication according to six rights and the developmental level of the child, including electronic bedside verification where available
6. Documents time, medication, dose and route.
7. Evaluates effectiveness of drug
Oral
1. Remains with client until medication is taken

Topical
1. Prepares area for medication
2. Applies with applicator or with gloved finger as indicated
3. Covers with dressing as indicated
4. Maintains anatomical position to allow absorption or distribution

Injections
1. Uses sterile technique
2. Positions or restrains as indicated
3. Using anatomical landmarks, locates and names acceptable sites for injection that are weight, age, & medication appropriate: Intramuscular (Vastus Lateralis, deltoid, ventral gluteal), subcutaneous (outer aspect of upper arm, anterior thigh, lower abdomen), intradermal (inner forearm)
4. Selects and cleanses site for injection
5. Maintains skin contact with selected site with non-dominant hand
6. Inserts needle with bevel up as indicated (90 degree angle for intramuscular, 45 to 90 degree angle as indicated for subcutaneous, 15 degree angle for intradermal)
7. Stabilizes syringe
8. Injects medication slowly and at an even rate of speed
9. Withdraws needle quickly
10. Applies pressure to injection site as indicated

*Pediatric Intravenous Therapy*

Intravenous Medication
1. Prepares medication based on the six rights
2. Verifies pharmacologic compatibility
3. Verifies patency and placement of intravenous device
4. Administers intravenous medication at the appropriate rate
   a. IV piggyback/additives
   b. IV push medications
5. Provides adjunctive assessment and interventions as indicated
6. Maintains patency of device

Infusion Devices
1. Correctly assembles equipment and sets up infusion
2. Inserts IV tubing into infusion device
3. Sets required rate
4. Initiates infusion
5. Monitors infusion per facility policy and procedure

*Diversional Activities for Hospitalized Children*
1. Prepares and/or instructs as appropriate for developmental age.
2. Employs therapeutic play activities for developmental age.

REFERENCE


ESSENTIAL SKILLS - CRITICAL CRITERIA
NURSING 220 – MEDICAL-SURGICAL NURSING II

In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time.
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

*Safety Practices*
1. Verifies care/order for client
2. Performs hand hygiene before and after preforming any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature, and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill

**Focused Respiratory Assessment**
1. Obtains vital signs and pulse oximetry (denotes room air or on prescribed oxygen)
2. Elicits respiratory history
3. Places the client in Fowler’s position
4. Elicits respiratory history
5. Obtains vital signs and pulse oximetry (denotes room air or on prescribed oxygen)
6. Inspects for tracheal deviation, cyanosis, and condition of nail beds
7. Determines shape, symmetry, and anterior posterior diameter of the chest
8. Notes rhythm, rate, and work of breathing
9. Auscultates breath sounds (tracheal, bronchial, broncho-vesicular, and vesicular)
10. Assesses for the presence of adventitious breath sounds (crackles, wheezes, rhonchi, pleural friction rub)
11. Performs assessment of tactile and vocal fremitus
12. Performs chest excursion
13. Documents and reports pertinent observations

**Focused Cardiovascular Assessment**

1. Obtains vital signs including pulse oximetry and rhythm strip if available
2. Elicits cardiovascular history
3. Assesses chest shape and symmetry and identify the cardiac landmarks (aortic, pulmonic, Erb’s point, tricuspid, mitral, and the point of maximum impulse (PMI))
4. Auscultates using the diaphragm of the stethoscope at the all cardiac landmarks
5. Repeats auscultation using the bell of the stethoscope, noting S1, S2, and any extra heart sounds
6. Turns the client to the left side when auscultating with the bell, to assess for extra heart sounds
7. Assesses and grades peripheral pulses (carotid, temporal, brachial, radial, femoral, popliteal, dorsalis pedis, and posterior tibial)
8. Assesses for peripheral and central edema and recent weight gain
9. Assesses and inspects the extremities to include skin color for normal and abnormal findings (pallor, cyanosis, rubor, skin turgor, skin temperature, hair distribution, and capillary refill)
10. Assesses for postural hypotension and paradoxical blood pressures
11. Documents and reports pertinent observations

**Focused Musculoskeletal Assessment**

1. Obtains history of present health and illness including risk factors, family history, smoking, medications, nutritional status, accidents, occupation, gender considerations, and psycho-social considerations
2. Obtains vital signs and observe for changes; focusing on pain in the joints, bones, or muscles associated with activity and rest
3. Observes posture when standing or sitting; notes abnormal curvatures of the spine
4. Observes the client while walking; notes gait and balance
5. Inspects and palpates all joints by comparing corresponding pairs for symmetry, function, active and passive range of motion; notes contractures and deformity if present that prevent normal function
6. Inspects the skin and surrounding tissue for color, edema, or masses
7. Assesses strength for each joint utilizing application of opposing force while the client flexes the muscle
8. Documents and reports pertinent findings

*Suctioning* (oropharyngeal, nasotracheal, nasopharyngeal and tracheobronchial)
1. Positions client appropriately and establishes communication signal
2. Selects correct vacuum setting
3. Uses appropriate aseptic technique
4. Oxygenates client and implements continuous pulse oximetry for procedure
5. Inserts lubricated (if appropriate), catheter to correct depth
6. Applies suction and rotates catheter as it is withdrawn
7. Re-oxygenates client when appropriate and re-assess respiratory status
8. Rinses catheter and tubing

*Tracheostomy Care*
1. Maintains patency of airway
2. Removes, cleans, and replaces inner cannula, when applicable using sterile technique
3. Cleans stoma area
4. Applies sterile dressing
5. Replaces tracheostomy securing devices
6. Ensures an extra tracheostomy tube and hemostats are in client’s room

*Basic Electrocardiograph (EKG) Strip Interpretation*
1. Determines heart rate, regularity and rhythm
2. Identifies each waveform of cardiac cycle
3. Checks configuration and placement of P wave, QRS complex, ST segment and T wave
4. Measures PR interval, QRS duration, and QT interval
5. Analyzes the ST segment
6. Identifies normal sinus rhythm
7. Recognizes the following rhythm disturbances: Sinus tachycardia, sinus bradycardia, PVC’s, V-tachycardia, V-fibrillation, asystole, atrial fibrillation, paced rhythm, SVT

*Central Lines*

Accessing Central Line
1. Verifies compatibility
2. Flushes lumen per facility policy and procedure
3. Administers medication at prescribed rate
4. Flushes lumen per facility policy and procedure
5. Administers correct dose/strength of heparin if C.V.C. is to be heparin packed
6. Resumes the infusion if continuous I.V.F. is ordered
7. Follows the manufacturer's instructions for use of administration products

Obtaining a Blood Sample via C.V.C.
1. Verifies the amount of the specimen
2. Verifies placement
3. Flushes lumen per facility policy and procedure
4. Withdraws serum waste
5. Withdraws serum specimen
6. Flushes lumen per facility policy and procedure
7. Administers correct dose/strength of heparin if C.V.C. is to be heparin locked
8. Resumes the infusion if continuous I.V.F. is ordered
9. Follows the manufacturer's instructions for use of administration products

Accessing Central Line /Implanted Port Utilizing Surgical Asepsis
1. Places mask on client or have client turn his/her head in the opposite direction
2. Cleanses site per facility policy and procedure
3. Primed extension set and non-coring needle if applicable
4. Inserts Non-Coring Needle while stabilizing implanted port (if applicable)
5. Aspirates for blood return
6. Flushes central access per facility policy and procedure
7. Administers correct dose/strength of heparin if access device is to be heparin packed
8. Initiates I.V.F. if ordered
9. Follows the manufacturer's instructions for use of administration products

*Follows all manufacturers’ recommendations for all central access devices

De-accessing Central Line/Implanted Port
1. Places mask on client or have client turn his/her head in the opposite direction
2. Loosens dressing
3. Verifies placement of device
4. Flushes per facility policy and procedure; follows the manufacturer's instructions for use of anticoagulant products
5. Removes access per facility policy and procedure, stabilizing port if applicable
6. Applies pressure to site until hemostasis is achieved and cleanses site
7. Applies dressing per facility policy and procedure

*Follows manufacturers’ recommendations for all central access devices

**Blood and Blood Products Administration**
1. Verifies health care provider's order for specific blood or blood product, date, time to begin transfusion, duration, and any pre-transfusion or post-transfusion medications to administer
2. Obtains client consent according to facility policy and procedure
3. Assembles blood administration set and primes with normal saline
4. Starts IV with large gauge access device
5. Assesses vital signs and laboratory values per facility policy such as; hemoglobin and hematocrit, coagulation values, platelet count ensuring a copy is on the client chart or EMR
6. Confirms blood’s label, compatibility tag, and client’s lab results with RN according to facility policy and procedure
7. Gently agitates unit of blood and inspects for abnormalities
8. Initiates infusion per facility policy and procedure
9. Remains with the client for the first 15 minutes and observes for reaction
10. Increases flow rate to deliver blood in less than 4 hours
11. Obtains and evaluates vital signs at prescribed intervals, according to facility policy
12. Monitor and document how the client is tolerating the transfusion

NOTE: Follows the manufacturer's instructions for use of administration products.

**Teaching - Learning**
1. Assesses client's knowledge of subject and readiness to learn
2. Reviews goals of session with client
3. Assembles materials and prepares the environment
4. Implements teaching plan, using appropriate content
5. Obtains evaluative feedback from client
6. Summarizes content taught
7. Evaluates effectiveness of session and documents

**Maintenance of Traction**
1. Assesses neurovascular status of affected limbs
2. Identifies skin irritation and breakdown
3. Maintains client in appropriate traction position
4. Ensures maintenance of effective traction
5. Provides instructions for follow up with health care provider to clients with abnormal findings

**Cast Care**
1. Assesses neurovascular status of affected extremity frequently throughout the day
2. Evaluates casted extremity for underlying skin problems frequently throughout the day
3. Maintains integrity of cast
4. Identifies self-care, comfort, and safety measures
5. Provides instructions for follow up with health care provider to clients with abnormal findings

**Crutch/Walker Ambulation**
1. Utilizes proper equipment for ambulation
2. Demonstrates proper stance for crutch/walker foot sequence
3. Practices safe crutch/walker maneuvering techniques
4. Identifies comfort and safety measures
5. Provides instructions for follow up with health care provider to clients with abnormal findings

**Management of Care**
1. Applies the nursing process to clinical decision-making and the management of care for a minimum of three clients with multiple, complex, dysfunctional health problems
2. Documents assessment of individual needs and establishes nursing care priorities based on the individual needs of a minimum of three clients
3. Constructs a plan and implements nursing care to meet individual needs of the assigned clients
4. Utilizes professional communications skills with verbal, non-verbal and written communications and ISBARR appropriate to the situation
5. Evaluates quality and effectiveness of nursing care of assigned clients.

**REFERENCE**


**ESSENTIAL SKILLS - CRITICAL CRITERIA**

**NURSING 230 – MEDICAL-SURGICAL NURSING III**
In addition to the critical criteria identified for each skill, the following will be used in the evaluation of the student’s performance:

*Denotes individual faculty check-off.

**General Principles**
1. Personal protective equipment must be utilized and appropriate medical asepsis must be maintained at all time
2. Correct supplies/equipment must be assembled and organized
3. Client instruction must be provided
4. The client must not be placed in physical jeopardy
5. The client must not be placed in emotional jeopardy
6. Pertinent information must be reported and/or documented

**Safety Practices**
1. Verifies care/order for client
2. Performs hand hygiene before and after preforming any client care or handling supplies
3. Verifies facility policy and procedure and assembles appropriate equipment/supplies
4. Consults manufacturer’s recommendations when equipment is involved
5. Knocks on the client’s door
6. Identifies client using two identifiers
7. Notes overall condition of the client
8. Explains procedure to the client and provides for privacy
9. Elevates bed to promote good body mechanics
10. Dons PPE if indicated
11. Upon completion, lowers bed, applies side rails according to the client’s care plan, places call system within reach
12. If any abnormal findings are present, reports findings to charge nurse immediately

The student is expected to utilize safety practices and provision for privacy when performing all essential skills. Documentation for all skills must include date, time, signature and other appropriate data. Any action or inaction on the part of the student which jeopardizes the emotional or physical well-being of the client will result in an unsatisfactory grade for the skill.

**Focused Neurological Evaluation**
1. Obtains vital signs including pain assessment
2. Determines level of consciousness (LOC), general appearance, behavior and language
3. Assesses intellectual functioning (memory, judgement, abstract thinking, and insight)
4. Assesses patellar reflex
5. Calculates Glasgow coma scale
6. Documents and report pertinent observations

*Management of Care for a Group of Clients*
1. Applies the nursing process to clinical decision-making and the management of care for a group of clients
2. Establishes nursing care priorities based on the individual needs of clients within a group
3. Constructs a plan and implements nursing care to meet individual needs of the assigned clients
4. Utilizes professional communications skills with verbal, non-verbal and written communications and ISBARR appropriate to the situation
5. Delegates appropriately
6. Evaluates quality and effectiveness of nursing care of assigned clients

**REFERENCE**


***ALL POLICIES ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTIFICATION

STANDARDIZED TESTING: (Revised Spring 2018 for implementation Fall 2018)

HESI TESTING:
The Henderson Community College AD nursing program administers a standardized (HESI) exam in each nursing course. The exam measures the student’s retention and application of content across the program curriculum. Students will earn theory points based on their performance on the exam. Research studies have found the HESI score to be highly accurate in predicting NCLEX success. A benchmark score of 850 has been set because it corresponds with acceptable performance on the HESI exam. Students receiving a benchmark score of 850 or higher are considered successful on the course HESI exam. In the event a student does not achieve the benchmark on the first attempt, the student must remediate per the instructor’s recommendation and take a second version of the HESI exam.

In the event a student is not successful on the second attempt, the student will be assigned an additional assignment / exam. The student must successfully complete the additional assignment/exam prior to completing the course.

In the event a student does not successfully complete the additional assignment/exam prior to completing the course, the student will receive an Incomplete and may not progress in the program.

Objectives:
1. Students will demonstrate application of nursing knowledge gained throughout the curriculum to successful completion of a standardized exam.

<table>
<thead>
<tr>
<th>Student Performance</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score of 850 or higher on HESI Exam 1st attempt</td>
<td>10 points</td>
</tr>
<tr>
<td>Score of 850 or higher on HESI Exam 2nd attempt</td>
<td>8 points</td>
</tr>
<tr>
<td>Score of 849-800 on HESI Exam 1st or 2nd attempt</td>
<td>6 points</td>
</tr>
<tr>
<td>Score of 799-750 on HESI Exam 1st or 2nd attempt</td>
<td>4 points</td>
</tr>
<tr>
<td>Score of 749-700 on HESI Exam 1st or 2nd attempt</td>
<td>2 points</td>
</tr>
<tr>
<td>Score of &lt; 700 on HESI Exam 1st and 2nd attempts</td>
<td>0 points</td>
</tr>
</tbody>
</table>

Students are expected to test on the day scheduled for the course HESI exam.
1. In the event a student does not test on the scheduled day for the HESI exam, 2 points will be deducted from the student’s performance-based score.
2. If the student is require to take the HESI 2nd attempt, 2 points will be deducted from the student’s performance-based score if the HESI second attempt is not completed on the scheduled retest day.
3. If the student is required to take both the 1st and 2nd attempt on the HESI exam and does not test on either of the scheduled exam days, 4 points will be deducted from the student’s performance-based score. **If any re-test attempts are required, the student may be required to pay an additional testing fee prior to testing. Payment via credit card is due prior to the time of testing.**

   *Standardized tests are considered as exams. Academic honesty standards apply.* (See Student Code of Conduct)

**KCTCS Administrative Policies & Procedures**

**Drug Testing**

Students will be required to be tested for the presence of drugs according to the affiliating clinical agencies used by Henderson Community College. Criminal Background screens for Indiana and Kentucky will also be required. Students will be notified of this requirement in writing beforehand.

KCTCS does **NOT** require drug testing for entry into instructional programs or any courses therein. Students who participate in instructional programs that require completion of practical experiences in affiliated institutions that do require drug testing will be subject to the policies below:

1. Students will be notified of the procedure to follow for drug testing.

2. The cost of all drug screening required by affiliating clinical agencies will be borne by the student or affiliating clinical agency, as determined by the affiliating clinical agency.

3. If a student tests positive for drugs, the student has the right to request a second drug test. The cost of the second drug test will be borne by the student.

4. If a student fails to submit to a required drug screen, if a student fails the first drug test and chooses not to retest, or if the student fails both the first and second drug test, the student will not be allowed to participate in the required practical experience. Failure to participate in required practical experiences shall be grounds for dismissal from the program.

5. The student has the right to reapply to the program subject to the program’s current readmission policy. The readmission policy may include a requirement for successful completion of a drug counseling program.
6. Confidentiality of the student will be protected.

HENDERSON COMMUNITY COLLEGE
ASSOCIATE DEGREE PROGRAM

STANDARDS AND PROCEDURES FOR DRUG SCREENING

I. Students who come to our institution expect to study in a condition free from alcohol and drugs. The use of controlled substances or alcoholic beverages by students, or students working under the influence of these chemicals, is inconsistent with the behavior expected of students, staff, faculty and visitors of our facilities. This behavior poses unacceptable safety risks, and undermines the College’s ability to operate effectively and efficiently. All students must remain free from impairment due to the use of drugs and alcohol while on campus and from use, possession, manufacture, or sale of any drug or alcohol on HCC property or the property of any of its affiliates or related hospitals/services. The unauthorized use of alcoholic beverages on campus or the unlawful use, possession, concealment, transportation, promotion, sale or distribution of controlled substances while on campus, or HCC property or while engaged in HCC business off HCC property is strictly prohibited and will subject the student to disciplinary action up to and including academic dismissal.

Kentucky Community and Technical College’s (KCTCS) Code of Student Conduct addresses controlled substances and illegal drugs under disciplinary offenses section (3.2). Number 10 under this section states “Manufacturing, possessing, using, selling, or distributing any type of controlled substances or illegal drugs.”
http://www.kctcs.edu/default/students/admissions/academic%20policies/~media/System%20Office/Academics/StudentCode2009.ashx
p 18-19.
The Code further states that the college has the authority to impose penalties and sanctions from a reprimand to permanent expulsion. 
http://www.kctcs.edu/default/students/admissions/academic%20policies~/media/System_Office/Academics/StudentCode2009.ashx

Students are permitted to take legally prescribed and/or over-the-counter medications consistent with appropriate medical treatment plans while attending classroom, laboratory, &/or clinical experiences. However, when such prescribed or over-the-counter medications affect the student’s safety, academic performance, the safety of fellow students, faculty/staff, patients, or members of the public, the Director of Nursing, Student Affairs Officer, or their designees should be consulted to determine if the student is capable of continuing to participate in academic and clinical programs and/or remain on campus, or if the student needs to be removed from the Academic Program by College Administrators.

II. TESTING REQUIREMENTS:
A. Admission Drug Screening:
In an effort to maintain a drug and alcohol-free environment, applicants who are accepted to the nursing programs at the College will be subject to drug testing as part of the preadmission health screening. The College utilizes Mobile Drug Screen Company for student pre-admission drug testing.

III. DEFINITIONS
A. “HCC Property”: For purposes of this policy, HCC Property includes premises, property, facilities, building, structures and vehicles that are owned, leased or under College Administration of HCC or its affiliates or related hospitals/services.

B. “Controlled Substances”: Drugs designated under the Federal Controlled Substances Act of 1970 which have or have the potential for, abuse or physical or psychological dependence.

C. “Student”: The term student refers to all HCC students and all students enrolled in courses at the College.
D. “Illegal Drug”: Any drug which is (a) not legally obtainable, (b) legally obtainable but has been illegally obtained by the student, or (c) a prescribed drug legally obtained, but not being used for prescribed purposes, or being used in a dosage other than that prescribed.

E. “Impaired”: The student is affected by a drug, alcohol, or both in a detectable manner where such use or influence may affect the student’s performance or the safety of the student, fellow students, faculty/staff, patients or members of the public.

F. “Legal Drug”: Prescribed drugs and over-the-counter drugs which have been legally obtained by the student and are being used for the purpose for which they were prescribed and/or manufactured.

IV. “For Cause” Screening Requirements

If criminal activity or substance abuse occurs, or is suspected, after the initial Criminal Background check and Drug Screen is completed, a “For Cause” screen may be required.

Clinical affiliate reserves the right to remove a student from the facility for suspicion of suspicion of substance use or abuse (including alcohol). The clinical affiliate will immediately notify the instructor/college to facilitate immediate removal of the student. In all instances, the clinical affiliate will provide written documentation of the student’s behavior(s) to the college. The student will be asked to consent to a “for cause’ drug test at a vendor site identified by the college. (Mobile Drug Screen). Testing must be completed on the same clinical day as the suspected drug or alcohol use/abuse was identified. Failure to comply will result in the student’s immediate expulsion from the program.

In all instances of drug screening, students are responsible for any costs related to the initial drug screen or additional testing. An individual with a positive drug screen may be denied enrollment and participation in clinical or practicum rotation.

At a minimum, students who violate this policy will receive a zero for the missed clinical/class/lab activity at the time the student was removed for testing.
HENDERSON COMMUNITY COLLEGE INTERVENTION PROCESS

Students suspected of drug/alcohol impairment may be asked to leave the clinical/classroom setting for evaluation prior to “for cause” drug testing. The following procedure will be implemented for suspected abuse. (If you need assistance, call the Nursing coordinator, the Dean of Student Affairs, or their designees)

1. Ask another administrator/faculty/staff member or designee to work with you and serve as a witness throughout the entire process and document the proceedings.

2. You and the other administrator/faculty/staff member are to complete the For Cause Testing Checklist forms.

3. Bring the student into your office or some other private place and, in the presence of the witness, complete the Questions for the Suspected Substance Abuse form. Read exactly what is written on the form. You and the witness are to sign the form.

4. Complete the Opinion Based on Observations and Questioning by Administrator/Faculty/staff member form. You and the other administrator/faculty/staff member are to sign the form.

5. If you conclude that the student does not appear to be impaired by the use of alcohol or drugs and is able to perform academically and clinically, have the student return to class/clinical/lab. Place the forms in confidential files.

6. If you conclude that the student may be impaired by the use of alcohol or drugs and/or the student admits to being impaired:
   • inform the student of the College rules that he or she violated;
   • tell him/her that disciplinary action, up to and including academic dismissal, may be taken;
   • suspend the student pending investigation of the situation;
   • contact the Nursing Coordinator or Dean of Student Services Affairs Director;
   • and if the student agrees proceed to #7 and if not proceed to #8.

If you conclude that the student may be impaired by the use of alcohol or drugs and student does not admit to being impaired:

   • ask if he or she is willing to submit to testing;
   • still test student even if student admits to drug/alcohol abuse;
   • inform the student of the College rules that he/she violated;
• tell him/her that disciplinary action, up to and including academic dismissal, may be taken;
• if the student agrees to testing, proceed to #7 below. If the student is unwilling to undergo testing, proceed to (Attachment B-6).

7. If the student agrees to a drug/alcohol test, have the student read and sign the Agreement.

8. Submit to Drug and/or Alcohol Screen form. You and the other administrator/faculty/staff member also are to sign the form.

   Arrange the test with the appropriate designated site. Day and evening on-site testing can be coordinated with Mobile Drug Screen). If you have to take/escort the student to the collection site, you will need to stay with the student through the testing process which can take about 90 minutes. The cost of the test will be the student’s responsibility.

9. If the student refuses a drug/alcohol test, have the student read and sign the Refusal to Submit to Drug and/or Alcohol Screen form. You and the other administrator/faculty/staff member also are to sign the form. If the student refuses to sign the Refusal to Submit to Drug and/or Alcohol Screen Form then you and the other administrator/faculty/staff member are to sign the form and make the notation that the student refused to sign. Tell the student that he/she is suspended and that further disciplinary action, up to and including academic dismissal may be taken.

10. Make arrangements to have the student taken home. Do not permit the student to drive or to go home alone. If the student refuses assistance, make sure you document the refusal.

11. After all forms are completed and signed, detach your copies, insert all forms in packet envelope, and deliver or send them to Nursing Coordinator, Dean of Student Affairs or their designees immediately or on the next business day.

Criminal Background Checks
Henderson Community College now requires background checks for all students enrolling in Nursing. This process is designed to meet requirements for student’s assignment to clinical practice in affiliating healthcare agencies. HCC will release the criminal background report and drug screen to agencies to which a student is assigned for clinical experiences, prior to beginning the assignment. Agencies may refuse student access to clients/patients based on this information and that criteria may differ from that for Henderson Community College.

Henderson Community College has worked with CastleBranch and the approximate cost is $30.00. (Cost is subject to change) Students who fail to submit a background check prior to the established deadline may not be eligible for clinical placement.

The Kentucky Board of Nursing is authorized by law to deny a license or to issue a license under disciplinary conditions because of an applicants’ criminal conviction. KRS 314.091 (1) states, in part: “The board [of nursing] shall have power to reprimand, deny, limit, revoke, probate, or suspend any license… to practice nursing issued by the board or applied for in accordance with this chapter… upon proof that the person… (b) has been convicted of any felony, or a misdemeanor involving drugs, alcohol, fraud, deceit, falsification of records, a breach of trust, physical harm or endangerment to others, or dishonesty…”. KRS 314.031 (4) requires that all misdemeanor and felony convictions occurring in Kentucky or in any other state, regardless of when they occurred, must be reported to the KBN. Refer to www.kbn.ky.gov for “Mandatory Reporting of Criminal Convictions” or call the Board of Nursing.
COMPLAINT/NURSING PROGRAM SUGGESTIONS CHAIN OF COMMAND

Each course will select a liaison to represent the class in bringing issues to the faculty. The liaison will meet with the faculty of the course on an agreed time and date to give input and verbalize concerns of the class. The faculty members will record the meeting and send the minutes to the Nursing Coordinator for review.

All students should be aware of the chain of communication:

1. The student will discuss the issue with the involved faculty. If the student feels the issue is not resolved, the student can proceed to step 2.
2. The student will discuss the issue with their nursing advisor. If the student feels the issue is not resolved, the student can proceed to step 3.
3. The student will discuss the issue with the Nursing Program Coordinator/Allied Health Division Chairperson. If the student feels the issue is not resolved, the student can proceed to step 4.
4. The student will discuss the issue with the Academic Dean in accordance with Guidelines listed in the Student Code of Conduct. If the student feels the issue is not resolved, the student can proceed to step 5.
5. Continue with the steps outlined in the Student Code of Conduct for a formal grade appeal or any other violation of a student right.

Liaison Officer: This officer solicits concerns, suggestions and complaints from the members of the class, obtains consensus about which topics should be brought to the Course Faculty Liaison monthly meeting. (An alternate should be selected to attend the meetings when the elected liaison officer cannot attend.)
GENERAL INFORMATION

ADVISING
Each student admitted to the program will be assigned a nursing faculty member to act as his/her academic advisor. Each advisor will have regularly scheduled office hours posted. Students are encouraged to seek assistance from advisors throughout the school year and are required to make at least one appointment each semester. All class schedules require the signature of your faculty advisor.

Pre-registration/advising for the next semester is scheduled at specific intervals within the appropriate time frame. Students should make an appointment with their faculty advisor to complete the process. Sign-up sheets are posted on the office door of each faculty member. The advisor will assist the student in making out a schedule for the next school term. Students are not excused from class or lab to meet with advisor. If there are problems in obtaining the classes needed to fulfill the degree requirements, students should make an appointment with the Nursing Program Coordinator. If satisfaction is not obtained, the next person in the chain of command is the Division Chairman.

Students experiencing academic difficulty in any course should first discuss the difficulty with the instructor of that course. For the nursing theory, the appropriate person to contact is the teacher of that section of the course. For the clinical, the appropriate person to contact first is the clinical instructor. The faculty advisor may also act as a resource person in the resolution of a problem.

Should you have questions about financial assistance, you should see the Financial Aid Counselor located in the Sullivan Technology Center on the HCC Campus.
General counseling service is available for assistance with personal concerns at no charge. Contact the Nursing Coordinator, your academic advisor, or the counseling center if you feel that you need these services.

ATTENDANCE POLICY FOR CLASS/CLINICAL

Attendance in Nursing class, campus lab, and clinical lab is required. The class content and its application in campus and clinical labs are necessary for evaluation and progression. Any student with excessive absences/tardiness/early departures from class as determined by the course faculty may be deemed unsafe and not allowed to continue in the course. (see page 128 for clinical/laboratory Make-Up Time Form).

Clinical Attendance:

Clinical attendance/punctuality is a part of professional standards and accountability. Students are required to contact the facility and the faculty/instructor prior to the beginning of clinical if an absence is anticipated. The student must call and speak to the faculty/instructor/clinical facility in person. E-mailing, texting or leaving voice mails will not be acceptable. Therefore any student who is absent and or *tardy to clinical two times per nursing course is a candidate for dismissal from the program.

*Tardy or tardiness is defined as being more than five minutes late to class/and or clinical unless approval has been received from the course faculty and/or clinical faculty member.

CLASSROOM/CAMPUS LAB/JEOPARDY POLICY

Classroom/Campus Lab Behavior protocol:

Students are expected to conduct themselves as professional individuals while attending class. Certain activities can be distracting to others as well as minimizing the optimum learning opportunity. Therefore listed activities including but not limited to will not be tolerated and will earn the student a classroom/lab jeopardy.

1. Arriving to class/campus lab tardy.
2. Disruptive talking, laughing, etc.
3. Texting, blogging, face-booking, talking on cell phones**
4. Standardized testing fees- Fees will be required to be paid by the designated time frame- by the end of the first week of each course.
**Specific policies may be initiated by individualized course faculty. In the event of an emergency, students will able to have cell phones on vibrate and may be excused to take or make a call if previous permission has been obtained from the instructor teaching the class/lab.

If any of the previous behaviors occur, the instructor may:

1. Ask the student to place the phone or device at the front of the room until class is over
2. Do not allow student to have device at any time during classroom/lab situations
3. Students will receive a classroom/campus lab jeopardy
4. After receiving the second jeopardy, a discussion with the student and faculty will occur
5. After receiving a third jeopardy, the faculty may request a meeting with the program coordinator to discuss further repercussions which may include unexcused absence from class/lab or ask for withdrawal from course.

**CLINICAL SAFETY/JEOPARDY POLICY**

Students who do not comply with stated clinical policies will be given a warning the first time. Subsequent non-compliance will result in a clinical jeopardy. Two clinical jeopardies will require a meeting with the Associate Dean/Director of Nursing. Additionally, the clinical tool will reflect the discretion for that week. Infractions that do not directly impact patient safety will result in a warning only!!

**CLINICAL JEOPARDY:**

Clinical Jeopardy is defined as a clinical situation in which a student, by omission or incorrect action, compromise the client’s physical and/or emotional safety, is unprepared for clinical or exhibits unprofessional behavior according to the clinical policy.

What constitutes a clinical jeopardy?

1. Lack of preparation for clinical
2. Tardiness/absence without notification to instructor/facility.
3. Failure to comply with overriding-principles of care.
4. Failure to demonstrate proficiency on previously learned skills.
5. Failure to comply with clinical policy, including failure to upload required documents to CastleBranch by the designated due date.
6. Failure to comply with safety according to clinical policy.
7. Failure to comply with professional behaviors according to clinical policy.

In the event of receiving a clinical jeopardy:

- The student may be sent home or to the college lab with a specific assignment or the student may remain in the clinical area with an alternate assignment.
• In addition to the above the student must make up the total number of hours for that scheduled clinical day.
• Two clinical jeopardy situations in a semester will require a student to make an appointment with the nursing coordinator.
• Three clinical jeopardy situations in a semester will constitutes a clinical failure. The clinical failure constitutes an “unsatisfactory in clinical”. An unsatisfactory in clinical results in the course failure with a grade of “E”.

**CPR CERTIFICATION**

All students are required to have current AHA "American Heart Healthcare Provider" CPR certification prior to the beginning of NSG 101. A copy of the signed CPR certification card must be presented to the instructional specialist. Students who are not certified will not be admitted to the clinical agencies.

**COURSE LOAD**

The course load carried by a student may not exceed that described in the KCTCS Catalog.

**NURSING STUDENT DRESS CODE**

**Campus:** Students are expected to dress in a comfortable and modest manner for class. Clothing worn to class should not be distracting or offensive. Campus simulations may require wearing the clinical uniform. Students must wear a scrub top during skill testing.

**Clinical:** All students will be in full uniform (Henderson Community College uniform, name pin, etc.) each day at the beginning of the clinical laboratory unless otherwise stipulated such as in Psychiatric facilities. Appropriate dress for observational experiences will be directed by the Nursing faculty. In general:

**Females must have:**
Safety goggles
Neutral color hose with dress or skirt
Neutral color socks may be worn with slacks
Clean, neutral color, non-porous shoes
Name badge (approximately $5)
Watch with second hand
Stethoscope and bandage scissors
Dark grey pants with HCC navy blue uniform top and dark grey jacket (recommended).

**No sweaters**
Males must have:
Safety goggles
Neutral color socks
Clean, neutral color, non-porous shoes
Name Badge (approximately $5)
Watch with second hand
Stethoscope and bandage scissors
Dark grey pants with HCC navy blue uniform top and dark grey lab jacket (recommended)
No sweaters

Students are expected to be neatly groomed and without body odor. For the comfort of the clients, smoking while in uniform is prohibited. Those who have long hair must wear the hair confined and not touching the collar. Hair must be of a natural color (for example: not purple or neon colors).

Males must be clean shaven. Males with established beards and moustache must keep them clean and well groomed. The student lab jacket may be worn in the clinical area for additional warmth. Bandage scissors, stethoscope, a pen and a small pocket notebook are necessary, unless otherwise specified, for use in the clinical laboratory. The only appropriate jewelry will be one (1) pair (only) of small stud type, silver, gold or pearl earrings to be worn in pierced ears and a watch with a second hand. Nail polish and/or acrylic nails are NOT permitted during clinical laboratory. Nails should be reasonably short for student and client safety. A plain wedding band may be worn. Rings with settings are not acceptable. It is expected that the student will be conservative in the use of makeup. Undergarments should not be visible through the uniform. Chewing gum is not allowed in clinical. Tattoos must not be visible.

The preceding dress code is applicable and must be adhered to whenever one is a representative of Henderson Community College. The clinical sites do not have safe places for student's belongings, therefore, do not bring purses or other valuables to clinical. Personal cellular phones or pagers may not be operated within any healthcare facility or community experience unless permission is given per clinical faculty and the clinical facility.

**Drug Resistant Pathogens**
Related to the increase of drug resistant pathogens in the community it is recommended that students need to change their uniforms immediately after the clinical experience. Uniforms should be laundered with hot water and bleach.

**BEHAVIOR IN CLINICAL FACILITY**
Behavior in clinical facilities should be quiet and refined. Any student jeopardizing the safety of clients for any reason or the delivery of patient care on the unit will be removed from the clinical site immediately. Profanity will not be tolerated. Unprofessional behavior will be cause for dismissal from the program. The student will receive an unsatisfactory for clinical.
BEHAVIOR IN LAB SETTING
Cell phone use is prohibited unless approved by the instructor for use in recording demos recording performance for review. Students should treat the mannequins as they would a real person. Students must be courteous and should always return the lab to orderly condition. Food or drink in the lab is considered a privilege and can be revoked if it interferes with practice time, becomes distracting or is not discarded properly.

BONUS POINTS
Frequently students are given opportunities to engage in activities that can earn bonus points. These bonus points can only be added to the student’s total points if a 78% on unit exams and other activities that earn points has been achieved prior to the end of the course. I understand that these bonus points can help raise my grade from one letter to the next (Ex: C to a B) but cannot provide me with a passing grade for the course if my total points are less than 78%.

FACILITY ORIENTATION
The individual clinical faculty may have a mandatory orientation to the clinical facility or unit prior to the first scheduled day of clinical. In order for students to be given fair treatment in the clinical facility, a student may not have a clinical experience on the unit in which he is employed. It is the responsibility of the student to inform the clinical instructor that he is employed at a health care facility at the beginning of the semester if he has been scheduled for such a unit.

RETENTION OF CONTENT
Students are expected to retain content covered throughout the program. All exams are considered comprehensive in nature, as any material covered previously in the current or past courses is testable. Beginning Fall of 2017, each med-surg course (with the exception of NSG 101), will have a 5 point quiz on the first day of class. This exam will cover material previously taught. Starting Spring 2018, each course (with exception of the pharmacology courses) will have two unannounced content retention quizzes that will be added to a future exam score. Each quiz will contain eight questions worth 0.25 points each.

EVALUATION
The course grade for passing a Nursing Course is determined by:
1. A final average in theory of at least 78%;
2. A grade of "satisfactory" in clinical laboratory;
3. A "satisfactory" evaluation in all essential skills.

GRADING SCALE
A = 91 - 100
B = 83 - 90.99
C = 78 - 82.99
D = 67 - 77.99  
E = 66.99 and below  
Grades will not be "rounded up or down." The student must maintain a 78% in all nursing courses in order to progress in the Associate Degree Nursing Program.

**AN OVERALL GRADE POINT AVERAGE OF 2.0 OR BETTER MUST BE MAINTAINED IN ORDER TO BE RETAINED IN THE NURSING PROGRAM.**

**General Education Student Learning Outcomes**

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<td>4.5-5.0</td>
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<td>90-100%</td>
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<td>Determine when computations are needed and execute</td>
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Each nursing course contains a dosage calculation quiz to assess the students’ ability to apply appropriate mathematical concepts and calculations to the safe preparation and delivery of medications. The dosage calculation quiz will be an online quiz consisting of 10 dosage calculation items. The quiz value is 5 points. The dosage calculation quiz will be made available for at least 48 hours and not more than 72 hours. Quizzes may not be made up. The dosage calculation quiz is an individual assignment, group work is not allowed. Academic honesty policies apply.

Each nursing course will also evaluate student learning based on the general education student learning outcome ensuring the students’ ability to utilize, understand, assess and cite academic sources in written work.
Professional Role Points

Summary: Nursing is recognized as a profession with a unique body of knowledge, defined scope of practice, and identification of professional values and behaviors. Attributes of professionalism in nursing include: knowledge, autonomy, spirit of inquiry, accountability, caring behaviors, advocacy, collegiality, civility, collaboration, honesty, and integrity.

Note: absence, tardy or early departure from any course activity (including but not limited to lecture and lab) is an occurrence regardless of reason. However, if a student is required to miss course activities more than one consecutive day for illness, hospitalization, death in the family or legal proceedings, and can bring forth a written document of proof of reason for absence, the student will receive one occurrence. If the absences are not consecutive, an occurrence will be given for each.

Learning Objectives:
1. The learner will demonstrate behaviors supporting professional accountability, collaborative teamwork, professional civility to peers and instructors, and professional communication.
2. The learner will exhibit academic accountability in preparation and classroom engagement.
### Attendance Status

- Greater than 5 occurrences of Classroom or Lab absence, tardy, or early departure
- 2 classroom/clinical jeopardy violations of 2 or more of the items listed below regardless of attendance status

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<td>OR</td>
<td>- Active participation in classroom lecture and in-class activities.</td>
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<td>AND</td>
<td>- Absence of disruptive/uncivil/unprofessional behavior related to the nursing profession</td>
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<td>AND</td>
<td>- 0 to 1 occurrence of Classroom or Lab absence, tardy, or early departure</td>
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**OR**

- 3 occurrences of Classroom or Lab absence, tardy, or early departure
- 1 classroom/clinical jeopardy violations of 1 or more of the items listed below

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<td>AND</td>
<td>- Completion of all pre-lecture assignments</td>
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**OR**

- 2 occurrences of Classroom or Lab absence, tardy or early departure
- 0 classroom/clinical or jeopardy violations of 1 or more of the items listed below

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<td>- Completion of all pre-lecture assignments</td>
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**OR**

- 0 to 1 occurrence of Classroom or Lab absence, tardy or early departure
- 0 classroom/clinical warnings or jeopardies

**Skill Testing Policy**

Emphasis will be placed on preparing student for the first skill test. Each skill will be
demonstrated by faculty at a designated time followed by a minimum of two scheduled lab practices during which faculty will be present. Students will be required to actually perform each step of a skill. Verbalizing what one would do in the situation is not acceptable. An ISBARR format report and incident report will be required following a skill failure. A reflective paper, including the appropriate disclosure of the error and potential legal implications will also be required and will be due prior to the scheduled second attempt. Two mandatory practices are required before re-testing a skill.

Note: No more than three exams/skills/retests, etc. can be scheduled in one day. This does not apply to quizzes.

SKILL TESTING
All second attempts of skill testing will be evaluated by two instructors. If a student fails an essential skill on the second attempt, he may no longer continue in the nursing course. Mandatory witnessed practicing of the skill must be documented before allowing a second attempt. A student may withdraw with a “W” up to midterm per KCTCS rules. After midterm, providing the theory grade is at least 78% and clinical performance is at a satisfactory level, the student may be allowed to withdraw with a “W” at the discretion of the instructor.

Students must maintain competency of all skills in current and previous courses. Students deemed incompetent in the lab or clinical setting may be required to prove proficiency by reskilling procedures. The student repeating the skill test will be provided two attempts for success.

GUEST POLICY
According to KCTCS policy, guests, visitors, and/or family members will not be allowed to attend lectures, lab activities or observations. For the consideration of the students and faculty, please adhere to this policy. On the days when the public school is cancelled, your instructors and classmates cannot be expected to tolerate having your children at school with you. Please arrange to have a plan of care for your children in case this situation occurs.

WORK LOAD
Students are advised not to work in outside employment more that 16 - 20 hours per week. These hours should be other than 11-7 before a 7AM clinical practicum.

Work schedules should not interfere with class schedules or clinical experiences. Academic learning experiences must take priority over employment schedules while in the nursing program.

PORTFOLIO
Each student is responsible for tracking his own professional career. In Nursing 101 each student will be given a folder and directions for maintaining a professional portfolio. The portfolio should contain any records that provide data that verify the student’s progress in his nursing career. The portfolio will be graded throughout the nursing program courses.
EMERGENCY

While on campus, if an emergency occurs, the Crisis Management Plan will be followed. If a life threatening emergency occurs, 911 will be contacted. The Crisis Management Plan is located in every classroom on campus. Faculty will request emergency contact numbers at the beginning of each semester and will place them on SharePoint. This will allow faculty access to contacts in the event of an on or off campus emergency. If an emergency occurs while a student is in a clinical experience off campus, your emergency contact will be notified and the emergency procedures of the clinical facility will be followed.

Should your family need to contact you on an emergency basis, please have your family telephone the Nursing Administrative Assistant, Dana Walker at 270-831-9740. We ask that you reserve this procedure for only true emergencies.

EXPENSES

In addition to regular college tuition, fees and cost of books, nursing students in the program will incur additional expenses for the following:

- Nursing Study Guide and Lab Manual
- Lab Packet
- School regulation uniform
- Name pin
- Neutral hose for women, neutral color socks for men
- Wristwatch with second hand
- Stethoscope
- Bandage Scissors
- Professional liability insurance (obtained through the college)
- Transportation to all health agencies
- KY Student Nurses Association Membership fees
- Lab Jacket
- Current Certification in CPR
- Specific Lab Tests and Immunizations required by health agencies*
- Graduation photo for composite
- Standardized Testing Program fee each semester
- NCLEX Review Course
IMMUNIZATIONS

1. Self-Reported Health History to be completed and signed by yourself.

2. Rubella and Rubeola titers or MMR immunizations (see Medical Form for details).

3. TB Risk Assessment, 2 step PPD test (TB skin test) unless you have had one in the last 12 months or Tspot. Must be updated annually.

4. **Tetanus-Diphtheria-Pertussis** (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years.). If you need to receive a tetanus vaccine, it is recommended **that you receive a Tdap injection.** (CDC Guidelines) This injection would also include the pertussis vaccine.

5. Documentation of at least the first injection of the Hepatitis B vaccine series. A waiver must be signed if you choose not to take the vaccine series or are unable to receive the vaccine at this time.

6. Proof of immunity to Chickenpox (Varicella) by reactive (positive) titer, OR proof of 2 doses of varicella immunization, unless documented contraindication verified by a physician.

7. Proof of having received the Meningitis vaccine. A waiver may be signed if you choose not to take the vaccine.

8. Documentation of flu shot (will accept drug store receipt including lot number and person administering the vaccination). Must be current for the year.

   * A Medical and Immunization Form and Self-reported health History will be emailed to you.

   Your forms, immunizations and labs will need to be completed and submitted to CastleBranch by the deadline set by your course instructor. Failure to do so may result in disciplinary action.

   If any of the lab work is contraindicated, please obtain a statement from your physician.

9. Liability Insurance - $11.00 fee will be included in the student’s tuition fee. The Liability
Insurance will cover you for the first semester.

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Henderson Community College  
Associate Degree Nursing Program  
Medical & Immunization Form

Name of Student: __________________________________________________________

**Immunizations Required** (Please have provider complete this form or attach documentation if immunizations and/or skin test given prior to receiving this form)

**Hepatitis B Vaccine**: (All college and health sciences students.)

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HCP Signature ______________________  

**OR**

**Hepatitis B Titre** (If performed)

Date: _________  Results: Reactive____ Non-reactive____  
HCP Signature: __________________________

---
MMR (Measles, Mumps, Rubella) (Two doses required at least 28 days apart for students born after 1956 and ALL health sciences students.)

Dose #1 ___________ Dose #2 ___________ HCP Signature: _____________________

OR

Born prior to 1957. Date of Birth: ________________

OR

Rubella Titer: Date: ___________ Results: _______ HCP Signature ____________________________

Rubeola Titer: Date: ___________ Results: _______ HCP Signature ____________________________

PPD (skin test for tuberculosis and must be within the last year)

Date given: ___________ Date read: ___________ Results: _______ Read by (signature): ____________________________

If results positive:

Chest x-ray: Date: ___________ Results: _______ Read by (signature): ____________________________

If medication prescribed for positive PPD:

Name of Medication(s): ____________________________

Dates taken: ____________________________

HCP Signature ____________________________

OR

Copy of Current Tuberculosis Questionnaire

Influenza

Date: ____________

Name of Student

Meningococcal Meningitis (Based upon recommendations from the CDC, the Kentucky Department of Public Health and the American College Health Association.)

Tetravalent conjugate Date: ____________ HCP Signature ____________________________

OR
Tetravalent polysaccharide Date: ____________ HCP Signature ________________________________

Tetanus-Diphtheria-Pertussis (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years.). If you need to receive a tetanus vaccine, it is recommended that you receive a Tdap injection. (CDC Guidelines) This injection would also include the pertussis vaccine.

Health science students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate.)

1. Primary series dates of four doses. #1 ___________ #2 ___________ #3 ___________ #4 ___________
2. Booster Tdap date: __________
3. Booster Td within last ten years: ______________
HCP Signature ________________________________

OR

Documentation of physician-diagnosed Pertussis.

Varicella (Chicken Pox)

1. Varicella antibody Date: _________ Result: Reactive_________ Non-reactive_________
2. Immunization Dose #1___________ Dose #2______________

HCP signature ________________________________

PREGNANCY AND CHANGE IN HEALTH STATUS

Students who are pregnant must submit to the Coordinator written permission from a physician to enter and/or continue in the Program. After surgery or and other hospitalization, a physician's release to return to clinical is required. The purpose of the statement is not to exclude the
student from the Program, but rather to safeguard the student and the student’s clients. If any of the immunization or PPD test is contraindicated due to pregnancy or other conditions, a physician’s statement should be submitted.

**PERSONAL INJURY**
Students who become injured and/or exposed to bloodborne pathogens at the college or at the clinical site must complete an incident form of the health agency and the College incident form (FM 84) immediately and file it in the Coordinator or Assistant Coordinator's office. The clinical faculty member will assist the student in completing the form FM 84. Additional laboratory test may be required and obtained at the Henderson County Health Department at the student’s expense.

**DISPOSABLE NEEDLE POLICY**
Due to the risk factor involved in transmission of bloodborne pathogens and the liability related to injury from discarded injection needles, the following policy will be adopted until further notice.

Students practicing with syringes in nursing must return all materials to the lab. Do not take syringes or needles out of the nursing area. Place the needle and syringe in a red plastic container marked bio-hazardous materials.

Anyone injured by a needle must complete an accident report to be filed in the nursing secretary's office. Routine puncture wound care will be initiated. This may include application of an antiseptic agent and Band-Aid, tetanus injection from your family physician, and follow up lab work. This is for your own protection.

**LIBRARY USE**
The Nursing Program of study requires a rather extensive use of the library. Selected books and journal articles have been placed on reserve in the library in order to be sure that at least one copy may be available to all students. All nursing books are limited to 3 day loan. Most of the journals are on microfilm except for the issues of the current year.

**GIFT POLICY**
No gifts are to be accepted from patient/clients. Awards/acknowledgements for nursing students will be handled by the nursing clubs or classes as a group. Students are discouraged from giving gifts to faculty.

**CHANGE OF ADDRESS**
The Nursing Program and the Admission's Office must be notified promptly of changes in name and address. Correct phone numbers must be available so that students can be reached in case of emergency or cancellation of class or clinical. Many request are received for the class list by area employers. Please notify the Coordinator if you do not wish your address and phone number printed on the roster for the class.
TRANSPORTATION
Students are responsible for transportation to assigned health care agencies.

BUILDING POLICIES
Henderson Community College is a tobacco/smoke free campus. The use of tobacco products is prohibited on campus and at clinical sites. Nurses are role models and providers of care and should avoid lifestyle factors associated with disease. Students are prohibited from smoking during clinical hours or immediately prior to reporting for clinical as smoke odor is offensive to many clients and may be harmful to clients with health issues. Students who do have the habit of smoking are encouraged to enroll in smoking cessation self-help groups available at the local hospitals and the American Cancer Society.

NURSING LAB POLICIES
1. Placebos (Candy pieces, Practi-Meds, water/flavored water will be used to simulate oral meds). Original medicine bottles will have medication discarded per accepted method and contain only water/flavored water.
2. IV fluids with expired dates will be used for demonstration and practice.
3. All drawers/closets with needles, IV catheters, any sharps will be locked at the end of the day.
4. Needles will be used only in the lab. Needles and syringes, ICV catheters that are in the first semester, NSG 101, Medication Packs will be turned in to lab personnel on their first lab day to be stored in the lab. IV catheters and needles will be discarded once used in sharps containers.
5. Students will only be allowed to recap needles when practicing drawing up medications under the supervision of the Faculty or Skills Lab personnel. Student must demonstrate safety policies when utilizing needles during practice.
6. No food or drinks around the computers.
7. All trash must be discarded or the privilege of food and drink may be rescinded.
8. At the end of the Lab session all needles used must be placed in the RED SHARP boxes. All trash and discarded gloves must be placed in appropriate receptacles. All practice skill supplies should be placed in assigned areas.
9. Cell phone use is prohibited without permission of the instructor. Cell phones may only be used for learning or instructional purposes.

Use of Nursing Learning Skills Lab: The Learning Skills Lab is available for all students to use. Students will have specific assignments to complete in the lab outside of the regular scheduled lab sessions. The hours of the Learning Skills Lab are 8:00 AM to 4:30 PM, Monday through Friday, and may be open on Saturday from 8:00 AM to 12:00 PM upon student request. Please inform the instructional specialist in the
lab if there is equipment or software not working properly. If the instructional specialist is not present, provide in writing a detailed description of the malfunction and give it to the secretary. Because of recent loss of expensive audio/visual materials, **no items will be loaned from the Nursing Lab.** Please be considerate and courteous to waiting students when using computers in the Nursing Lab. Students taking the Pharmacology course via the internet will be given priority to the computer work stations.

**Bulletin Boards:** There are bulletin boards located in the nursing labs and in the classrooms. The bulletin boards provide information topics of interest to the student nurses. Before posting a flyer or information on the bulletin boards, please check with the secretary. A three-week time period will be allowed for each item. Please remove your posting after that time frame.

**Mailboxes:** In the lab area there are mailboxes for each student. Please check your mailbox regularly. Students and faculty may leave messages or other items in the boxes.

**PREPARATION FOR CLASS AND LABORATORY**
Generally, it is accepted that for every hour of class, there should be at least two hours of preparation. This may be too little for some students. In nursing, it is expected that there will be preparation for laboratory sessions. It would seem then that reasonable minimum time for nursing students would be two hours of preparation for each hour of class PLUS one hour of preparation for each scheduled laboratory (college or clinical).
Hospital regulations regarding dress code must be observed when preparing for clinical.

**ASSIGNMENTS**
All written work must be completed neatly using proper grammar and spelling, using acceptable standards of English. If unacceptable, the student will be required to rewrite the paper. Referral will be made to the Learning Resource Center for assistance. If papers are handwritten, ink is required and leave a margin of 1 1/2 inches to the left. Please do not use sheets with ragged edges. Use one side of the paper only. Typewritten papers should be double-spaced. All pages should be numbered. Patient/client names are never to be used in written assignments. Initials are to be used. A face sheet is expected to be attached to all written materials. Computers for student use are available throughout the campus. Exceptions apply when detailed otherwise by a course faculty person.

**ASSOCIATION OF STUDENT NURSES (HANS/KANS)**
All students are **expected** and strongly encouraged to join and participate in the professional Student Nurses Association: Henderson Community College Association of Nursing Students and the Kentucky Association of Nursing Students. Students will be allowed to elect officers and a class representative at the beginning of each year. At the discretion of the faculty, student members of HANS/KANS who are in good academic standing may attend the annual KANS convention.
NURSING STUDENTS CLASS OFFICERS
The following class officers are elected each semester or year according to the majority of the class:
President: responsible for keeping the class abreast of issues in the Program of Nursing as well as Henderson Community College and HANS. Leads the class to make decisions. The other class officers are responsible to the president.
Vice-President: takes the place of the president when he cannot be present. Presents and researches projects for the class to undertake. Is responsible to the president.
Treasurer: responsible for collecting money for class projects. Is responsible to the president.
Secretary: maintains correspondence for the class and president. Keeps records and announcements for the class. Is responsible to the president.

EXAMINATION POLICY (Revised May 2018)
TEST REVIEW/REMEDICATION
The HCC nursing faculty conduct one-on-one review/remediation to foster student success. It is the faculty’s belief one-on-one exam review/remediation supports individualized assessment of student learner strengths and weaknesses related to content concepts and test-taking strategies. Individualized review/remediation provides an opportunity for collaboration and plan development with the student.
1. Faculty will provide one-on-one exam reviews for all students who are unsuccessful on any exam, excluding the final exam.
2. Students who are unsuccessful on an exam must complete the one-on-one test review/remediation prior to sitting for the next exam. Students must complete the one-on-one remediation to be eligible to sit for the next exam.
3. Students are responsible for scheduling one-on-one exam review/remediation sessions with faculty. Faculty should make reasonable effort to remind and facilitate scheduling and completion of the one-on-one review/remediation session.
4. Faculty will provide opportunities for all students to set up one-on-one test review by student request.
5. One-on-one exam reviews/remediation are only provided prior to the next scheduled exam. Thereafter reviews are closed.
6. All test reviews are to be one-on-one between the student and faculty member(s). To facilitate test security, group test reviews are not permitted.
7. Exams/quizzes administered online in a non-proctored setting are not to be opened to the class for student review purpose post student submission. On-line exam/quiz reviews are offered on a one-on-one basis per student request.

TEST ADMINISTRATION
1. Students will be asked to sign a confidentiality statement prior to each test.
2. Students should use Mozilla Firefox, Microsoft Edge OR Chrome to sign on to Blackboard. No other programs should be running during the testing time. Students must make every effort to arrive on time for testing. If a student is ≤14 minutes late for an exam, the student will be allowed to sit for the test but no extra time will be allotted. Therefore, if the exam time was set for 60 minutes and a student is 10 minutes late, the student will have 50 minutes to test. If a student is ≥15 minutes late for an examination the student will be considered absent and will not be allowed to test.
3. Students are expected to utilize the restroom facilities prior to testing. Should a special circumstance arise and a student needs to leave the examination area, only one student will be allowed to leave at a time.

4. In the event a student is found to be or have cheated on an exam, the student will receive an “E” for the course and automatic withdrawal from all nursing courses. Students found in violation of this policy will not be eligible for readmission to any Henderson Community College nursing program. Cheating constitutes any form of academic dishonesty including but not limited to the following: copying, printing, emailing, or selling an exam or otherwise reproducing any portion of an exam and accessing a web site or other documents /materials during the exam.

5. The students are to completely turn off the computer as soon as the test is submitted and reviewed. Students should not close the desk lids to the computers to avoid distracting noises. Students may not use the computer for any other activities during the testing time. This includes checking email, using Google, etc. Students may exit quietly when testing is complete, unless instructed otherwise by nursing faculty. Students may not loiter in the hallway outside the testing room.

6. Students must turn in their keys, phone and smartwatches prior to testing. If a student doesn’t bring their phone, they will be asked to retrieve it from their vehicle or they will be seated at the computer closest to the proctor. Only a pen, blank sheet of paper (provided by faculty) and testing form can be on the student’s desk. A blank sheet of paper or notecard provided by faculty may be used to obstruct answers to test questions so that the students can read each answer with each question if this is helpful. All paper/notecard must be turned in to faculty prior to exiting the test room. Jackets, sweaters and hooded sweatshirts will be subject to inspection by the nursing faculty.

7. There will be a hard copy of an answer sheet provided for students to mark in addition to using the Blackboard. This is a safeguard measure and will be kept by the faculty of the course. The answers recorded on this document will only be reviewed in the event that Blackboard malfunctions and doesn’t record a response. Otherwise, answers recorded by the computer stand. Students must notify the faculty of the malfunction as it occurs during the test or the student forfeits the right for that question to be reviewed.

8. Students are expected to open and minimize the computer calculator prior to opening their test. Students will utilize the computer calculator for testing purposes.

9. In the event a test is found to be available for review outside of testing time, the student is responsible to notify the faculty. At no point is a student allowed to copy/print/discuss any part of a test without written faculty consent.

10. Students may wear earplugs during a test. In the event a test has an audio question the student is responsible to supply their own ear buds and ensure their proper functioning prior to the exam.
11. Two proctors are recommended for any test administration.

12. As students log in to blackboard, faculty should circulate the room to view computer screens noting any extra open window markers. Faculty should continue circulating the room for the duration of the test. Faculty should position themselves in a manner that allows them the ability to visualize as many screens as possible.

13. Once all students are logged on the password is given and the exam begins. Once all students re logged the faculty will change the password.

14. All tests are timed and test options in Blackboard are set to automatically submit the test when time is up. The faculty will set individual time for students with documented accommodations.

15. Faculty will enter the test room prior to the test and place students in randomized seating. When possible leave a space between computers. When computer availability does not allow for spacing between students, faculty should use the row closest the faculty for side by side seating.

16. Tests questions may be randomized at the discretion of the instructor. In the event there is a concern students are cheating, exam questions must be randomized.

17. In the event a student requires accommodations, the student is responsible for meeting with the Coordinator of Disability Services and securing proper documentation of their accommodation each semester. The faculty must have received documentation from the Coordinator of Disability Services before an accommodation may be honored. If a student has documented accommodations for testing, the student will take exams with the Coordinator of Disability Services. The faculty will communicate with the Coordinator of Disability services for scheduling.

18. Exams are to be analyzed and results communicated within five business days.

19. Faculty will make available the test question challenge form at the time of the test. In the event a student wishes to question a test item, the student is required to complete the test question challenge form provided by the faculty within the designated parameters.

20. Once all exams are completed faculty will ensure test papers are secured and the test availability is closed.

21. In the event a student misses one exam in a six (6) or nine (9) hour nursing course the score for the missed exam will be the average of the other course unit exams minus 5%. The score for additional missed exams in the course will be a zero. In the event a student misses one exam in a three (3) hour course the score for the missed exam will be the average of the other course unit exams and the final minus 5%.

22. The final of all nursing courses must be attempted. Failure to attempt the final exam will result in a grade of “I” for the course.
23. In the event a student does not take the final exam in any nursing course a make-up final exam will be scheduled at the instructor’s discretion and may be subject to increased difficulty and/or alternate format. There will be a 5% deduction in the student’s final exam score.

Unannounced quizzes may be given throughout the semester. Students must be present and seated in the classroom while the quiz is being administered, in order to take the quiz. No one will be allowed to take the quiz after the time allotted for it, and no make-up quizzes will be given.

*Students found cheating shall be disciplined according to the Student Code of Conduct and are subject to getting no credit for the exam/quiz or dismissal from the program.*

**AWARDS**
Several awards may be given to nursing students graduating. Usually these awards are for the most improved nursing graduate, nursing excellence and leadership or service. Priority in selection of recipients for the awards will be given to students who are members of Henderson Association of Nursing Students. The nursing faculty selects and students who receive the most nursing faculty votes receive the awards.

**WEATHER-RELATED CLASS CANCELLATION/DELAY POLICY**
Faculty will follow the College policy for cancellation of classes due to inclement weather. In general, listen to 680-WSON AM, 99.6-WKDQ FM, or watch Channel 25-WEHT for instruction. Additionally, in Owensboro 96.0-WSTO FM and 92.5-WBKR FM. If you must leave early before the announcement is made in order to arrive at clinical on time, contact your individual clinical instructor. For general, non-clinical closings, students should sign up for SNAP alerts.

**PATIENT/CLIENT CONFIDENTIALITY/HIPAA**
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 establishes national standards for insuring the security and privacy of identifiable patient information. Healthcare providers are required to be in full compliance with the standards or face potential civil and criminal penalties. The privacy standards established new rights for patients to control the use and disclosure of their personal health information. The following guidelines were established to provide direction while on clinical rotations:

- Patient information should only be discussed with other members of the health care team who have a "need to know".
- **Do not** discuss patient information with anyone else, including fellow students, employees, and your family members. Be especially careful on the hospital elevators, cafeteria and coffee shops.
- Do not tell unauthorized persons that you saw or have knowledge of a patient being admitted or being seen as an outpatient unless the patient authorizes you to do so.
- Do not access any patient information (i.e. looking up a neighbor's medical record) unless authorized in your job duties.
- Speak quietly and discreetly so patients, visitors, and others will not overhear your telephone or other conversations with or about patients.
- Do not leave papers containing patient information in open view of non-authorized persons.
- Do not leave a computer on the bright screen if you must be away for a moment.
- Do not discard papers containing patient information in the trash can without first shredding them.
- Remember that when fellow students, friends, faculty members receive medical treatment, that person is a patient and all measures should be taken to protect their confidentiality.
- Ask visitors to step out of a patient's room when conversations take place regarding medical treatment, diagnosis, etc. unless the patient authorizes the visitor to be present.
- When you are assigned to handle confidential information of your friends or acquaintances, if possible ask to be reassigned to another patient to protect that person's privacy as much as possible.
- Do not ask fellow students, hospital employees or faculty about confidential matters of their assigned patients unless absolutely necessary to help in the performance of your assignment.
- **Breaching confidentiality could result in prosecution for invasion of privacy and termination from the Nursing Program.**

*All Nursing students must sign the “confidentiality agreement” located in this handbook.*

**FERPA (Family Education Rights and Privacy Act)**

The Family Educational rights and Privacy Act (PL 93-380) includes provisions that protect the privacy of students. These include:

1) The right to inspect and review their education records with 45 days of the college receives a request for access.

2) The right to request the amendment of their education records that they believe are inaccurate.

3) The right to consent to disclosure of personally identifiable information contained in their education record, except to the extent that FERPA authorizes disclosure without consent. An exception is disclosure to school officials within the college who have a legitimate education interest.

4) The right to file a complaint with the U.S. Department of Education concerning alleged failures by the college to comply with the requirements of FERPA.

*(More detailed information is located in student code of conduct section 1.4)*
From
American Nurses' Association, Code for Nurses with Interpretive Statements
1985

1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by consideration of social or economic status, personal attributes, or the nature of health problems.
2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.
4. The nurse assumes responsibility and accountability for individual nursing judgements and actions.
5. The nurse maintains competence in nursing.
6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.
8. The nurse participates in the profession's efforts to implement and improve standards of nursing.
9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.
10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.
11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

Statement on Academic Honesty

Honesty is central to the profession of nursing as well as to the academic process. Acts of academic dishonesty are serious offenses at Henderson Community College AD Nursing Program. The Kentucky Community and Technical College System Code of Student Conduct outlines nonacademic, and academic offenses in Article III. The following are further examples of both types of offenses:

1. Claim or submit the academic work of another as one’s own.
2. Procure, provide, accept or use any materials containing questions or answers to any Examination or assignment without proper authorization.
3. Complete or attempt to complete any assignment or examination for another individual 
    Without proper authorization.
4. Alter, tamper with, destroy or otherwise interfere with the use of institutional property, 
    Including but not limited to classroom fixtures, laboratory and/or computer equipment and 
    supplies and instructional materials.
5. Fabricate or falsify data or results.

You commit plagiarism if you submit as your own work:
--part or all of an assignment copied or paraphrased from another person’s manuscript, notes or 
    Talk (lecture);
--part or all of an assignment copied or paraphrased from anything published.

You are an accomplice in plagiarism if you:
--allow your work, in outline, draft, or finished form, to be copied and submitted as the 
    work of another;
--prepare an assignment for another student which he/she submits as his/her own 
    work;
--keep or contribute to a file of papers or presentations which anyone other than the 
    author adopts and submits as his/her own work.

Students participating in such activities will be subject to disciplinary sanctions in accordance with the Kentucky Community and 
Technical College System Code of Student Conduct.

Henderson Community College Policy Statement on Plagiarism and Cheating

The following statements and information are taken from the Kentucky Community and Technical College System Code of Student Conduct, 
Section 2.3.1.1 through 2.3.1.4 page 11.

2.3.1.1 Plagiarism
Plagiarism is the act of presenting ideas, words, or organization of a source, published or not, as if they were one’s own. All quoted material 
must be in quotation marks, and all paraphrases, quotations, significant ideas, and organization must be acknowledged by some form of 
documentation acceptable to the instructor for the course.
Plagiarism also includes the practice of employing or allowing another person to alter or revise the work that a student submits as the student’s own. Students may discuss assignments among themselves or with an instructor or tutor, but when the actual material is completed, it must be done by the student and the student alone. The use of the term “material” refers to work in any form including written, oral and electronic. All academic work, written or otherwise, submitted by a student to an instructor or other academic supervisor, and is expected to be the result of the student’s own thought, research, or self-expression. In any case in which a student feels unsure about a question of plagiarism involving the student’s work, the student must consult the instructor before submitting the work.

2.3.1.2 Cheating
Cheating includes buying, stealing, or otherwise obtaining unauthorized copies of examinations, or assignments for the purpose of improving one’s academic standing. During examinations or in-class work, cheating includes having unauthorized information and/or referring to unauthorized notes or other written or electronic information. In addition, copying from others, either during examinations or in the preparation of homework assignments is a form of cheating.

2.3.1.3 Student Co-Responsibility
Anyone who knowingly assists in any form of academic dishonesty shall be considered guilty as the student who accepts such assistance. Students should not allow their work to be copied or otherwise used by fellow students, nor should they sell or give unauthorized copies of examinations to other students.

2.3.1.4 Misuse or Student Falsification of Academic Records
The misuse or actual attempted falsification, theft, misrepresentation, or other alteration of any official academic record of the college is a serious academic offense. As used in this context, “academic record” includes all paper and electronic versions of the partial or complete academic record.
Students participating in such activities will be subject to disciplinary sanctions in accordance with the Community College Code of Student Conduct. (located on page 11 in the student code of conduct.)
Students have the right to appeal and this process can be located on pages 12 through 18 in the student code of conduct.

DISRUPTIVE CLASSROOM BEHAVIOR
The following statements and information are taken from the Kentucky Community and Technical College System Code of Student Conduct Article 3.1 page 18-19. This is a partial list. For a complete list refer to Article 3.1.

3.1 General Regulations Concerning Student Behavior
Students are responsible for knowing the college’s regulations, disciplinary procedures, and penalties. It should be emphasized that students are subject to criminal statutes and legal action, in addition to the college’s regulations and disciplinary system.

3.2 Disciplinary Offenses:
Though not an inclusive list, the offenses are defined as below are punishable disciplinary offenses. Lack of intent may be asserted as an affirmative defense by any student charged with an offense listed below.

The following is a few of the offenses that are listed in the code of conduct.

1. Material disruption or obstruction of teaching, research, administration, disciplinary proceedings, or any other college activities. Under no circumstances will fighting be tolerated while on college property or at off-campus events sponsored by the college.
2. Assault and/or battery.
3. Verbal or psychological abuse or harassment.
4. Participating in or inciting of a riot or an unauthorized disorderly assembly.
5. Seizing, holding, commandeering, or damaging any property or facilities of the college upon direction by college officials or other persons authorized by the institution.
7. Use of alcoholic beverages, including the purchase, consumption, possession, or sale of such items except where specifically authorized by state law and regulations of the college.
8. Failure to comply with the official and proper order of a duly designated college official.
9. Unauthorized use of computers on word processors or unauthorized efforts to penetrate or modify the computer or word processing security system or any program software.
10. Allowing children under the age sixteen (16) to remain unsupervised while on campus.
11. Threats and/or threatening behavior.

HENDERSON COMMUNITY COLLEGE
SMOKING POLICY

There will be no smoking, e-cigarette use, or any other tobacco products used on HCC campus property. You may use these products in private vehicles as long as no smoke, ash or butts escape the vehicle.
SOCIAL NETWORKING POLICY

The growing use of social media (Facebook, My Space, Twitter, etc.) by students and staff has led many schools to consider developing acceptable use policies. There is tremendous opportunity for improving education through the use of social media. There is also potential risk because social media can be used to access age inappropriate information and to engage in aggressive online behavior.

 Posting personal images, experiences and information on these kinds of public sites pose a set of unique challenges for all members of the Henderson Community College personnel (employees, faculty, students, and administrators). Each of these people has a responsibility to the institution regardless of where or when he/she posts something that may reflect poorly on Henderson Community College (HCC) and specifically the nursing program. The following guidelines outline appropriate standards of conduct related to all electronic information (text, image or auditory) that is created or posted externally on social media sites by Personnel affiliated with the Henderson Community College nursing program.

Best Practices

1. **Take responsibility and use good judgment:** you are responsible for the material you post. Be courteous, respectful, and thoughtful about how other people may perceive or be affected by posting. Incomplete inaccurate, inappropriate, threatening harassing or poorly worded posting(s) may be harmful to others. The postings may damage relationships, undermine HCC’s brand or reputation, discourage teamwork, and negatively impact the institution’s commitment to patient care, education, and community service.

2. **Think before you post:** anything you post is highly likely to be permanently connected to you and your reputation through internet and email archive. Future employers can often have access to the information and use it to evaluate you. Take great care and be thoughtful before placing your identifiable comments in the public domain.

3. **Protect patient privacy:** disclosing information about patients without written permission, including photographs or potentially identifiable information is strictly prohibited. These rules also apply to deceased patients and to posts in the secure section of your Facebook page that is accessible by approved friends only.

4. **Protect your own privacy:** make sure you understand how the privacy policies and security feature work on the sites where you are posting material

5. **Respect work commitments:** ensure that your blogging, social networking, and other external media activities do not interfere with your work or classroom commitments.

6. **Identify yourself:** if you communicate in social media about Henderson Community College &/or the nursing program and your role, use good judgment and strive for accuracy in you communications. False and unsubstantiated claims and inaccurate or inflammatory posting may create a liability for you.

7. **Use a disclaimer:** where your connection to HCC is apparent, make it clear that you are speaking for yourself and not on behalf of HCC. A disclaimer, such as, “The views expressed on the (blog, website) are my own and do not reflect the views of my “employer” or school” may be appropriate.
8. **Respect copyright and fair use laws:** For Henderson Community College’s nursing program’s protection as well as your own, it is critical that you show proper respect for the laws governing copyright and fair use of copyrighted material owned by others, including Henderson Community College’s own copyrights and brands.

9. **Protect Proprietary Information:** Do not share confidential or proprietary information that may compromise Henderson Community College’s business practices or security. Similarly, do not share information in violation of any laws or regulations.

10. **Seek expert guidance:** Consult with the Marketing and Communications department if you have any questions about the appropriateness of material you plan to publish or if you require clarification on whether specific information has been publicly disclosed before you disclose it publicly.

REFER TO STUDENT CODE OF CONDUCT
Students participating in such activities will be subject to disciplinary sanctions in accordance with the Kentucky Community and Technical College System Code of Student Conduct. Information on plagiarism & cheating can be found in The Community College Code of Student Conduct, Section 2.3.1.1 through 2.3.1.4 page 11.

FORMS
HENDERSON COMMUNITY COLLEGE ASSOCIATE DEGREE/LICENSED PRACTICAL NURSING PROGRAM FOR CAUSE TESTING CHECKLIST

Student Name (Print) ________________________________________ Date: ____________
Department: __________________________ EMPL ID # ___________ Time: ____________
Administration/Faculty/Staff Member (Print): ________________________________________
Witness (Print): ________________________________________________________________

The following check list is to be completed by the administrator/faculty/staff member involved, to help determine whether or not a student will be tested for current impairment from alcohol/drugs. This section must be completed prior to the interview conducted with the student. If a student smells of alcohol, he/she will be tested immediately on that basis alone.

Drug abuse must be suspected in order to test. Testing will not be conducted on the basis of performance issues only.

BEHAVIOR/GAIT

__ Alternate period of high and low productivity __ Unsteady
__ Disappearance from College: classes/clinicals __ Deliberate or overly careful
__ Difficulty performing ordinary tasks* __ Swaying
__ More time needed to complete job* __ Leaning
__ Boisterous __ Stooped
__ Difficulty recognizing individuals
__ Easily agitated SPEECH
__ Erratic and disjointed actions*
__ Sleeping in class/clinicals/lab __ Slurred speech________
__ Hostile, crying, talkative __ Unusually loud
__ Increased errors __ Unusually fast
__ Credible report of suspect drug/alcohol use or abuse __ Unusually slow __ Accident or injury __ Incoherent

OVERALL PHYSICAL APPEARANCE/CLOTHING EYES

__ Flashed, red face __ Red
__ Lethargic, sleepy __ Watery
__ Hyperactive* __ Heavy eyelids
__ Tense, unduly nervous* __ Pupils constricted
__ Poor coordination* __ Pupils dilated
__ Drooling
__ Coming to College with a dramatic change in physical appearance

**ODOR CONFUSION**

__ Distinctive odor of intoxicant on breath
__ Difficulty in recalling instructions,
__ Distinctive odor on clothing or about person details, etc.
__ Mints, gum, mouth wash or breath spray
__ Difficulty in recalling mistakes
__ Difficulty remembering recent events

*Please provide specific information to help clarify your observations:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Other observations or details: __________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

For Cause Testing Checklist and Questions for Suspected Substance Abuse, must be completed before drug testing. Forms should be filed with the Chief Student Officer.

Signed: ________________________________________________________________

Completed by: ______________________ Title: _____________________ Date: __________

Witnessed by: ____________________________________________________________
### Re-Admission Application

<table>
<thead>
<tr>
<th>Re-Admit Applicant Information</th>
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<tbody>
<tr>
<td>Student Name:</td>
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<td>Student ID #:</td>
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<td>Student Address:</td>
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<td>Student Phone #:</td>
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<td>Program:</td>
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**COMMUNITY COLLEGE SYSTEM RULES, Sec. IV, Pg. 33, 2.30, Re-Admission**

1. A student who withdraws from or earns lower than a grade of C in a nursing course will be dropped from the Nursing Program.
2. Applicants who wish to apply for re-admission should do so prior to March 1 if
planning to enroll for the subsequent Fall semester in Nursing I or by July 1 if planning to enroll for the subsequent January semester in Nursing I. Otherwise applicants should apply at least two months prior to expected date of enrollment.

3. Re-admission to the Nursing Program will be dependent upon available resources.

4. Meet current guidelines for admission. A composite standard score of 20 or above on the ACT or equivalent on the SAT is required for the Associate Degree Nursing Program, minimum Preadmission standardized testing score, and completion of MAT 150 – College Algebra (with a grade of “C” or better). A composite standard score of 18 or above on the ACT or equivalent on the SAT is required for the Practical Nursing Program.

5. If more than 3 years have elapsed since initial enrollment in any registered Nursing Program, an applicant must repeat all nursing courses.

6. A student may be re-admitted to the Nursing Program one time. The Nursing Admissions Committee may recommend re-admission a second time if a student furnishes sufficient evidence of remedial study, additional preparation or resolution of factors contributing to unsuccessful course completion.

7. Students seeking readmission to NSG 210, 220 or 230 (and relative practicing corresponding courses) or NPN 135, 202, or 206 will be required to establish retained competency and the student be required to take the previous Medical-Surgical course Comprehensive Final Exam and earn at least a 78%.

8. Students may be required to readmit into the program beginning with the first nursing course (NSG 101). When this occurs, the student must take all nursing courses in succession, regardless of past success.

9. When a student reads into courses (with the exception of NSG 225 or NSG 213), but is not required to restart in NSG 101, they will only be required to retake the course in which they were unsuccessful. If a student is not successful in NSG 225 and / or NSG 213, the student must also retake NSG 230, regardless of past success in the course.

Please respond to the following questions below:

1. Have you ever been re-admitted to this or any nursing / allied health program before?

☐ Yes       ☐ No

2. If “yes,” list the name of the program and the name of the college or university.

_______________________________________________________________________________________________
3. How many times have you been re-admitted to a nursing/allied health program before?

☐ None ☐ Once ☐ Twice ☐ Three times or more

4. If you marked any box other than "none" on the previous page, please specify the name of the program and the college or university for each occasion you were readmitted.

Date(s): ____________________________

Name of program(s): ____________________________

Location(s): ____________________________

5. Are you currently working?  ☐ Yes  ☐ No

If yes, how many hours per week are you currently working?

1-6 hours  ☐ 6-12 hours  ☐ 12-18  ☐ 18-30  ☐ 30-40

6. If readmitted, how many hours per week will you be working? ____________________________

7. In the space provided, describe why you were unable to complete the program. Be specific and share only relevant details.
8. In the space provided, describe all changes you’ve made and steps you’ve taken to ensure your success should you be readmitted.
9. I certify that all the information provided above is accurate and true.

(Readmission applicant signature) ___________________________ (Date) ___________________________ (Empl ID #)

10. **References:** You will need the endorsements of two nursing faculty in whose classes you were enrolled when you were last in the Nursing Program. One must be theory and the other may be theory or clinical. Please give this page to the Nursing faculty member to complete. The faculty member should return it to the Coordinator of the Nursing Program.

11. Nursing Faculty #1 Name: _______________________________________________________________________

   Program and institution: _______________________________________________________________________

   Student's name: _____________________________________________________________________________

12. Check one of the following: I recommend ______________________________________  be readmitted to the ___ program beginning ___________ term with no stipulations

    □ be readmitted to the _____________ program beginning _____________ term with stipulations listed below

    □ not be readmitted at this time.

    **Use this space to provide additional information not listed above and any stipulations you deem necessary:**
13. This page has been verified for its accuracy and receives my full endorsement.

_____________________________________________________________________________________________

(Nursing Faculty #1 Signature) (Date)

14. Nursing Faculty #2 Name: __________________________________________________________________

   Program and institution: _____________________________________________________________________

   Student's name: ____________________________________________________________________________

15. Check one of the following: I recommend ____________________________________________________

   □ be readmitted to the __________ program beginning __________ term with no stipulations

   □ be readmitted to the __________ program beginning __________ term with stipulations listed below

   □ not be readmitted at this time.

Use this space to provide additional information not listed above and any stipulations you deem necessary:
16. This page has been verified for accuracy and receives my full endorsement.  

(Nursing Faculty #2 Signature)       (Date)  

17. Date this form received by Nursing Department: _______________________________  

18. Date and action of Nursing Admissions Committee: _______________________________  

19. Signature of Chair Nursing Admission Committee: _______________________________  

COMPUTER TESTING POLICY/Cover SHEET
24. Students will be asked to sign a confidentiality statement prior to each test.

25. Students should use Mozilla Firefox to sign on to Blackboard. No other programs should be running during the testing time.

26. Students must make every effort to arrive on time for testing. If a student is \( \leq 14 \) minutes late for an exam, the student will be allowed to sit for the test but no extra time will be allotted. Therefore, if the exam time was set for 60 minutes and a student is 10 minutes late, the student will have 50 minutes to test. If a student is \( \geq 15 \) minutes late for an examination the student will be considered absent and will not be allowed to test.

27. Students are expected to utilize the restroom facilities prior to testing. Should a special circumstance arise and a student needs to leave the examination area, only one student will be allowed to leave at a time.

28. In the event a student is found to be or have cheated on an exam, the student will receive an “E” for the course and automatic withdrawal from all nursing courses. Students found in violation of this policy will not be eligible for readmission to any Henderson Community College nursing program. Cheating constitutes any form of academic dishonesty including but not limited to the following: copying, printing, emailing, or selling an exam or otherwise reproducing any portion of an exam and accessing a web site during the exam.

29. The students are to completely turn off the computer as soon as the test is submitted. Students may not use the computer for any other activities during the testing time. This includes checking email, using Google, etc. Students may exit quietly when testing is complete, unless instructed otherwise by nursing faculty. Students may not loiter in the hallway outside the testing room.

30. Students must turn in their keys, phone and smartwatches prior to testing. If a student doesn’t bring their phone, they will be asked to retrieve it from their vehicle or they will be seated next to the proctor. Only a pen, blank sheet of paper (provided by faculty) and testing form can be on the student’s desk. A blank sheet of paper may be used to obstruct answers to test questions so that the students can read each answer with each question if this is helpful. Jackets, sweaters and hooded sweatshirts will be subject to inspection by the nursing faculty.

31. There will be a hard copy of an answer sheet provided for students to mark in addition to using the Blackboard. This is a safeguard measure and will be kept by the faculty of the course. The answers recorded on this document will only be reviewed in the event that Blackboard malfunctions and doesn’t record a response. Otherwise, answers recorded by the computer stand. Students must notify the faculty of the malfunction as it occurs during the test or the student forfeits the right for review.

32. Students are expected to open and minimize the computer calculator prior to opening their test. Students will utilize the computer calculator for testing purposes.

33. In the event a test is found to be available for review outside of testing time, the student is responsible to notify the faculty. At no point is a student allowed to copy/print/discuss any part of a test without written faculty consent.

**I have read and understand the computer testing policy as provided and will keep the test information confidential.**
Please record your score and return this sheet before leaving the test center. Score:______________ out of ________________ = __________%  

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A satisfactory performance is defined as one in which the student demonstrates **ALL** of the critical requirements for **each** skill tested.

**SKILL TESTING POLICY**
Each skill will be demonstrated by faculty at a designated time followed by a scheduled lab practice during which faculty will be present. No more than three exams/skills/retests, etc. can be scheduled in one day. This does not apply to quizzes.

Emphasis will be placed on preparing student for the first skill test. Two mandatory practices will be required before re-testing a skill. An ISBARR format report and incident report will be required following a skill failure. A reflective paper, including the appropriate disclosure of the error and potential legal implications will also be required and will be due prior to the scheduled second attempt.

A minimum of one week and a maximum of 2 weeks shall elapse before the second test. The student should make arrangements with a faculty member or instructional specialist for the practice sessions before the date of retest. No student will be allowed to retest until all practice sessions and assignments have been completed. The signed sheet is to be turned in to the instructional specialist/faculty as confirmation of the practice period.

The student should also review all pertinent reading and audio-visual aids, and practice independently. When a second test is necessary, two faculty members will participate in the evaluation of the student’s performance. An “unsatisfactory” performance on second test will result in a final grade of “W” for the course if theory is at least 78% and clinical is satisfactory.

**Appointment for supervised practice:**
1.) Date____________ Time __________ Teacher ____________________
2.) Date____________ Time __________ Teacher ____________________

Additional Practices:
1. Date_____________________ Time______________ Teacher____________________

2. Date_____________________ Time______________ Teacher____________________

Date when skill must be completed ___________________________________________ Additional instructions:
------------------------------------------------------------------------------------------------------------
Appointment for supervised practice:
Date: _________________ Time ______________ Teacher________________________

Appointment for retesting:
Date: _________________ Time ______________ Teacher________________________

Teacher________________________

HENDERSON COMMUNITY COLLEGE NURSING PROGRAM
Clinical Safety/Jeopardy Form

Student Name _________________ Date Incident Occurred _____________

Instructor Name _______________ Clinical Affiliate ___________________

Detailed description of incident:
Remediation required:

Remediation instituted:

Student Comments:

This is Clinical jeopardy # 1 2 3 for the student (please circle)

Student Signature _______________________________Date ___________

Instructor’s Signature ____________________________Date ___________
HENDERSON COMMUNITY COLLEGE NURSING PROGRAM
Clinical/Laboratory Make-Up Time Form

Student Name _________________________________________________

Instructor Name _______________________________________________

Reason______________________________________________________

Clinical Affiliate ______________________________________________

The student was absent/tardy (circle)

Yes     No

Amount of make-up time required _________________________________

Date make-up time must be completed _____________________________

Specific make-up assignment ___________________________________

I am aware of the make-up time required and realize that failure to complete the make-up time as outlined will affect my success in clinical.
Student Signature _____________________________ Date ____________
Instructor Signature ___________________________ Date ____________
Instructional Specialist _________________________ Date ____________

Laboratory Make-Up

Student Name _________________________________________________

Time ________________________________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Time In</th>
<th>Time Out</th>
<th>Total Time Spent</th>
<th>Instructor/Instructional Specialist</th>
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HENDERSON COMMUNITY COLLEGE NURSING PROGRAM
Student Conference Form

Date ______________ Location ______________________ Time ________
Student ______________________ Name of Faculty___________________

I. Initiator of Conference:
   _____ Faculty Request  _____ Student Request

II. Focus of this conference – to evaluate and clarify the student’s:
   ___Clinical Progress   ___Academic Progress   ___Cumulative Average
   ___Tardiness        ___ Illness                   ___Missing Assignments
   ___Interpersonal    ___Failure to Complete Clinical Assignments
   ___Other

III. Type of Conference: ___Awareness  ___Verbal  ___Written
   Student Status: ___ Jeopardy Situation, Clinical
                    ___Academic Below Clinical Standard
   Failure to Complete: ___Liability ___ Health Form Requirements

IV. Reason/Situation Basis for Conference: _____________________________________
    ________________________________________________________________
    ________________________________________________________________

V. Student’s Explanation of Events: _______________________________________
   ________________________________________________________________
   ________________________________________________________________

VI. Student’s Proposed Action Plan for Behavior Change (by): _________________
VII. Faculty’s Proposed Action Plan (by): _____________________________

VIII. Agreement reached?    ___ Yes    ___ No
    Specify: ________________________________

IX.   A. Faculty Recommendation/Decision to Prevent Further Occurrence:

    ___ Skill Testing (use of laboratory) Specify ___

    ___ Continuation in Nursing Sequence

    ___ Repeat Course ___ Forms completed and sent to Registrar

    ___ Withdrawal

    ___ Speak with mental health professional

    ___ Speak with nursing coordinator

    ___ Speak with _____________________________

    B. Action Taken:
___ Faculty Review

___ Clinical Make-Up

___ Ineligible To Continue

___ Dismissed From Program       Date Of Re-Evaluation _____________

Comments:

Student Signature: _____________________ Date: ______________

Faculty Signature: _____________________ Date: ______________
HENDERSON COMMUNITY COLLEGE NURSING PROGRAM

Classroom/Lab Protocol/Jeopardy Form

Student Name__________________________ Date incident occurred ________

Instructor Name________________________

Detailed description of incident:
Remediation required:

Remediation instituted:

Student Comment:

This is Classroom/Lab Jeopardy # 1 2 3 for the student (please circle)

Student’s Signature_________________________ Date_______
Instructor’s Signature__________________________

SIGNATURE PAGES
(NSG 101)

Standardized Testing Policy

By signing below, I attest that I have read the statement and understand the Standardized Testing Policy.
INFORMED CONSENT

I, ________________________________, acknowledge that I have a copy of the Nursing Course Outline and have in my possession the HCC Associate Degree Nursing Student Handbook. I have read, discussed and understand the policies and guidelines set forth in the aforesaid documents. I further agree to abide by the same and understand that failure to do so may result in dismissal from the Nursing Program.

_________________________________  _________________
Signature                  Date

Witness  _________________ Date

Release of Information
I hereby give the Nursing Program Coordinator, or any faculty member of the Nursing Program who is familiar with my nursing education record, the following permission:
A. to anonymously use my ACT, CNET, GPA, NCLEX, achievement test scores etc. for the purpose of evaluation and research;
B. to release references to health care agencies, potential employers or institutions of higher learning as they pertain to my performance as a nursing student.

_________________________________  _________________
Signature                  Date

Confidentiality
I understand that information concerning the condition, care, or treatment of patients should be used only in the care of that patient. Special care should be taken to never discuss patient information outside the clinical facility or its affiliated entities in public areas. This responsibility is shared by employees, volunteers, students, persons under contract, or any other authorized individual serving in any capacity for the clinical facilities, whether it be direct patient care, documentation in the patient’s health record, computer generated information, or verbal communication. In addition, Clinical facility business, financial information, or employee information should be kept within the respective departments and committees, i.e. work related conversations of sensitive nature, committee minutes/reports, and computer information. Persons handling confidential information are responsible for its security. Extreme care must be exercised to ensure that it is safeguarded to protect the patients, employees, the clinical site, and its vendors.
I agree with this policy and understand that failure to comply may be cause for immediate discharge from the Nursing Program and/or legal action.

Signature: ________________________________ Date: _______________________

**Criminal Background Check and Drug Screen Release**

I, __________________________, hereby give Henderson Community College Associate Degree Nursing Program permission to release the criminal background report and drug screen to agencies to which I am assigned for clinical experiences prior to beginning the assignment. I understand the agencies may refuse my access to clients/patients based on this information and that their criteria may differ from that for Henderson Community College.

I hereby release the College, its agents and employees from any and all claims including but not limited to, claims of defamation, invasion of privacy, wrongful dismissal, negligence, or any other damages of or resulting from or pertaining to the collection of this information.

I understand that I am responsible for all costs associated with this process.

______________________________________________
Signature                                          Date

**Immunizations/Lab Tests**

I understand the immunization and lab test requirements as stated in the Henderson Community College AD Nursing Student Handbook and I am in compliance with the immunization schedule.

Signature: ___________________________ Date: ____________

OR

I have the read the above and still need the following immunizations: ____________

Signature: ___________________________ Date: ____________

**CPR**

I understand the HCC requirement for current CPR (American Heart Association) certification.

I have read the above and I am in compliance with the CPR requirements.
**Universal Precautions**

I understand that as a nursing student, I may be exposed to blood and other body fluids of patients or others who may be infected with the Human Immunodeficiency Virus (HIV or AIDS), Hepatitis B, and/or other bloodborne pathogens. Therefore, I agree to adhere to the Center for Disease Control Guidelines for minimizing the risk of exposure to blood and body fluids in both campus and clinical laboratories. I have been taught about universal precautions and the Center for Disease Control Guidelines. I understand precautions for my own and other’s protection.

Signature: ____________________________  Date: ______________

---

**Kentucky Board of Nursing Policy Regarding Conviction Record**

I understand and have read the Kentucky Board of Nursing (KBN) Guidelines for Review of Licensure Applicants Conviction Record, and that there is a definite procedure to follow in order to be admitted to the National Council Licensure Examination (NCLEX) and have read this policy. I further understand that all convictions must be reported to the KBN and that upon my application to take the NCLEX, KBN will determine my eligibility to take the exam.

Signature: ____________________________  Date: ______________

---

**Computer Ethics**

Computer ethics laws will be strictly abided by and enforced in the Nursing Program. Under no circumstances are persons allowed to copy others’ software and use in this course or copy any software copyrighted and belonging to the College or Nursing Program. The hardware and software available at Henderson Community College is for you to use in a responsible manner. Any abuse, vandalism, or alteration in any manner will not be tolerated. Do not make any alterations whatsoever without explicit permission from a faculty member. Failure to adhere to these guidelines will result in academic or legal penalties to the fullest extent available under the law and/or existing guidelines. These penalties may include but are not limited to a failing grade in the course, expulsion from the College and Nursing Program and legal fines. If in doubt, do not do it until you ask a faculty member.

I have read and understand the above statement.

Signature: ____________________________  Date: ______________
**Academic Honesty**
I have read the Henderson Community College AD Nursing Program policy on academic honesty and understand that participation in such activities will be cause for disciplinary sanctions in accordance with the Community College System Code of Student Conduct.

Signature: _______________________________ Date: __________________

**Employment/Liability Insurance Policy**
Nursing students enrolled in a clinical course are scheduled to practice in a clinical setting under the guidance of a nursing faculty member. Student liability insurance only covers practice within these parameters. Students are held liable for their own actions by the Kentucky Board of Nursing and thus should study their job descriptions to ascertain what is allowed within an employing institution and that they are not practicing nursing without a license.

I understand that if I am employed, my work schedule cannot interfere with class, lab, or clinical schedules. I am expected to arrive on time and remain until dismissed by the instructor.

Signature: _______________________________ Date: __________________

**Photo/Taping of Class**
For educational purposes, I agree to be audio or videotaped or have a photo taken as an individual or member of a group. I may withdraw this permission provided that I assume the responsibility to notify the instructor(s) prior to the taping/photography.

Signature: _______________________________ Date: __________________

**Accidental Exposure Policy**
As a student at Henderson Community College, I understand that I am not entitled to compensation from any clinical facility to which I am assigned.

I further understand if while attending a class or lab, I have a parenteral or mucous membrane exposure to blood or other bodily fluid, included, but not limited to, a cutaneous exposure because of skin which is chapped, abraded or has dermatitis; the Safety Officer and/or the Bloodborne Pathogens Coordinator shall be immediately notified. An incident report shall be completed as soon as possible.

The Bloodborne Pathogens Coordinator or designee will inform the source person* (if known) of the incident and request serological testing for evidence of HIV and Hepatitis B infection (regardless of previous testing for HIV and/or Hepatitis B).
If the source person is able to produce evidence of prior Hepatitis B vaccination, testing for Hepatitis B infection will not be necessary.

If the source person has AIDS, is HIV or Hepatitis B positive, refuses the test, or is physically unavailable for testing, I will be urged to be evaluated clinically and serologically by the health care provider of my choice, for evidence of HIV or Hepatitis B infection as soon as possible after the exposure.

I will also be advised to seek medical attention for any acute febrile illness that occurs within 12 weeks after the exposure and on a periodic basis thereafter (e.g. 12 weeks and 6 months after exposure or as indicated by my personal physician).

I realize that reports of all actions taken and the results thereafter must be filed with the Safety Officer and the Bloodborne Pathogens Coordinator on campus.

I understand that the above as well as all emergency health care, will be at my own expense and that of my insurance carrier.

____________________________________  _______________________
Signature                              Date

*Source person:  A person from which another human is exposed to his/her blood or bodily fluids via parenteral, sexual, mucous membrane, cutaneous or perinatal contact.

Written Work as a Sample
I give permission to Henderson Community College AD Nursing Program for my work to be anonymously used for teaching, learning, evaluation and accreditation purposes.

Signature: ___________________________ Date: _______________________

Class/Clinical/Lab Jeopardy Policy
I have read and understand the class/lab jeopardy policy as provided.

Signature________________________________________ Date_____________________

See Clinical Jeopardy Form
I have read and understand the clinical safety/clinical jeopardy policy.

Signature________________________________________ Date_____________________
**Attendance Policy**

My signature verifies I have read and understand the attendance policy for both class and clinical as stated above.

Signature: ___________________________

Date: ___________________________

**Chain of Command and Tests below 78%**

By signing below, I attest that I have read the statement and understand the chain of command and the policy regarding receiving 4 failing grades in a 9 hours course, 3 failing grades in a 6 hours course on unit exams requiring mandatory withdrawal from the class.

Signature: ___________________________

Date: ___________________________

---

**Henderson Community College**
**Nursing Program**
**Criminal Background Check Notification and Waiver**

I understand and agree that as a precondition to assignment to or placement with any affiliating clinical agency, I am subject to that particular agency’s criminal background check policies.

I understand and agree that I will be responsible for the cost of any criminal background screening required by any affiliating clinical agency with which I may be placed.

I understand and agree that if I fail a criminal background screen, or if I fail to submit to a criminal background screen, I may be dismissed from the HCC Nursing program.

I understand and agree that the clinical agency and the HCC Nursing Program have a legitimate need to receive the result of my criminal background screen, and give my consent to, and hereby authorize any criminal background screening facility and its employees to furnish originals or copies of the results of my criminal background check to the Dean of Nursing or designee.
I understand and agree that as a precondition to assignment to or placement with any affiliating clinical agency, I am subject to that particular agency’s substance abuse policies and/or drug/alcohol testing policies, and I may be required to submit to pre-clinical placement drug
screening, random drug screening, or drug screening when there is reasonable suspicion to believe I may be impaired or have been engaged in substance abuse as defined by the affiliating clinical agency.

I understand and agree that I will be responsible for the cost of any drug screening required by any affiliating clinical agency with which I may be placed.

I understand and agree that if I fail a drug screen, or if I fail to submit to a drug screen, I may be dismissed from the HCC Nursing program.

I understand and agree that the clinical agency and the HCC Nursing program have a legitimate need to receive the result of my drug screens, and give my consent to and hereby authorize any drug testing facility and its physicians and/or employees to furnish originals or copies of the results of my drug screening to the Dean of Nursing or designee.

___________________________  ___________________________  _______________________
Student’s Printed Name  Student’s Signature  Date

**Cell Phone Policy**

Should there be misuse or disruption of class due to cell phone use, additional rules may be instituted. These include placement of a basket at the front of the class and sticky notes. If you have a sick child you can give the care giver Dana Walker's number of 831-9740 or the switchboard campus number of 827-1867 and they can get a message to you. **IF** you have a loved one acutely ill and you need to be available to take a call, then put the phone on silent/vibrate and place it on the top of the desk in front of you. The most practical solution would be to leave your phone in the car or in your backpack T Turned off and not on your person or near you where you would be tempted to text.

I, acknowledge receiving this policy regarding cell phone usage in the classroom/lab setting.

Student signature____________________________________________________________

Date____________________________________________________________

**NOTES**