# Henderson Community College Associate Degree Nursing Student Handbook 2021-2022

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

**The vision of Henderson Community College is:**
To be the area's educational leader providing opportunities for personal growth, professional training, and cultural enrichment.

**The mission of Henderson Community College is:**
To enhance the quality of life and employability of our community by serving as the leading provider of

- College and Workplace Readiness
- Transfer Education
- Technical Education and Workforce Training
- Lifelong Learning and Cultural Enrichment

Henderson Community College, a member of the Kentucky Community and Technical College System, is a public associate degree granting institution serving Northwest Kentucky.

**The values of Henderson Community College are:**

- Academic Freedom
- Access and Opportunity
- Accountability
- Community
- Cultural Appreciation
- Diversity
- Integrity
- Partnerships
- Quality
- Student and Employee Success

**Institutional Goals:**
To fulfill its mission, the college has adopted six institutional goals to coincide with the KCTCS goals.

The goals of HCC are as follows:

- Raise the level of educational attainment in HCC's service area by positioning the College as the most accessible, affordable, and relevant postsecondary education choice.
- Increase access and success for HCC's students, particularly among traditionally under-represented populations.
- Develop clear pathways through postsecondary education with an emphasis on experiential learning that leads to successful employment outcomes for HCC's graduates.
- Improve student learning, engagement, support, experiences, and success with exceptional academic and student services.
- Align programs and curricula with needs of employers that enhance the employability, job placement, and career development of HCC's graduates.
- Promote the recognition and value of HCC.

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 and your course syllabus will provide you with invaluable information for successful completion of the program.

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.

FACULTY/STAFF DIRECTORY

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**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. Over the past 10 years, the program has consistently achieved pass rates at or above 80%, with a number of graduating cohorts reaching 100% success rates. We continue to strive to improve performance on the exam.

The Henderson Community College Associate Degree Nursing Program at Henderson Community College located in Henderson, KY is accredited by the:

Accreditation Commission for Education in Nursing (ACEN)
3390 Peachtree Road NE Suite 1400
Atlanta, GA 30326
(404)975-5000

The most recent accreditation decision made by the ACEN Board of Commissioners for the Henderson Community College Associate Degree Nursing Program is accredited .View the public information disclosed by the ACEN regarding this program at http://www.acenursing.us/accreditedprograms/programSearch.htm .

**KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM**

**ASSOCIATE DEGREE NURSING**

## PHILOSOPHY

The philosophy of the Associate Degree Nursing (ADN) program is congruent with the Kentucky Community and Technical College System (KCTCS) mission statement and is supported by the works of the National League for Nursing (NLN) Education Competencies and Quality and Safety Education in Nursing (QSEN).

The nursing faculty believe nursing is holistically evolving, blended with science, and the art of caring. Nursing demonstrates the provision of patient-centered care based on quality standards and evidence-based practice through the inclusion of theoretical concepts.

Learning in an educational setting is enhanced by a teacher-student relationship and clearly defined student learning outcomes. The nurse educator's responsibility is to structure and facilitate optimal conditions for critical thinking from simple to complex. The student brings to this relationship the willingness to learn and is accountable for his/her education.

The ADN graduate, having achieved the graduate outcomes is prepared to practice in a variety of settings with the parameters of individual knowledge and experience according to the standards of practice.

REFERENCES

National League for Nursing. (2010). Outcomes and Competencies for Graduates of Practical/Vocations, Diploma, Associate Degree, Baccalaureate, Master's, Practice Doctorate, and Research Doctorate Programs in Nursing. New York, NY: National League for Nursing.

Quality and Safety Education for Nurses (QSEN) Institute. (2018). *QSEN Competencies*.

**KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM**

**ASSOCIATE DEGREE NURSING**

**CONCEPTUAL MODEL**

The conceptual model is a visual representation of the relationships among the core competencies essential to entry-level registered nursing practice. This model serves as a guide for curriculum development and instruction, which promotes the attainment of end of program student learning outcomes.


**REFERENCES**

National League for Nursing. (2010). Outcomes and Competencies for Graduates of Practical/Vocations, Diploma, Associate Degree, Baccalaureate, Master's, Practice Doctorate, and Research Doctorate Programs in Nursing. New York, NY: National League for Nursing.

Quality and Safety Education for Nurses (QSEN) Institute. (2018). *QSEN Competencies*.

**KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM**
**ASSOCIATE DEGREE NURSING**
**OPERATIONAL DEFINITIONS**

Core competencies in nursing education are those elements of Associate Degree Nursing that are essential to entry level registered nursing practice and are inherent of nursing practice. The National League for Nursing (NLN) Outcomes and Competencies for Graduates of Associate Degree Programs in Nursing which serve as 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 Judgement: 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)
    - Holistically Evolving: encompasses all mind-body-spirit interactions along the continuum of the human experience while providing care in a dynamic and progressive health care environment
- 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)

Quality and Safety Education in Nursing (QSEN) competencies which were developed to prepare future nurses to have the knowledge, skills and attitudes necessary to continuously improve the quality and safety of healthcare are defined as:

- Patient-Centered Care: “Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values, and needs” (QSEN, 2018).
- Safety: “Minimizes risk of harm to patients and providers through both system effectiveness and individual performance” (QSEN, 2018).
- Informatics: “Use information and technology to communicate, manage knowledge, mitigate error, and support decision making” (QSEN, 2018).
- Teamwork and Collaboration: “Function effectively within nursing and inter-professional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care” (QSEN, 2018).
- Evidence-Based Practice: “Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care” (QSEN, 2018).
- Quality Improvement: “Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems” (QSEN, 2018).

**REFERENCES**

National League for Nursing. (2010). Outcomes and Competencies for Graduates of Practical/Vocations, Diploma, Associate Degree, Baccalaureate, Master’s, Practice Doctorate, and Research Doctorate Programs in Nursing. New York, NY: National League for Nursing.

Quality and Safety Education for Nurses (QSEN) Institute. (2018). *QSEN Competencies*.

**KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM**
**ASSOCIATE DEGREE NURSING**
**GRADUATE OUTCOMES**

**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 patients' informed decision-making to support and achieve positive outcomes 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 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. Exhibit continuous learning within the nursing profession.

Nursing – Associate Degree

**Degrees:**
AAS Nursing

**Tracks:**
Modular 62-66
Standard 62-66

**Description:**
The Associate Degree Nursing program prepares graduates to use their skill and knowledge to fulfill the role of the nurse and is supported by the works of the National League for Nursing (NLN) Education Competencies and Quality and Safety Education in Nursing (QSEN). The NLN Outcomes and Competencies for Graduates of Associate Degree Programs in Nursing which serve as goals of nursing education for entry into nursing practice are: human flourishing, nursing judgment, professional identity, and spirit of inquiry. QSEN competencies which were developed to prepare future nurses to have the knowledge, skills and attitudes necessary to continuously improve the quality and safety of healthcare are: patient centered care, safety, informatics, teamwork

and collaboration, evidenced based practice, and quality improvement. 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.

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. Completion of the nursing program will meet the KCTCS graduate requirement of digital literacy.

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, 3390 Peachtree Rd. NE, Suite 1400, Atlanta, GA 30326, www.acenursing.org, telephone: (404) 975-5000:
Ashland Community and Technical College, Bluegrass Community and Technical College, Elizabethtown Community and Technical College, Henderson Community College, Hopkinsville Community College, Jefferson Community and Technical College, Madisonville Community College, Somerset Community College, Southeast Kentucky Community and Technical College, West Kentucky Community and Technical College.

The following Associate Degree Nursing program is accredited by the National League of Nursing Commission for Nursing Education Accreditation (CNEA), 2600 Virginia Avenue, NW, The Watergate, Washington, DC 20037, www.nln.org/cnea, telephone: (202)-909-2487: Owensboro Community and Technical College.

Implementation: Fall 2019

**Competencies:**
**Nursing – Associate Degree**
**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 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. Exhibit continuous learning within the nursing profession.

**Outline: AAS in Nursing (Modular Track)**

| **Course Prefix** | | **Course Number** | | **Course Title** | **Credit Hours** |
|---|---|---|---|---|---|
| | | | | | |
| General | | Courses | | | |
| BIO | | 137 | | Human Anatomy & Physiology I | 4 |
| BIO | | 139 | | Human Anatomy & Physiology II | 4 |
| BIO | | 225 | | Medical Microbiology | 4 |
| PSY | | 110 | | General Psychology | 3 |
| ENG | | 101 | | Writing I | 3 |
| | | | | Quantitative Reasoning Course at AA/AS Level | 3 |
| | | | | Heritage/Humanities Course | 3 |
| | | | | | |
| | | | | Subtotal | 24 |
| | | | | | |
| Technical | | Courses: | | | |
| | | | | | |
| NAA | | 100 | | Nursing Assistant Skills I | 0-3 |
| CPR | | 100 | | CPR for Healthcare Professionals | 0-1 |
| NSG | | 101 | | ***Nursing Practice I | 9 |
| NSG | | 219 | | ***Medical/Surgical Nursing I OR | 7 |
| NSG | | 195 | | **Transition to ADN OR | (4) |
| NSG | | 199 | | **Accelerated Transition: PN-ADN Bridge | (2) |
| NSG | | 211 | | Maternal Newborn Nursing | 3 |
| NSG | | 212 | | Behavioral Health Nursing | 3 |
| NSG | | 213 | | Pediatric Nursing | 3 |
| NSG | | 229 | | Medical/Surgical Nursing II | 7 |
| NSG | | 239 | | Medical/Surgical Nursing III | 6 |
| | | | | | |
| | | | | **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. | |
| | | | | Completion of the nursing program will meet the KCTCS graduate requirement of digital literacy. | |

**Dates of Actions:**

**Approved:** May 2001

**Revised:** May 2002, Fall 2003, May 2004, Fall 2006, May 2008; December 2008; October 2011; December 2013, March 2017, December 2017

**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 on CastleBranch. 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.

## CURRENT CURRICULUM

**NSG 101 - Nursing Practice I - 9 Credits**

**Description:**

Focuses on nursing practice within the context of the contemporary health care delivery system by introducing the nursing process and basic nursing concepts as a framework for organizing care delivery. Emphasizes foundational knowledge of nursing practice, skills acquisition, and the basic care of diverse patient populations. Introduces the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN).

**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 Quantitative Reasoning Course at AA/AS level with a grade of "C" or better, PSY 110, 75 hour nursing assistant course or its equivalent.
**Pre- or Co-requisite**: BIO 139 with a grade of "C" or better

Implementation: Fall 2019

**Competencies:**

**Upon completion of this course, the student can:**

1. Examine assessment data to develop and implement a patient centered plan of care for the adult and gerontologic patient that promotes independence, maintenance and restoration of health or supports a peaceful death; (1A, 3B, 4A) *
2. Perform identified foundational nursing skills according to evidenced based critical criteria documented in the Essential Skills; (2B, 2C, 3B, 4A) *
3. Identify and apply at a beginning level, the nursing process to nursing judgment and the holistic management of care for one patient experiencing alterations in health; (1A, 2A, 2C, 3B, 4A) *
4. Utilize basic communication techniques with patients and members of the health care team; (1A, 2B, 3C) *
5. Recognize caring behaviors in self and others; (1A, 2B, 3B) *
6. Demonstrate a beginning knowledge of professional behaviors as identified by the standards of nursing practice; (2C, 3A, 3B, 3C, 4A, 4B) *
7. Identify and respond to situations that require basic knowledge of teaching and learning strategies; (1B, 2A, 4A, 4B) *
8. Recognize and report situations that require collaboration with the patient and other members of the health care team. (1A, 2B, 2C, 3A, 4A) *
9. Demonstrate digital literacy with ethical and responsible knowledge, behavior, and skills (including communication) required for nurses to collect, store, retrieve, and process information. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A)*

* This indicates which end of program student competency that the course competency reflects.

**Outline:**

I. Professional Identity: Context of Nursing Practice
    A. The Nursing Profession as a Context for Practice
    B. Health Care Delivery System as a Context for Practice
II. Nursing Judgement: Framework for Nursing Practice
    A. Developing a Framework for Practice: Nursing Process
    B. Critical Thinking and Clinical Judgment
    C. Physical Assessment Techniques
    D. Managing Care of a Patient
III. Human Flourishing: The Tools of Practice
    A. Patient Teaching and Learning
    B. Communication
    C. Caring Interventions
    D. Patient Advocacy
IV. Spirit of Inquiry and Nursing Informatics
    A. Tools of Technology
    B. Ethical/Responsible Use
    C. Manage Information
V. Growth and Development and Health Promotion
    A. Young Adult
    B. Middle Adult
    C. Older Adult
    D. Variability in the Adult Lifespan
VI. Role of the Nurse in the Management of Care
    A. Safety
    B. Infection Control
    C. Basic Concepts of Medication Administration
    D. Perioperative Care
VII. Basic Nursing Care Concepts and Introduction to Illness

    A. Sensory Perception
    B. Oxygenation/Circulation/Perfusion
    C. Nutrition
    D. Urinary Elimination
    E. Bowel Elimination
    F. Activity/Exercise
    G. Sleep/Rest
    H. Pain/Comfort
    I. Fluid and Electrolytes/ Acid-Base
    J. Skin Integrity
    K. Psychosocial

Experiments/Activities:
*General Principles (overriding)
*Safety Practices (overriding)
*Standard Precautions (overriding)
* Physical Assessment
*Administration of Medications
*Teaching – Learning
*Surgical Asepsis
Heat Application
Cold Application
*I.V. Maintenance and Termination
Oxygen Administration

Glucose Monitoring
Enemas
Basic Care and Comfort
Therapeutic Communication
Rest and Sleep
Pain Management
Activity and Mobility
Application of Soft/Medical Physical Restraints
Measuring and Evaluating Intake and Output
Assessing, Evaluating, and Facilitating Nutrition Needs
*Management of Care
Library orientation to health related databases (locating, evaluating, etc.)
Technology tools (learning management system, computerized examinations, electronic health record, etc.)
Accessing and inputting data through electronic means

**Learning Resources:**

Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**NSG 219 – Medical Surgical Nursing I - 7 Credits**

**Description:**
Focuses on the application of the core components of nursing practice to adult patients experiencing actual or potential alterations in health. Strengthens the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN). Emphasizes the concepts of nutrition, metabolism, endocrine, elimination, and integumentary.

**Components:** Lecture: 4 credit hours (60 contact hours). Lab/Clinical: 3 credits (135 contact hours).

**Pre-requisite**: NSG 101 and BIO 139 with a grade of "C" or better

**Pre- or Co-requisite**: NSG 212 with a grade of "C" or better and ENG 101

**Implementation:** Fall 2019

**Competencies:**

**Upon completion of this course the student can:**

1. Interpret assessment data to develop and implement a patient centered plan of care for the adult and gerontologic patient experiencing actual or potential alterations in nutrition, metabolism, elimination, and integumentary. (1A, 3B, 4A) *
2. Provide safe nursing care while maintaining previously learned skills and acquiring additional essential skills that adhere to evidence based critical criteria. (2B, 2C, 3B, 4A) *
3. Apply the nursing process as a basis for nursing judgment and the management of care for a minimum of two patients. (1A, 2A, 2C, 3B, 4A) *
4. Communicate effectively with patients, families, significant others and members of the health care team. (1A, 2B, 3C) *
5. Translate caring behaviors into nursing practice. (1A, 2B, 3B) *
6. Demonstrate professional behaviors according to the standards of nursing practice in the delivery of patient care. (2C, 3A, 3B, 3C, 4A, 4B) *
7. Implement understanding of the teaching-learning processes. (1B, 2A, 4A, 4B) *
8. Demonstrate teamwork/collaboration with the patient, family, significant others and members of the health care team in the delivery of safe, quality, cost effective health care. (1A, 2B, 2C, 3A, 4A) *
9. Apply information technology in an ethical and responsible manner to enhance the delivery of safe and quality patient care. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A) *

***This indicates which end of program student competency that the course competency reflects.***

**Outline:**

I. Managing Care for Patients with an emphasis on wellness/illness related to Nutrition and Metabolism
   a. Nursing management of nutritional alterations
   b. Nursing management of upper and lower gastrointestinal alterations
   c. Nursing management of liver, biliary tract, and pancreatic alterations
   d. Nursing management of endocrine alterations

II. Managing Care for Patients with an emphasis on wellness/illness related to Elimination
   a. Nursing management of urinary alterations
   b. Nursing management of bowel alterations

III. Managing Care for Patients with an emphasis on wellness/illness related to Integumentary
   a. Nursing management of integumentary alterations
   b. Nursing management of burn injuries

**Experiments/Activities:**

*General Principles (overriding)
*Safety Practices (overriding)
*Focused Abdominal Assessment
*Focused Integumentary Assessment
*Intravenous Therapy – IV (Fluids and Medications)
*Gastrointestinal Intubation
*Suctioning (Gastric)
*Teaching-Learning
*Management of Care

***Requires individual faculty check off**

**Learning Resources:**

Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**NSG 211 - Maternal Newborn Nursing - 3 Credits**

**Description:**
Focuses on the application of the core components of nursing practice to the care of childbearing families. Illustrates the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN).

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

**Pre-requisite:** NSG 219 and NSG 212 with a grade of "C" or higher, and ENG 101
**Pre- or Co-requisite:** NSG 229 and BIO 225 with a grade of "C" or higher.

Implementation: Fall 201

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

1. Prioritize assessment data to develop and implement a patient centered plan of care for the childbearing family. (1A, 3B, 4A) *
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 evidence based critical criteria. (2B, 2C, 3B, 4A) *
3. Apply the nursing process as a basis for nursing judgment and the management of care for childbearing families. (1A, 2A, 2C, 3B, 4A) *
4. Demonstrate effective therapeutic communication techniques to the care of childbearing families. (1A, 2B, 3C) *
5. Integrate caring behaviors in the care of childbearing families. (1A, 2B, 3B) *
6. Employ professional behaviors according to the standards of nursing practice in the care of childbearing families. (2C, 3A, 3B, 3C, 4A, 4B) *
7. Model the teaching- learning process in the care of childbearing families. (1B, 2A, 4A, 4B) *
8. Participate in a teamwork/collaboration with the patient, family, significant others and members of the health care team in the delivery of safe, quality, cost effective health care. (1A, 2B, 2C, 3A, 4A) *
9. Analyze information technology in an ethical and responsible manner to enhance the delivery of safe and quality patient care. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A) *

***This indicates which end of program student competency that the course competency reflects.***

**Outline:**

I. Managing Care for Patients with an emphasis on wellness related to the concepts of Sexuality and Reproduction.
   A. Introduction to family nursing
   B. Maternal/newborn care
II. Managing Care for Patients with an emphasis on alterations related to the concepts of Sexuality and Reproduction.
   A. Nursing management of reproductive alterations
   B. Nursing management of pregestational alterations
   C. Nursing management of childbearing alterations
   D. Nursing management of newborn health alterations

**Experiments/Activities:**

*General Principles (overriding)

*Safety Practices (overriding)

*Postpartum Assessment

*Timing Contractions (including electronic fetal monitoring)

*Fetal Heart Rate (including fetal monitoring)

*Immediate Care of the Newborn

*Teaching – Learning

**Requires individual faculty check off*

**Learning Resources:**

D Hockenberry, M.J., Wilson, D., & Rodgers, C.C. (2016). Wong's essentials of pediatric nursing. St. Louis, MO: Elsevier.

Ricci, S.S. (2016). Essentials of maternity, newborn, and women's health nursing. Philadelphia, PA: Wolters Kluwer.

Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**NSG 212 - Behavioral Health Nursing - 3 Credits**

Focuses on the application of the core components of nursing practice to adult patients experiencing actual or potential alterations in mental health. Strengthens the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN).

**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

**Pre- or Co-requisite:** NSG 219 with a grade of "C" or higher, and ENG 101

**Implementation**: Fall 2019

**Competencies/Student Outcomes:**

**Upon completion of this course, the student can:**

1. Interpret assessment data to develop and implement a patient centered plan of care for the adult and gerontologic patient experiencing actual or potential alterations in mental health. (1A, 3B, 4A) *
2. Provide safe nursing care while demonstrating competency with previously learned skills and acquiring additional essential skills that adhere to evidence based critical criteria. (2B, 2C, 3B, 4A) *
3. Apply the nursing process as a basis for nursing judgment and the management of care of patients with actual or potential alterations in mental health. (1A, 2A, 2C, 3B, 4A) *
4. Utilize therapeutic communication techniques with patients, families, significant others and members of the health care team. (1A, 2B, 3C) *
5. Translate caring by exhibiting spontaneous caring behaviors in nursing practice. (1A, 2B, 3B) *
6. Demonstrate professional behaviors according to the standards of nursing practice in the delivery of patient care and self-improvement. (2C, 3A, 3B, 3C, 4A, 4B) *
7. Implement teaching-learning processes in the management of patient care. (1B, 2A, 4A, 4B) *
8. Demonstrate teamwork/collaboration with the patient, family, significant others and members of the health care team in the delivery of safe, quality, cost effective health care. (1A, 2B, 2C, 3A, 4A) *
9. Apply information technology in an ethical and responsible manner to enhance the delivery of safe and quality patient care. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A) *

***This indicates which end of program student competency that the course competency reflects.***

**Outline:**

I. Introduction to Behavioral Health Nursing
   a. Legal/ethical issues
   b. Theorists
   c. Therapeutic communication

II. Managing Care for Patients with an emphasis on wellness/illness related to concepts of Mental Health
   a. Nursing management of stress disorders
   b. Nursing management of anxiety disorders
   c. Nursing management of somatoform/dissociative/non-dissociative disorders

III. Managing Care for Patients with an emphasis on wellness/illness related to concepts of Role-Relationship
   a. Nursing management of altered role-relationship alterations.
   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 schizophrenia
   g. Nursing management of clients experiencing self-destructive behaviors
   h. Nursing management of sexual alterations

**Experiment/Activities:**

*General Principles (overriding)

*Safety Practices (overriding)

*Focused Psychosocial Assessment

*Therapeutic Communication

De-Escalation Techniques

Emergency Behavioral Interventions

Psychiatric Physical Restraint

**Requires individual faculty check off*

**Learning Resources:**

Townsend, M. (2014). Psychiatric mental health nursing: Concepts of care in evidence-based practice. Philadelphia, PA: F.A. Davis.

Varcarolis, E. (2017). Essentials of psychiatric mental health nursing: A communication approach to evidence-based care. St. Louis, MO: Elsevier.

Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**NSG 213 - Pediatric Nursing - 3 Credits**

**Description:**
Focuses on the application of the core components of nursing practice to the care of the child and family. Validates the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN). (Unsuccessful completion of NSG 213 will require mandatory withdrawal from NSG 239; 201 KAR 20:320)

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

**Pre-requisite:** NSG 229 and NSG 211 and BIO 225 with a grade of "C" or better

**Co-requisite:** NSG 239 or Consent of Instructor.

**Pre- or Co-requisite:** Heritage/Humanities.

Implementation: Fall 2019

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

1. Integrate assessment data in the development and implementation of patient centered plans of care for the child and family. (1A, 3B, 4A)
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 evidence based critical criteria. (2B, 2C, 3B, 4A)

3. Construct a plan utilizing the nursing process as a basis for nursing judgement, and the management of care for the child and family. (1A, 2A, 2C, 3B, 4A)
4. Employ therapeutic communication techniques to the care of the child and family. 1A, 2B, 3C)
5. Synthesize caring behaviors into the care of the child and family. (1A, 2B, 3B)
6. Incorporate professional behaviors, according to the standards of nursing practice, into the care of the child and family. (2C, 3A, 3B, 3C, 4A, 4B)
7. Evaluate the teaching- learning process in the care of the child and family. (1B, 2A, 4A, 4B)
8. Facilitate a teamwork/collaborative team approach in the delivery of safe, quality, cost effective health care. (1A, 2B, 2C, 3A, 4A)
9. Integrate digital literacy with ethical and responsible behaviors to create and evaluate information to improve the quality and safety in the care of the child and family. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A)

***This indicates which end of program student competency that the course competency reflects.***

**Outline:**

I. Managing Family-Centered Care for Children: Unique Care Focuses
   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 an emphasis on wellness/illness
   a. Nutrition
   b. Endocrine
   c. Elimination (urinary and bowel)
   d. Respiratory
   e. Cardiovascular
   f. Neurologic
   g. Skin Integrity
   h. Sensory

**Experiments/Activities:**

*General Principles (overriding)

*Safety Practices (overriding)

*Physical Assessment

*Administration of Pediatric Medications

*Pediatric Intravenous Therapy

*Diversional Activities for Children

***Requires individual faculty check off***

**Learning Resources:**

Hockenberry, M.J., Wilson, D., & Rodgers, C.C. (2016). Wong's essentials of pediatric nursing. St. Louis, MO: Elsevier

.Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**NSG 229 – Medical Surgical Nursing II - 7 Credits**

**Description:**
Focuses on the application of the core components of nursing practice to adult patients experiencing actual or the potential for alterations in health. Illustrates the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN). Emphasizes the concepts of oxygenation, circulation, perfusion, and activity/exercise

**Components:** Lecture: 4 credit hours (60 contact hours). Lab/Clinical: 3 credit hours (135 contact hours)

**Pre-requisite:** NSG 219 and NSG 212 with a grade of "C" or higher and ENG 101

**Pre- or Co-requisite:** NSG 211 and BIO 225 with a grade of "C" or higher

Implementation: Fall 2019

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

1. Prioritize assessment data to develop and implement a patient centered plan of care for the adult and gerontologic patient experiencing actual or potential alterations in oxygenation, circulation, perfusion, and activity/exercise. (1A, 3B, 4A) *
2. Illustrate safe nursing care while maintaining previously learned skills and acquiring additional essential skills that adhere to evidence based critical criteria. (2B, 2C, 3B, 4A) *
3. Apply the nursing process as a basis for nursing judgment and the management of care for a minimum of three patients. (1A, 2A, 2C, 3B, 4A) *
4. Demonstrate effective communication with patients, families, significant others and members of the health care team. (1A, 2B, 3C) *
5. Integrate caring behaviors into nursing practice. (1A, 2B, 3B) *
6. Employ professional behaviors according to the standards of nursing practice in the delivery of patient care. (2C, 3A, 3B, 3C, 4A, 4B) *
7. Model understanding of the teaching-learning processes. (1B, 2A, 4A, 4B) *
8. Participate in a teamwork/collaboration with the patient, family, significant others and members of the health care team in the delivery of safe, quality, cost effective health care. (1A, 2B, 2C, 3A, 4A) *
9. Analyze information technology in an ethical and responsible manner to enhance the delivery of safe and quality patient care. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A) *

***This indicates which end of program student competency that the course competency reflects.***

**Outline:**

I. Managing Care for Patients with an emphasis on wellness/illness related to Circulation and Perfusion
   a. Nursing management of hematological alterations
   b. Nursing management of blood pressure alterations

c. Nursing management of coronary artery alterations
d. Nursing management of cardiac alterations
e. Nursing management of vascular alterations

II. Managing Care for Patients with an emphasis on wellness/illness related to Oxygenation
a. Nursing management of upper respiratory alterations
b. Nursing management of lower respiratory alterations
c. Nursing management of obstructive pulmonary alterations
d. Nursing management of total respiratory alterations

III. Managing Care for Patients with an emphasis on wellness/illness related to Activity and Exercise (Musculoskeletal)
a. Nursing management of musculoskeletal alterations
b. Nursing management of arthritis and connective tissue alterations

**Experiments/Activities:**

*General Principles (overriding)
*Safety Practices (overriding)
*Focused Respiratory Assessment
*Focused Cardiovascular Assessment
*Focused Musculoskeletal Assessment
*Suctioning (oropharyngeal, nasotracheal, nasopharyngeal, and tracheobronchial)
*Tracheostomy Care
*Basic Electrocardiograph (EKG) Strip Interpretation
*Central Lines
*Blood and Blood Products Administration
*Teaching-Learning
*Management of Care

***Requires individual faculty check off**

**Learning Resources:**

Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**NSG 239 – Medical Surgical Nursing III - 6 Credits**

**Description:**

Focuses on the application of the core components of nursing practice to adult patients experiencing actual or the potential for alterations in health. Validates the four competencies of nursing practice including human flourishing, nursing judgment, professional identity, and spirit of inquiry and Quality and Safety Education for Nurses (QSEN). Emphasizes the concepts of: 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 239 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 229 and NSG 211 and BIO 225 with a grade of "C" or better

**Pre- or Co-requisite:** NSG 213 with grade of "C" or better and Heritage/Humanities

Implementation: Fall 2019

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

1. Integrate assessment data in the development and implementation of patient centered plans of care for multiple adult and gerontologic patients experiencing actual or potential alterations (1A, 3B, 4A) *
2. Demonstrate competency in all essential skills and adhere to evidence based critical criteria. (2B, 2C, 3B, 4A) *
3. Construct a plan utilizing the nursing process as a basis for nursing judgment and the management of care for a group of patients. (1A, 2A, 2C, 3B, 4A) *
4. Employ therapeutic communication techniques with a group of patients, significant others and members of the health care team. (1A, 2B, 3C) *
5. Synthesize caring behaviors into the management of care for a group of patients. (1A, 2B, 3B) *
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. (2C, 3A, 3B, 3C, 4A, 4B) *
7. Evaluate teaching-learning processes to assure achievement of positive patient outcomes. (1B, 2A, 4A, 4B) *
8. Facilitate a teamwork/collaborative team approach in the delivery of safe, quality, cost effective health care. (1A, 2B, 2C, 3A, 4A) *
9. Integrate digital literacy with ethical and responsible behaviors to create and evaluate information to improve the quality and safety of patient care and the life and employability of graduates. (1A, 1B, 2A, 2B, 3A, 3B, 3C, 4A) *

***This indicates which end of program student competency that the course competency reflects.***

**Outline:**

I. Tools for Managing Care for Multiple Patients with Alterations in Health
   a. Clinical judgment
   b. Nursing process
II. Managing Care for Patients with an emphasis on wellness/illness in Immunity and Multiple System Alterations
   a. Nursing management of altered immune response
   b. Nursing management of the client with cancer
   c. Nursing management of clients with multiple organ systems alterations
III. Managing Care for Patients with an emphasis on wellness/illness in Neuro and Perceptual Alterations
   a. Nursing management of visual alterations
   b. Nursing management of auditory alterations
   c. Nursing management of acute neurologic alterations
   d. Nursing management of chronic neurologic alterations
   e. Nursing management of peripheral nerve and spinal cord alterations
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

VII. Nursing Informatics
a. Creating and evaluating information
b. EBP for safe, quality patient care
c. Integrating technology for employment marketability

VIII. Spirit of Inquiry
a. Nursing research
b. Continuous learning

IX. Trauma/Emergency/Disaster Planning
a. Community
b. Facility-based

**Experiments/Activities:**

*Neurological Evaluation
*General Principles (overriding)
*Safety Practices (overriding)
*Focused Neurological Evaluation
*Management of care for a group of clients
Development of an electronic professional portfolio
Evidence based practice presentation
Documentation/communication as a member of a team through electronic means

*_**Requires individual faculty check off**_

**Learning Resources:**

Ignatavicius, D & Workman, M. (2017), Medical-surgical nursing patient-centered collaborative care (9th ed.). St. Louis, MO: Elsevier.

McCuistion, Vuljoin-DiMaggio, Winton & Yeager (2018). Pharmacology: A patient-centered nursing process approach (9th ed). St. Louis, MO: Elsevier.

Abrams, A.C. (2017) Clinical drug therapy (11th ed.), Philadelphia, PA: J. B. Lippincott.

Ackley, B. J., Ladwig, G. B., & Makic, M. F. (2017) Nursing Diagnosis Handbook (11th ed.). St. Louis, MO: Elsevier.

Potter, P. A., Perry, A. G., Stockert, P., & Hall, A. (2017) Fundamentals of nursing (9th ed.). St Louis: Elsevier.

Jarvis, C. (2016) Physical examination and health assessment (7th ed.). St Louis: Elsevier.

Fischback, F. R. & Fischback, M. A. (2017). Fischback's A manual of laboratory and diagnostic tests (10th ed.). Philadelphia, PA: J. B. Lippincott.

Cherry, B. & Jacobs, S. R. (2017) Contemporary nursing: Issues, trends, and management (7th ed.). St. Louis, MO: /Elsevier

**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. Standard 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 or emotional jeopardy
5. 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

***Standard Precautions**

1. Standard Precautions are addressed under General Principles

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**

Interview

1. Demographics
2. Health History
3. Family Medical History
4. Current Situation/Complaint
5. History of the Present Illness
6. Medications

Vital Sign Evaluation

1. Demonstrates temperature measurement using a variety of devices
2. Obtains pulse based on assessment needs including rate, rhythm, and strength
3. Demonstrates blood pressure measurement as determined by the patient's condition
4. Assesses respirations as to rate, depth and rhythm

5. Demonstrates oxygen saturation measurement as determined by the patient's condition

Functional Assessment (Inspection, Auscultation, & Light Palpation)

1. Appearance - Stage of growth and development, general health, striking features, height, weight, behavior, grooming, hygiene, communication
2. Skin – Color, 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 (identify S1 and S2), central and peripheral pulses, temperature, edema, capillary refill
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, ostomy, external genitalia, appearance and patency of the anus
11. Reproductive –breast exam, testicular exam

***Administration of Medications**

1. Verifies healthcare provider's written order for medications
2. Prepares medication based on ~~six~~ medication rights: may include, but not limited to, right drug, right indication, right dose, right time, right route, right client (uses two identifiers), right documentation
3. Verifies allergies
4. Administers medication according to medication 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 release~~d~~ 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 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. Identifies which elements of I & O tasks can be delegated to the UAP
5. Reports inappropriate intake and output
6. 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 communicates 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


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

ESSENTIAL SKILLS - CRITICAL CRITERIA

NURSING 195 – TRANSITION TO ADN

**AND**

**NURSING 199 – ACCELERATED TRANSITION: PN – ADN BRIDGE**

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**

~~6.~~ Standard precautions must be utilized and appropriate asepsis must be maintained.
7. Correct supplies/equipment must be assembled and organized
8. Client instruction must be provided
9. The client must not be placed in physical or emotional jeopardy
10. Pertinent information must be reported and/or documented

***Safety Practices**

13. Verifies care/order for client
14. Performs hand hygiene before and after preforming any client care or handling supplies
15. Verifies facility policy and procedure and assembles appropriate equipment/supplies
16. Consults manufacturer's recommendations when equipment is involved
17. Knocks on the client's door
18. Identifies client using two identifiers
19. Notes overall condition of the client
20. Explains procedure to the client and provides for privacy
21. Elevates bed to promote good body mechanics
22. Dons PPE if indicated
23. Upon completion, lowers bed, applies side rails according to the client's care plan, places call system within reach
24. If any abnormal findings are present, reports findings to charge nurse immediately

***Standard Precautions**

1. Standard Precautions are addressed under General Principles

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**

Interview

7. Demographics
8. Health History
9. Family Medical History
~~10.~~ Current Situation/Complaint
~~11.~~ History of the Present Illness
12. Medications

Vital Sign Evaluation

6. Demonstrates temperature measurement using a variety of devices
7. Obtains pulse based on assessment needs including rate, rhythm, and strength
~~8.~~ Demonstrates blood pressure measurement as determined by the patient's condition

9. Assesses respirations as to rate, depth and rhythm
10. Demonstrates oxygen saturation measurement as determined by the patient's condition

Functional Assessment (Inspection, Auscultation, & Light Palpation)

12. Appearance - Stage of growth and development, general health, striking features, height, weight, behavior, grooming, hygiene, communication
13. Skin – Color, temperature, turgor, integrity, texture, lesions, mucous membranes
14. Hair – Color, texture, amount, distribution, presence or absence of parasites
15. Nails – Color, texture, shape, size
16. Neurologic – Pupil reaction and size, gait and balance
17. Musculoskeletal – Range of Motion, gait, tone, posture
18. Cardiovascular – Heart rate and rhythm (identify S1 and S2), central and peripheral pulses, temperature, edema, capillary refill
19. Respiratory – Rate, rhythm, depth, effort quality, expansion, cough, breath sounds, sputum, nasal patency
20. Gastrointestinal – Abdominal contour, bowel sounds, nausea, vomiting, ostomy type and care, fecal frequency, consistency, presence of blood
21. Genitourinary – Urine color, character, amount, odor, ostomy, external genitalia, appearance and patency of the anus
22. Reproductive –breast exam, testicular exam

***Administration of Medications**

7. Verifies healthcare provider's written order for medications
8. Prepares medication based on ~~six~~ medication rights: may include, but not limited to, right drug, right indication, right dose, right time, right route, right client (uses two identifiers), right documentation
9. Verifies allergies
10. Administers medication according to medication rights, including electronic bedside verification where available
11. Documents time, medication, dose, and route
12. Evaluates drug response and effectiveness

Oral

4. Does not alter extended release~~d~~ or enteric coated medications
5. Remains with client until medication is taken
6. Examines for pocketing prior to leaving the client

Topical

5. Prepares area for medication
6. Applies with applicator or with gloved finger as indicated
7. Covers with dressing as indicated
8. Maintains anatomical position to allow absorption or distribution

Injections

12. Uses sterile technique
13. Positions as indicated
14. Using anatomical landmarks, locates and names acceptable sites for injection
15. Selects and cleanses site for injection
16. Maintains skin contact with selected site with non-dominant hand
17. 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
18. Stabilizes syringe
19. Injects medication slowly and at an even rate of speed
20. Uses Z-Track method, if indicated, for IM injections
21. Withdraws needle quickly
22. Applies pressure or bandage to site unless contraindicated

Intramuscular Sites

4. Ventrogluteal
5. Vastus lateralis
6. Deltoid

Subcutaneous Sites

4. Outer aspect of upper arm
5. Anterior thigh
6. Abdomen two inches at or below the umbilicus

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

Intradermal Sites

3. Inner forearm
4. Scapular region for allergy testing

***Teaching – Learning**

7. Assesses client's knowledge of subject and readiness to learn
8. Reviews goals of session with client
9. Assembles materials and prepares the environment
10. Implements teaching plan, using appropriate content
11. Obtains evaluative feedback from client (summarizes content taught)
12. Evaluates effectiveness of session and documents

Breast Self-Examination

6. Explains best time to perform breast self-exam
7. Demonstrates visual inspection of breast before mirror
8. Demonstrates breast examination (standing and lying down)
9. Checks nipples and palpates axillae (circular, vertical, and wedge method)
10. Provides instructions for follow up with health care provider to clients with abnormal findings

Testicular Self-Examination

5. States time for examination
6. Demonstrates palpation technique
7. Identifies testes and epididymis
8. Provides instructions for follow up with health care provider to clients with abnormal findings

Perioperative Concepts

8. Documents client's understanding of surgical procedure and expected outcome
9. Explains legal forms and procedures to be completed prior to surgery
10. States reasons for and demonstrates to client how to move, perform leg exercises, and Coughing/deep breathing exercises
11. Clarifies clients' concerns related to postoperative pain and its control
12. Explains and completes preoperative assessment
13. Explains and conducts postoperative assessment
14. Evaluates achievement of identified outcomes

***Surgical Asepsis**

5. Prevents anything that is not sterile from coming in contact with that which is sterile
6. Prepares a sterile field maintaining visual contact at all times
7. Avoids reaching across the sterile field with unsterile objects
8. Dons sterile gloves avoiding contamination

Dressings

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

Catheterization

10. Cleanses perineal area
11. Determines comfortable position and drapes for exposure
12. Opens catheter kit and applies sterile drape if appropriate
13. Organizes supplies using sterile technique

14. Cleanses urinary meatus: Female - Maintains exposure, uses anterior/posterior strokes; Male - Exposes meatus and straightens urethra, cleanses using circular motion from meatus downward
15. Uses the uncontaminated hand, inserts lubricated catheter into the urethra and obtains urine
16. Replaces foreskin over glans for the male client
17. Inflates balloon completely if using Foley catheter
18. Stabilizes tubing according to facility policy and procedure

**Heat Application**

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

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

**Cold Application**

6. Fills container 1/2 to 2/3 capacity with chipped or cracked ice
7. Expels air and closes securely
8. Dries bag and tests for leakage
9. Provides protective covering
10. 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

3. Assesses site for patency and complications (infection, phlebitis, infiltration), reporting abnormalities
4. Documents findings

Termination

5. Stops flow
6. Removes intravenous device
7. Assesses site. Inspects and assures device is intact
8. Applies pressure and applicable dressing

**Oxygen Administration**

7. Removes articles which can produce a spark or open flame
8. Places “Oxygen in Use” signs in view according to facility policy and procedure
9. Provides for humidification of oxygen (per facility policy and procedure)
10. Sets, adjusts and maintains oxygen flow at prescribed rate
11. Secures and maintains integrity of devices used for flow of oxygen
12. Observes skin condition under delivery device frequently to prevent pressure injuries to skin

**Glucose Monitoring**

9. Assembles equipment and supplies
10. Calibrates equipment and performs control per facility policy and procedure
11. Selects and prepares puncture site
12. Obtains blood specimen on reagent strip
13. Processes strip according to manufacturer's instructions
14. Verbalizes expected peripheral glucose levels for adult
15. Follows facility protocol for critical values
16. Measures and documents blood glucose

**Enemas**

12. Verifies order for enema
13. Selects appropriate equipment for client
14. Prepares correct amount of solution assuring correct temperature

15. Drapes and positions client
16. Expels air from tubing
17. Lubricates tip
18. Inserts colon tube appropriate distance into rectum: Adult 3-4 inches (7-10 cm)
19. Holds container no higher than 12-18 inches (30-45 cm) above anus and releases clamp
20. Observes client during procedure
21. Assists client to toilet or places on bedpan
22. 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**

2. Evaluates environmental comfort: (room temperature, cleanliness and orderliness, bed/linens, environmental stimulation)

**Therapeutic communication**

3. Employs various communication techniques in communicating with consideration to lifespan, culture, sociocultural influences
4. Uses elements of professional communication

**Rest and sleep**

3. Assesses environment for rest & sleep according to the client's preferences
4. Implements nursing interventions conducive to rest and sleep

**Pain Management**

5. Assesses pain including scale, description and effective relief measures
6. Verbalizes independent nursing interventions to address pain
7. Evaluates interventions
8. Provides adjunctive pain medication measures (pharmaceuticals), when indicated

**Activity & Mobility**

4. Assesses ability to perform ADLs and implement measures to maintain mobility
5. Assesses for use of assistive devices and implement measures to compensate for impairment
6. Identifies safety issues that impair activity and/or mobility

**Application of Soft/Medical Physical Restraints**

10. 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.
11. Verbalizes alternative methods that can be utilized to avoid restraints (weight and motion sensors, alarms on doors, etc.)
12. Reviews provider's order for type of restraint including type, purpose, location and tie or duration of restraint
13. Implements and applies according facility policy and in accordance with regulatory agencies
14. Verbalizes safety checks and interventions for restraints: belt, extremity (ankle or wrist), mitten, elbow
15. Assesses for proper placement including skin integrity, pulses, skin temperature, color, and sensation of restrained body part
16. Identifies which elements of soft restraints can be delegated to the UAP
17. Removes restraint at least every 2 hours or more frequently or according to facility policy
18. 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**

7. Assembles appropriate measuring container(s)
8. Measures amount of fluid intake in appropriate unit of measurement
9. Measures amount of fluid output in appropriate unit of measurement
10. Identifies which elements of I & O tasks can be delegated to the UAP
11. Reports inappropriate intake and output
12. Documents intake and output data including client preferences according to facility policy

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

8. Assesses client's ability to chew and swallow and communicates findings to the health care team

9. Prioritizes safety needs and assignment of personnel to feed client based on assessment
10. Identifies which clients can be fed by the UAP and which clients need to be fed by licensed staff
11. Prepares client and environment
12. Verifies food on tray with prescribed diet
13. Assists client as necessary
14. Documents food and fluid intake including any special occurrences, and client response

***Management of Care**

6. Provides care for one client experiencing dysfunctional health patterns
7. Documents assessment of individual needs and establishes nursing care priorities based on individual needs
8. Constructs a plan to implement nursing care to meet individual needs of the assigned client
9. Utilizes professional communications skills with verbal, non-verbal and written communications and ISBARR appropriate to the situation
10. Evaluates effectiveness of nursing care of assigned client

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

15. Assesses client's ability to chew and swallow and collaborates findings to the health care team
16. Prioritizes safety needs and assignment of personnel to feed client based on assessment
17. Identifies which clients can be fed by the UAP and which clients need to be fed by licensed staff
18. Prepares client and environment
19. Verifies food on tray with prescribed diet
20. Assists client as necessary
21. 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

***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
    a. 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

**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

***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


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## ESSENTIAL SKILLS - CRITICAL CRITERIA
## NURSING 219 – MEDICAL SURGICAL NURSING 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 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. 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

***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

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**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. Assesess 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. Assesess 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

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**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


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## ESSENTIAL SKILLS - CRITICAL CRITERIA
## NURSING 213 – PEDIATRIC 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.

***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.

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## ESSENTIAL SKILLS - CRITICAL CRITERIA
## NURSING 229 – 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. Primes 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

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

***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


Hockenberry, M. J. Wilson, D., & Rodgers, C. C. (2022). *Wong's essentials of pediatric nursing.* Elsevier.

Ignatavicius, D. & Workman, L. M. (2021). *Medical-surgical nursing: Concepts for interprofessional collaborative care*. Elsevier

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Phillips, L & Gorski, L. (2018). *Phillip's manual of I. V. therapeutics: Evidence-based practice for infusion therapy.* F. A. Davis.

Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. M. (2021). *Fundamentals of Nursing*. Elsevier.

Ricci, S. S. (2020). *Essentials of maternity, newborn, and women's health nursing*. Wolters Kluwer.

The Joint Commission. (2021). *National patient safety goals.* Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx

Varcarolis, E. M. & Fosbre, C. D. (2022). *Essentials of psychiatric mental health nursing: A communication approach to evidence-based care.* Elsevier.


## ESSENTIAL SKILLS - CRITICAL CRITERIA
## NURSING 239 – 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**

Hockenberry, M. J. Wilson, D., & Rodgers, C. C. (2022). *Wong's essentials of pediatric nursing.* Elsevier.

Ignatavicius, D. & Workman, L. M. (2021). *Medical-surgical nursing: Concepts for interprofessional collaborative care*. Elsevier

Jarvis, C. (2020). *Physical examination & health assessment*. Elsevier.

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Phillips, L & Gorski, L. (2018). *Phillip's manual of I. V. therapeutics: Evidence-based practice for infusion therapy.* F. A. Davis.

Potter, P. A., Perry, A. G., Stockert, P. A., & Hall, A. M. (2021). *Fundamentals of Nursing*. Elsevier.

Ricci, S. S. (2020). *Essentials of maternity, newborn, and women's health nursing*. Wolters Kluwer.

The Joint Commission. (2021). *National patient safety goals.* Retrieved from https://www.jointcommission.org/standards_information/npsgs.aspx

Varcarolis, E. M. & Fosbre, C. D. (2022). *Essentials of psychiatric mental health nursing: A communication approach to evidence-based care.* Elsevier.

# PROGRAM POLICIES

**State Registered Nursing Assistant (SRNA) Requirement**

Effective January 2022: All students must have an active SRNA registry by the first day of their entry into the nursing program; In the event a student is unsuccessful or withdraws and seeks readmission, an active SRNA certification is required as a part of the readmission process with the following exceptions:

- Applicants who have tested but have pending results will be ranked and considered for admission with the stipulation of successful certification by end of their first semester in the nursing program. In the event a student is unsuccessful obtaining certification by end of their first semester in the nursing program, the student will be required to withdraw from the nursing program.
- Applicants from the high school direct entry cohort (pathway) have until the end of the first semester to secure SRNA certification.
- Applicants who hold an active LPN/LVN license are exempt from this SRNA requirement.

**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 Director of Nursing. If satisfaction is not obtained, the next person in the chain of command is the Allied Health Division Chair.

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.

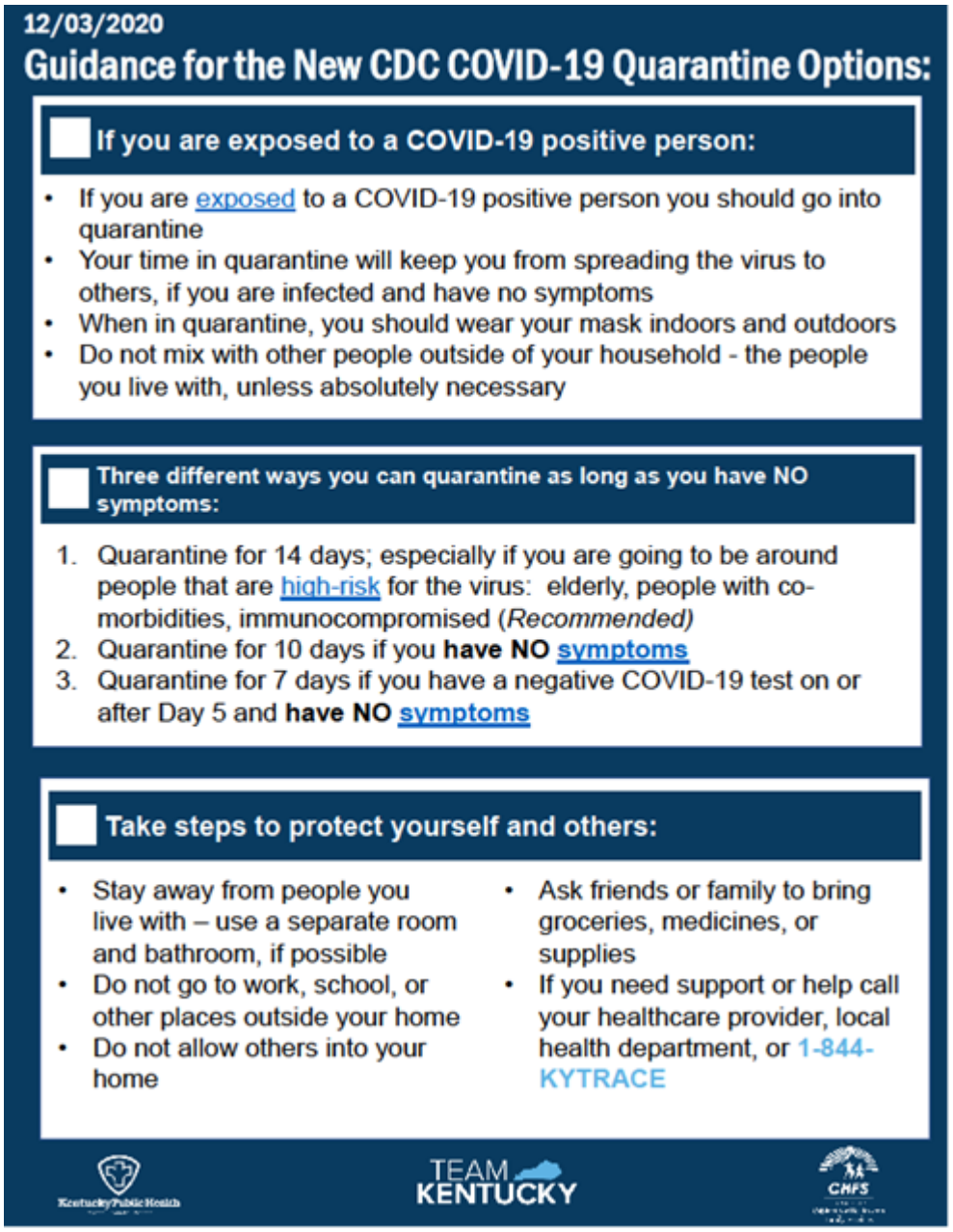
General counseling service is available for assistance with personal concerns at no charge. Contact the Director of Nursing, your academic advisor, or the counseling center if you feel that you need these services.

**Isolation Policy: COVID-19**

Students required to quarantine by the health department due to COVID-19 will be granted leave from face-to-face course requirements that cannot be converted to a virtual format during the mandated quarantine period with the following conditions:

**The student must submit official notice of quarantine.**

In the event the student does **not** test positive, the student will be required to attend all virtual class related events. Leave will follow the most current Henderson Community College guidelines as defined by the HCC Healthy at Work Officer. Guidelines as of 12/3/2020 are :




However, should more current guidelines be issued, the policy will follow the updated guidelines. The face-to-face class related events that fall due/occur during the quarantine period that cannot be converted to a virtual format with proof of health department order to quarantine due to COVID-19.

In the event the student tests positive for COVID-19 and experiences debilitating symptoms, the student must develop a plan with the instructor. The agreed upon plan may include leave from virtual components of the course. Leave will follow the most current HCC guidelines (see above). Application of quarantine days for course related events that fall due/occur during the quarantine period requires proof of health department order to quarantine due to COVID-19.

A student who misses lecture, lab, clinical, assignments, and/or skill testing experiences because of an isolation event will be responsible for scheduling a meeting with his or her instructor to develop a plan to makeup all required work missed.

A student will have the opportunity to utilize this policy a maximum of one (1) time per semester. If more than one (1) quarantine event occurs, the student will only be allowed to utilize this policy for one (1) event.

A student who misses any required course component because of an isolation event that cannot be resolved by the end of the semester will receive an "I" (incomplete). Refer to HCC policies "I" incomplete grades.

Note: If a student misses **one** exam the missed exam policy will be applied accordingly, BUT the student will receive no penalty. In the event that an isolation event occurs during a final exam, the student will be ineligible for an averaged exam score and must take the final at a later date. Pop quiz or other additional point opportunities will be ineligible for makeup.

Henderson Community College
Associate Degree Nursing Program
Testing Policy

**BEST PRACTICES: TEST REVIEW/REMEDIATION**

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.
8. If a student has concerns regarding a question(s) on the exam, the student must notify the instructor within 24 hours of the exam. The question will only be reviewed with the student face-to-face.

**BEST PRACTICES: 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.
3. 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.
4. 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. A faculty or staff member will monitor to ensure the student only utilizes restroom facilities and does not leave the area.
5. 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.

6. 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 hallways of the 3rd floor of the STC and A/T Buildings.**

7. 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. Inspection of body extremities may be requested.

8. 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.

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

10. 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.

11. 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.

12. Two proctors are recommended for any test administration.

13. 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.

14. Once all students are logged on the password is given, and the exam begins. Once all students are logged into the exam, the faculty will change the password.

15. 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.

16. 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.

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

18. 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.

19. If a student who has previously utilized accommodations does not want to take an exam in the testing center with the Coordinator of Disability Services, the student must notify the instructor, in writing, at least 24 hours prior to the scheduled exam. A student who chooses to forgo accommodations will not be provided special seating arrangements when he or she remains in the general testing area with peers.

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

21. If a student earned points on a test review or pop quiz and a student misses an exam, those points will be tallied in the student's theory grade.

22. 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 percentage points. 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 percentage points. (EXAMPLE-3 credit hour course-missed exam 1, exam 2-81% (40.5/50) + exam 3- 81% (40.5/50) + final exam-72% (72/100) / 3= 78% + 1% point for pop quiz earned before exam 1= 79%, deduct 5% points = 74% which is equivalent to 37/50 for Exam 1).

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 10-percentage point deduction in the student's final exam score.

**Note: A student cannot be subject to more than three exams/skills/retests, etc. scheduled in one day. This does not apply to quizzes.**

**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 to progress in the Associate Degree Nursing Program.

**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. Each med-surgical course (except for NSG 101), will have a 5-point quiz on the first day of class. This exam will cover material previously taught. Each course 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.

**Learner Evaluation Bonus Point**

At the end of each semester, students are given the opportunity to evaluate their course instruction. These evaluations are important because their responses are used to inform and improve learning at HCC. Students have full anonymity as instructors will not have access to the evaluations until after grades have been posted. A student who completes the evaluation will be awarded a maximum of one bonus point for all learner evaluations completed for all faculty in a course (i.e. one bonus point total per course). This bonus point 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. This bonus point can help raise a grade from one letter to the next (Ex: C to a B) but cannot provide a passing grade for the course if total points are less than 78%.

**Standardized HESI Exam Rubric/Policy (effective Fall 2021)**

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. Students must successfully complete any pre-exam assignments prior to sitting for the first HESI attempt. 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.

Objectives:

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

| Student Performance | Points |
|---|---|
| Score of 850 or higher on HESI Exam | 5 Points |
| Score of 849-825 on HESI Exam | 4 Points |
| Score of 824-800 on HESI Exam | 3 points |
| Score of 799-775 on HESI Exam | 2 Points |
| Score of 774-750 on HESI Exam | 1 Points |
| Score <750 on HESI Exam | 0 Points |

**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, the student will be required to take an assigned HESI quiz worth a total of 5 points. The student will test at the instructor(s) availability.

**Total Solutions:**

In the spirit of continually improving our nursing program to provide students with the best possible preparation for the NCLEX® exam and clinical practice, nursing courses will be integrating the use of Elsevier Total Solutions into Nursing Courses. Students will be charged for the products by course fees, added to a student's account upon enrollment in specific nursing courses. Students can find information about estimated cost on the nursing program website and within the Nursing Student Handbook. Costs are labeled as "HESI fee(s)" on the website and the Handbook. Fees associated with Elsevier Total Solutions are not refundable. Estimated costs are updated each semester.

Students will be scheduled to attend orientation for Elsevier Total Solutions. Attendance is necessary to ensure students are able to fully utilize products and submit assignments. Failure to attend orientation will likely hinder a student's benefit of the products. Other consequences may also occur (See Jeopardy Policy).

Each course will have different requirements as to the extent the products in this package will be used. If the instructor creates assignments through Total Solutions, it is the student's responsibility to complete all assignments in each course. (See Assignment Policy and Jeopardy Policy in Current semester ADN handbook).

**SKILL TESTING**

Emphasis will be placed on preparing students for the first skill test. Each skill will be demonstrated by faculty at a designated time followed by lab practices required by the instructor(s). Students will be encouraged to utilize the resources of the nursing lab when open and available.

HCC student scrub uniform is required for skill testing.

If a student does not complete their required practices prior to the scheduled skill test day, it will constitute as an automatic failure of the skill.

If tardy (> 5 minutes but < 15 minutes late) for scheduled time on skill test day, the student will be rescheduled at the instructor's availability. If absent (> 15 minutes late), it will count as a failed skill and the re-skill procedure will ensue.

An ISBARR format report and incident report may be required following a skill failure by the instructor(s) discretion. A reflective paper, including the appropriate disclosure of the error and potential legal implications may also be required and will be due prior to the scheduled second attempt. The instructor(s) will designate mandatory re-mediation before re-testing a skill.

All second attempts of skill testing will be evaluated by two instructors. If a student fails an essential skill on the second attempt, he/she will no longer continue in the nursing course. The student will be required to withdraw with a "W".

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 and will be given a jeopardy. The student repeating the skill test will be provided two attempts for success.

**DOSAGE CALCULATION/ MEDICATION ADMINISTRATION QUIZ**

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 on-line quiz consisting of 10 dosage calculation items. Quizzes may not be made up. The dosage calculation quiz is an individual assignment, group work is not allowed. Academic honesty policies apply.

**ASSIGNMENTS**

All assignments must be attempted. Students who fail to complete assignment(s) will be assigned an Incomplete "I" for the course.

**DISABILITIES/ACCOMODATIONS**

Students in need of assessment, testing or accommodation must contact (preferably at the beginning of or prior to each semester)

**Dr. Lavonia Lewis**
Coordinator of Engagement, Retention and Success
Henderson Community College
The Start Center
2660 S. Green Street
Henderson, KY 42420
P-270-831-9661
F-270-831-9843
lavonia.lewis@kctcs.edu

Accommodations are not transferred from one college to another, one course to another or one semester to the next. Students must request accommodations for each course each semester from Dr. Lewis. 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 Dr. Lewis.

**Academic Honesty**

Honesty, integrity and ethics are essential elements of nursing. Students are held to the standards of a professional nurse. Students are also governed by the KCTCS Student Code of Conduct. A copy of the Code of Conduct can be found at

https://kctcs.edu/current-students/media/kctcs-code-of-student-conduct-revised-4-19.pdf. Cheating and plagiarism are serious violations of conduct.

**Concerning Student Behavior**

Professional/ethical behavior is expected when in the classroom, clinical and lab setting. Students representing the college and nursing profession in any setting must conduct themselves in a professional manner. ***Students who exhibit unprofessional or unethical behaviors will face disciplinary action up to and including dismissal from the nursing program***. Students may be reprimanded for the following (this is not an all-inclusive list):

1. Aggressive behavior / Threats to harm others
2. Destruction of property
3. Defamatory remarks
4. Violations of confidentiality
5. Sexual assault
6. Impairment by mood altering substances
7. Possession of intoxicating substances
8. Unauthorized access to documents
9. Leaving children unsupervised on campus
10. Behavior that is disruptive to the learning environment
11. Possession of firearms on campus or clinical properties
12. Falsification of records
13. Cheating or plagiarism
14. Bullying or harassment
15. Disrespectful communication (including but not limited to cursing) with peers, faculty, staff, and/or contacts within clinical facilities, the classroom and lab settings
16. Violation of college and/or nursing program policy

**Tobacco Products:** 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.

**Artificial Scents:** Students must be free of artificial scents when in clinical facilities. Examples include but are not limited to: perfume, scented lotion, cologne, smoke, personal care products, air fresheners, candles, and e-cigarettes.

**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, the instructors and classmates cannot be expected to tolerate having children at school. Please arrange to have a plan of care for children in case this situation occurs.

**EMAIL ETIQUETTE**

We welcome questions and feedback from our students, but please note proper netiquette when communicating with instructors. Netiquette is the intranet etiquette and includes professionalism in the way you address the instructor, as well as the use of proper grammar. Please include both instructors in every email. We will respond within 24-48 hours, or sooner if possible, except on weekend, holidays, and after 4:30pm.

**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.

**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.

**Note: Students who request review of their record will not be allowed to obtain copies of exams or quizzes.**
(More detailed information is located in Student Code of Conduct)

**<u>Students are expected to uphold Provisions of the Code of Ethics for Nurses with Interpretive Statements (American Nurses Association [ANA], 2015):</u>**

**Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person (ANA, 2015).

**Provision 2:** The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population (ANA, 2015).
**Provision 3:** The nurse promotes, advocates for, and protects the rights, health, and safety of the patient (ANA, 2015).
**Provision 4:** The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care (ANA, 2015).
**Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth (ANA, 2015).
**Provision 6:** The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care (ANA, 2015).
**Provision 7:** The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy (ANA, 2015).
**Provision 8:** The nurse collaborates with other health professional and the public to protect human rights, promoted health diplomacy, and reduce health disparities (ANA, 2015).
**Provision 9:** The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy (ANA, 2015).
**Reference:** American Nurses Association, (2015). Code of ethics for nurses with interpretive statements. (Silver Spring, MD: American Nurses Association, 2015).

**ASSOCIATION OF STUDENT NURSES (HANS/KANS)**

All students are 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. This is a student ran organization promoting leadership and professional identity. Leadership positions are held by students elected by the membership.

**WORKLOAD**

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/lab schedule(s) or clinical experience(s); therefore, it is also strongly advised to avoid any work shifts from 11pm – 7 am immediately prior to a scheduled class/lab day. Should a student choose to work an 11pm – 7 am shift prior to a scheduled class/lab day, it must be with the understanding such work could have a negative impact on academic learning. Academic learning experiences must take priority over employment schedules while in the nursing program.

**PORTFOLIO**

Students will begin their electronic portfolio in Nursing 101 and continue to develop it throughout their time in the program. The electronic portfolio should contain any records that provide data that verify the student's progress in his/her nursing career. The electronic portfolio will be graded throughout the nursing program courses.

**EMERGENCY**

If an emergency occurs, 911 will be contacted. While on campus, if an emergency occurs, faculty or designated person will use the phone in the classroom to dial 911. 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, the student's emergency contact will be notified and the emergency procedures of the clinical facility will be followed. Should the student's family need to contact the student on an emergency basis, please have the family telephone the Allied Health Administrative Assistant, Dana Walker, at 270-831-9740. Nursing faculty ask that the student reserve this procedure for only true emergencies.

**EXPENSES**

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

*Name badges*
*Wristwatch with second hand*
*Stethoscope*
*Bandage Scissors*
*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*

**Henderson Community College Associate Degree Nursing - Estimated Student Costs**

Costs are estimated. "Semester One" is the semester a student enrolls in NSG 101. A student beginning the program in the second semester may incur additional costs typically associated with the first semester. Items in this document are required unless indicated otherwise. Failure to obtain listed items may result in dismissal from the program, based on nursing program policy. ***HESI charges and CastleBranch fees are not refundable.***

| YEAR ONE | SEMESTER ONE | SEMESTER TWO | TOTAL |
|---|---|---|---|
| Tuition and Fees:<br>Resident –<br>Credit Hour Fee – | <br>$2327 ($179/credit hour)<br>$104 ($8/credit hour) | <br>$2327 ($179/credit hour)<br>$104 ($8/credit hour) | <br>$4654<br>$208 |
| Non-Resident (highest out of state cost) – | $8151 ($627/credit hour) | $8151 ($627/credit hour) | |
| Miscellaneous:<br>Liability Insurance Fee<br>HESI Fee(s) | $11<br>$1375 | $11 | <br>$22<br>$1375 |
| Required Textbooks<br>Lab Supply Kit<br>CastleBranch (includes clinical site fee)<br>Uniform<br>Other supplies: (watch, stethoscope, *laptop* see requirements) | $39<br>$163<br>$157<br><br>$100<br>$650 | $83<br>$ | $122<br>$198<br>$157<br><br>$100<br>$650 |
| | Total for full-time resident = $4,926 | Total for full-time resident = $2,601 | Total = $7,527 |

| YEAR TWO | SEMESTER THREE | SEMESTER FOUR | TOTAL |
|---|---|---|---|
| Tuition and Fees:<br>Resident –<br>Credit Hour Fee – | <br>$2327 ($179/credit hour)<br>$104 ($8/credit hour) | <br>$2327 ($179/credit hour)<br>$104 ($8/credit hour) | <br>$4654<br>$208 |
| Non-Resident – (highest out of state cost) | $8151 ($627/credit hour) | $8151 ($627/credit hour) | |

| | | | |
|---|---|---|---|
| Miscellaneous:<br>Liability Insurance Fee<br>HESI Fee(s)<br><br>Required Textbooks<br>Lab Supply Kit<br><br>Nursing Picture<br>Nursing Pin (optional)<br><br>Licensure fees<br><br>CastleBranch (includes clinical site fee) | $11<br><br>$1375<br><br>$184<br><br>$27 | $11<br><br><br><br><br>$40<br><br>$60<br><br><br><br>$400 | <br>$22<br><br>$1375<br><br>$40<br><br>$60<br><br><br><br>$400 |
| | Total for full-time resident =$4,236 | Total for full-time resident =$2,962 | Total = $7,162 |

**Technology Requirements**

Students will need to have access to a computer with a webcam and microphone to be used in completing assignments off campus. The computer must be up to date with software that allows the student to perform research, write papers, save and submit documents, and complete or participate in virtual activities. Students must also maintain Internet access throughout their time in the nursing program. If home access is not available it is the student's responsibility to find places of free access that can be utilized in the event they are not able to come to campus to complete assignments. Please see below list of requirement for further guidance.

**Hardware & Software Requirements**

- **Supported Operating Systems:** Windows 8 and Windows 10 (Suggest **NO MAC, NO Chrome Book** due to program compatibility.)
- **Internet Access:** High-speed internet connection, such as DSL or a cable modem. Your internet connection is critical for viewing videos, Blackboard, and downloading/uploading exams, if completed off-site.
- Firefox and Chrome are the browsers that are supported by all sites used. Some may or may not work with internet explorer or safari.
- **Audio:** Working speakers will be required.
- **Webcam & Microphone:** Web content for classes will require a microphone and webcam to complete assignments/projects and interact with classmates and instructor(s).
- **Printer:** When you login to your online course resources you will find your articles and assignments. Most students find access to a printer imperative. While you may feel comfortable accessing documents online, having a hard copy is important. Also, having the ability to take notes and highlight main points in assigned readings can help you when studying and/or completing research projects. Printers with scanners are even better!
- Microsoft Office is required and Adobe Acrobat Reader DC is recommended. Microsoft office has a free download link on the HCC website. You can also download Adobe Acrobat Reader DC for free from the internet.
- There is tech support available from HCC and Blackboard. These are posted in each program website.

## CASTLE BRANCH REQUIREMENTS

### HEALTH HISTORY

Self-Reported Health History to be completed and signed by the student. The form is available on Castle Branch.

**IMMUNIZATIONS**

****All forms need to include student's name and date of birth****

**Measles, Mumps, Rubella (MMR)**

*One of the following is required:*
2 vaccinations
OR
Positive antibody titer (any titer result documented by a medical professional)
ONLY positive titers are acceptable
If your series is in process, submit where you are in the series, and new alerts will be created for you to complete the series.

**Varicella (Chicken Pox)**

*One of the following is required:*
2 vaccinations
OR
Positive antibody titer (any titer result documented by a medical professional)
ONLY positive titers are acceptable
If your series is in process, submit where you are in the series, and new alerts will be created for you to complete the series.

**Hepatitis B**

*One of the following is required:*
3 vaccinations
OR
Positive antibody titer (any titer result documented by a medical professional)
ONLY positive titers are acceptable
If your series is in process, submit where you are in the series, and new alerts will be created for you to complete the series.

**Tuberculosis (TB)**

*One of the following completed within the past 12 months is required:*
2 step TB skin test (administered 1-3 weeks apart)
OR
Quantiferon Gold blood test (lab report required)
OR
T-Spot blood test (lab report required)
OR
If positive results, submit a clear chest x-ray dated within the last year (lab report required).

**IMPORTANT NOTE:** Documentation must be submitted ALONG with a current TB Risk Assessment form completed by a Healthcare Provider. There is a Risk Assessment form available to download for this requirement. TB Risk Assessment forms from other providers will also be accepted. You may also submit any TB Risk Assessment is required initially AND upon renewal. The renewal date will be set for 1 year.

***Upon renewal, one of the following is required:***
1 step TB skin test (skin test must be dated no more than 12 months from your previous test. If renewal skin test is more than 12 months old, it will be rejected and you must submit another 2-step skin test
OR
Quantiferon Gold blood test (lab report required)
OR
T-Spot blood test (lab report required)
OR
If previous positive results, submit your TB Risk Assessment.

**IMPORTANT NOTE:** The attached TB Risk Assessment document has a space labeled "SSN." Please do **NOT** enter your Social Security

Number in this space. Only the last 4 digits are required. Entering the entire Social Security Number on the TB Risk Assessment will result in this requirement being REJECTED.

**Tetanus, Diptheria, and Pertussis (TDaP)**

Submit documentation of a Tetanus, Diptheria, & Pertussis (TDaP) vaccination, administered within the past 10 years. The renewal date will be set for 10 years from the date of administration.

**Influenza (Flu)**

*Please submit one of the following:*
Documentation of a flu vaccine administered during the current flu season (August 1st-October 31st)
OR
Documented contraindication verified by healthcare provider statement. (History of allergic reaction or adverse event related to vaccination).
Please note: If documented contraindication submitted, mask will be required in all clinical facilities.

**If flu vaccine submitted, documentation MUST include the following:**

- Lot number
- Date vaccine was administered
- Name of the healthcare provider who administered the vaccine
- The renewal date will be set for 10/31 the following flu season
- Meningococcal Vaccine

Submit one of the following:
Documentation of at least one Meningococcal vaccine
OR
Documented contraindication verified by healthcare provider

**Hepatitis A Vaccine**

*Submit one of the following:*
Documentation of 2 vaccines administered 6 months apart
OR
Documented contraindication verified by healthcare provider

**Herpes Zoster**

Are you 50 years or older?
If No, requirement will be marked complete and a renewal will be set for 1 year
If Yes, please submit one of the following:
1 vaccine
OR
Documented contraindication verified by healthcare provider
No renewal will be set for "Yes" answers.

**COVID Vaccine**

**CPR CERTIFICATION**

Submit your American Heart Association BLS Provider CPR certification.

The front AND back of the card must be submitted at the same time and the "Holder's Signature" line on the back of the card must be signed. eCards are also acceptable and do not need to be signed. Temporary approval will be granted for 30 days with the submission of either a certificate of completion or a letter stating course completion from the provider, by which time the permanent certification must be submitted. The renewal date will be set based on the expiration of your certification.

**PROFESSIONAL LICENSE**

Are you an LPN?
If yes, please submit one of the following:
Current Professional License
OR
Verification of your licensure through the state website
The renewal date will be based on the expiration of your license.
If no, you are not required to submit documentation and this requirement will be marked complete

**PROFESSIONAL LIABILITY INSURANCE**

Provide documentation of your current Professional Liability Insurance.
Documentation MUST show line item for payment of "Professional Liability Insurance" for approval.
Note: Documentation MUST include student's name for approval. This can be found on your PeopleSoft student account.

**STUDENT PHOTO**
Please upload a standard photo headshot to this requirement. This photo will be used to create your clinical facility ID (If needed by clinical facility).

**DRUG TESTING/CRIMINAL BACKGROUND CHECK**

Please upload your Castle Branch urine drug test result to this requirement. Urine drug screen must be completed at Lab Corp in either Evansville, IN or Owensboro, KY. **NOTE: Lab Corp will not test anyone that arrives at or after 3:30 p.m. CST.**

Students will be required to be tested for the presence of drugs on at least two occasions. Criminal Background screens for Indiana and Kentucky will also be required on at least two occasions. This serves as student written notification of this requirement and policy.

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, Allied Health Division Chair, Provost 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.

While KCTCS does **NOT** require criminal background checks or drug testing for entry into instructional programs or any courses therein, students who participate in the nursing program require completion of practical experiences in affiliated institutions that do require criminal background checks and drug testing and will be subject to the policies below:

1. Students will be notified of the procedure to follow for drug testing and criminal background check.
2. All nursing students are subject to two drug screens / criminal background checks during the nursing program. The first screening will be required prior to admission or readmission. The second screening will be during year two of the program and students will be notified directly by nursing faculty and asked to complete this screening by the close of business on the same day. The refusal to submit to a screening OR a positive drug screening will result in immediate dismissal from the nursing program with an ineligibility to reapply.

3. A student who is not successful (receives a W, D, or E) and is later readmitted into the nursing program will be required to submit a new criminal background check and drug screening. The refusal to submit to either screening OR a positive drug test will result in immediate dismissal from the nursing program with an ineligibility to reapply.
4. The cost of all criminal background checks and drug screenings required by the nursing program or affiliating clinical agencies will be the student's financial responsibility.
5. Students taking prescribed medications will be required to disclose the information (proof of prescription) to the designated third party vendor (Example: Castle Branch). Failure to comply, will result in a positive drug screen. The student will have 3 business days to resolve the positive drug screen. The result must be resolved by the end of the 3rd business day (4 p.m. CST). Failure to do so will result in immediate dismissal from the program with an ineligibility to reapply.
6. If a student tests positive for drugs, the student has the right to request a second drug test on the same specimen within 1 business day of notification of positive results. The cost of the second drug test will be the student's financial responsibility.
7. If a student fails to submit to a required drug screen or fails the drug test, the student will be immediately dismissed from the nursing program with an ineligibility to reapply.
8. At any point, a nursing student is subject to a "For cause" screening in addition to the previously mentioned screenings. "For cause" screenings will be completed when nursing faculty and/or staff of a clinical affiliate have reason to suspect a student is under the influence of mood altering substances which are impairing the student. The student will be required to have screening completed by the close of business (Lab Corp will not accept anyone at or after 3:30 p.m. CST) on the same day. Nursing faculty will contact the student's emergency contact of choice to transport the student to a designated testing facility. If the emergency contact is not available, a transport service will be contacted at the student's expense. If the student refuses transport and leaves the premises on their own accord, law enforcement will be contacted. The refusal to submit to a screening or a positive screening will result in immediate dismissal from the nursing program with an ineligibility to reapply.
9. Any violations on criminal background check will be reviewed by nursing faculty. A final determination will be made by the Director of Nursing if a student is allowed to remain in the program.

**NON-COMPLIANCE OF CASTLE BRANCH REQUIREMENT CONSEQUENCES**

If requirement is pending or rejected by due date (4 p.m. CST), a jeopardy will be given (jeopardy results in consequences-see policy on jeopardy). The pending or rejected requirement will need to be resolved by 4 p.m. CST the day prior to clinical. If unresolved in Castle Branch at this time, unable to attend any portion of the course (lecture/lab/class activity/clinical) resulting in an additional jeopardy and a required meeting with the Director of Nursing. The student may have additional consequences (such as if occurrence occurs on skill day, exams or quiz administered in class, those policies will be followed) or any other set-in place by the Director. The student will then have until 4 p.m. CST prior to the next clinical to resolve the requirement in Castle Branch. If the requirement is still pending or unresolved by this time, the student will be immediately dismissed from the nursing program. He/she will no longer continue in the nursing program. The student will be required to withdraw with a "W" in all nursing courses.

**Important Information Regarding Castle Branch**

- Paper or e-mail copies of records will not be accepted. They must be submitted in Castle Branch.
- Drug screening and criminal background checks can take up-to 4 weeks to show complete in Castle Branch, students should immediately complete these requirements when notified.
- Students will have 10 days from due date to complete any series requirements (Ex: Hepatitis A must be given at 6 months apart-you will be given 10 days from the date of the due sequential immunization to have it completed in Castle Branch)
    - If having issues with things being completed in Castle Branch, call Castle Branch to assist with any difficulty with completion.

**Liaison Job Description**

- Responsible for bringing forward majority class concerns to the instructor(s) of the course in which the concern is associated
- Responsible for bringing suggested solutions to the aforementioned concerns in order to be proactive in the resolution of the concern
- Responsible for attending scheduled liaisons meetings throughout the semester
- 4th semester liaisons will be responsible to meeting with 1st semester students in the beginning the of each semester

- Responsible to behave professionally when in the role of liaison.
    - Failure to uphold professional behaviors in the role of liaison will be subject to removal of the student from this leadership position
- Responsible to follow the Chain of command:
    - Nursing instructor of the course in which the concern is associated, if issue not resolved to the class's satisfaction
    - Then the liaisons have the option to make an appointment with the Director of Nursing, if issue not resolved to the class's satisfaction,
    - Then the liaisons may make an appointment with the Allied Health Division Chair, if issue not resolved to the class's satisfaction
    - Then the liaisons may make an appointment with the Provost of Henderson Community College
- 4th semester liaisons are expected to attend one nursing advisory board meeting per semester
- Responsible to attend designated nursing faculty meeting(s) per semester
- If concerns brought forward are not of class majority, liaison is to inform individual(s) students(s) to bring concerns forward personally to the instructor(s)
- If an elected liaison requires a Jeopardy or has a disciplinary violation, the liaison will be required to forfeit the role.

**Nursing Committees Opportunities**

Each year students will be chosen to serve as members of the Nursing Resources and Nursing Policy Committees. Student may be self, peer or faculty nominated. Nursing Faculty will select student representatives from the pool of nominees.

**Chain of Command / Complaints**

Each course will select a liaison(s) to represent the class in bringing class 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.

All students should be aware of the chain of communication. We strongly believe in the importance of following the Chain of Command when individual concerns arise, as it prepares students for the expectations of the nursing workforce and allows for better resolution of conflicts. In nearly all instances, failure to follow the Chain of Command is considered unprofessional behavior. Students with concerns are asked to address them in this manner:

1. The student will request a meeting with the faculty member involved to discuss the concern.
2. If the student feels the concern has not been resolved, the student will request a meeting with the Director of Nursing (Chardae Kelly) to discuss the concern.
3. If the student believes the concern has not been resolved to his or her satisfaction, the student will request a meeting with the Allied Health Division Chair (Dr. Carole Mattingly) to discuss the concern.
4. In the event that steps 1-3 have not resulted in an equitable resolution, the student may wish to file an appeal. Students who believe their rights have been violated or wish to appeal a grade have the ability to file a grievance / appeal. Students who wish to file an appeal **must** follow the steps detailed in the KCTCS Student Code of Conduct.

**SOCIAL NETWORKING POLICY**

The growing use of social media (Facebook, Instagram, SnapChat, 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.

The following rules apply to all students in the nursing program.

Students will be immediately dismissed from the nursing program and will be ineligible for re-admission if the following occurs:

- Electronic threats (indirect or direct).

- Any patient privacy rights violated

Students will be required to meet with the Director of Nursing for punitive repercussions, up to dismissal from the nursing program with an ineligibility to re-apply if the following occurs:

- Messages with derogatory or inflammatory remarks about an individual's race, age, disability, religion, national origin, physical attributes, sexual orientation, preference, or gender identity.

Students who post electronically with the language "Henderson Community College" or "Henderson Community College of Nursing" give rights to the school to monitor electronic activity. Posts made are a direct reflection of the school and any violation of the above policy are subject to punitive actions, including dismissal from the nursing program.

**Mandatory Nursing Orientation:**

Failure to attend any scheduled orientation will result in the loss of accepted seat in the nursing program.

**Clinical Attendance:**

Clinical attendance/punctuality is a part of professional standards and accountability. Students are required to contact the faculty/instructor prior to the beginning of clinical if an absence or tardy is anticipated. The student must call and speak to the faculty/instructor. E-mailing, texting or leaving voice mails will not be acceptable.

***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.**

**JEOPARDY POLICY**

Students are expected to conduct themselves as professional individuals while attending course related activities. Some behaviors can be distracting to others as well as minimizing the optimum learning opportunity. Therefore, activities <u>including but not limited</u> to these listed, will **<u>not be tolerated</u>** and will earn the student a jeopardy. **<u>Jeopardies received are per semester, not per course.</u>**

<u>What constitutes a jeopardy</u>?

- Arriving to course activity tardy <u>more</u> than one time (This includes arriving late or early departure)**-Tardy is defined as being >5 five minutes later than the designated time**
- Clinical absence-**Absence is defined as being > 15 minutes of arriving late or leaving early from the designated time)**
- Cell phone use during class/campus/lab/clinical
- Unprepared for class/campus/lab/clinical (Examples-unfamiliar with medications prior to administering, unfamiliar with client condition before providing care, failure to complete pre-lecture assignments, etc.)
- Failure to comply with overriding-principles of care
- Failure to demonstrate proficiency on previously learned skills
- Failure to comply with clinical policy- including failure of documents approved in Castle Branch by the designated due date
- Failure to comply with safety according to clinical policy
- Failure to comply with professional behaviors (Refer to concerning student behavior section of the handbook)
- Failure to comply with dress code (This includes virtual course activities)
- Failure to turn in clinical assignments on designated due date assigned by instructor.

* 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 student will be subject to the jeopardy procedure:

1. Students will be notified by the instructor and receive a jeopardy form with additional instructions.
2. The student will be given a due date for any assignment pertaining to the jeopardy given.
3. The student will complete all associated assignment by the designated due date.
4. If the student does not complete the associated assignment by the designated due date, a subsequent jeopardy will be given. The student will also be required to meet with the Director of Nursing.

**Two jeopardies will require a meeting with the Director of Nursing. If a student receives three jeopardies in a semester, the student will be dismissed from the program.**

**Bereavement Policy**

Students will be granted bereavement leave and will not be penalized for absences, late arrivals or late submissions that result (applies to exams, assignments, quizzes, skill tests, and clinical):

Up to three (3) consecutive business days for attending to funeral related matters in the case of the death of a parent, spouse, brother, sister, child (includes steps or halves of the same relationship), grandparent, grandchild, parent-in-law, brother-in-law, sister-in-law, domestic partner, step-parent, daughter or son of the student's spouse or domestic partner, and any other person who resides in the student's household, or other persons with whom the student has an "in loco parentis"* relationship. Upon request, the instructor may authorize up to an additional two days of bereavement leave with proof of extenuating circumstances, such as extended, lengthy travel. Total bereavement leave, including additional leave with proof of extenuating circumstances, shall not exceed five (5) consecutive business days.

One (1) business day in the case of the death of an aunt, uncle, niece, and nephew.

In the event the student experiences a bereavement, the student will have the opportunity to utilize this policy a maximum of one (1) time per semester.

A student who misses lecture, lab, clinical, assignments, and/or skill testing experiences as a result of bereavement leave will be responsible for scheduling a meeting with his or her instructor to develop a plan to makeup all required work missed.

Note: If a student misses one exam and/or one quiz the missed exam policy will be applied accordingly, BUT the student will receive no penalty. In the event that bereavement occurs during a final exam, the student will be ineligible for an averaged exam score and must take the final at a later date. Pop quiz or other additional point opportunities will be ineligible for makeup.

# HENDERSON COMMUNITY COLLEGE ASSOCIATE DEGREE
# 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. Impairment must be suspected in order to test.

**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**
__slurred
__ pressured
__ unusually loud
__ unusually slow
__ incoherent

**ACTIONS**
__ Erratic and disjointed actions*
__ Sleeping in class/clinicals/lab
__ Hostile, crying
__ Increased errors
__ Credible report of suspect drug/alcohol use or abuse
___Accident or injury

**OVERALL PHYSICAL APPEARANCE/CLOTHING EYES**
__ Flushed, red face
__ Red eyes
__ Lethargic, sleepy
__ Watery eyes
__ 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 Provost:**

Student Signature:_____

Completed by: _____ Title: _____ Date: _____

Witnessed by: _____

**KBN and Convictions**

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 be reported to the KBN. Refer to www.kbn.ky.gov for "Mandatory Reporting of Criminal Convictions" or call the Board of Nursing.

**NURSING STUDENT DRESS CODE**

*COURSE RELATED ACTIVITIES (INCLUDING VIRTUAL MEETINGS):*

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 require wearing the clinical uniform. Students must wear uniforms during skill testing.

*CLINICAL:*

All students will be in full uniform (Henderson Community College uniform, name badge, etc.) each day at the beginning of most clinical experiences. Behavioral Health and observational experiences (not in acute care hospital facilities) will require use of the navy polo uniform shirt and khaki pants or skirt (knee length or longer) dress. In general:

*Females must have:*

Safety goggles and/or face shield
Neutral color hose with dress or skirt (knee length or longer)
Neutral color socks may be worn with slacks
Clean, neutral color, non-porous shoes (leather, vinyl or rubber)

Name badge (approximately $5)
Watch with second hand
Stethoscope and bandage scissors
Dark grey pants or skirt with HCC navy blue uniform top and dark grey jacket (recommended).
Khaki color relaxed, loose fitting pants (not scrubs) or skirt (knee length or longer)
Navy blue polo uniform shirt
No sweaters

*Males must have:*
Safety goggles and/or shield
Neutral color socks
Clean, neutral color, non-porous shoes (leather, vinyl or rubber)
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)
Khaki color relaxed, loose fitting pants (not scrubs)
Navy blue polo uniform shirt
No sweaters

Students are expected to be neatly groomed and without body odor. Those who have long hair must wear the hair confined and not touching the collar (Example: When a student leans forward, hair should not fall past their face). 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 earlobes (only compatible flesh toned gauges allowed) and a watch with a second hand. Nail polish and/or artificial nails are **NOT** permitted during clinical. Nails should be short (no more than 1/4 inch from nail bed) 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.

**PREGNANCY AND CHANGE IN HEALTH STATUS**

Students who are pregnant, require surgery and/or other hospitalization, must submit the Health-Related Event Form to enter the program or return to the lecture, lab or clinical setting. The purpose of the requirement 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 Director of Nursing or Division Assistant's office. The clinical faculty member will assist the student in completing the form FM 84. Additional laboratory test may be required and obtained by a health care provider 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. *Note: If required to perform skill off-site, the student can receive special permission from the course instructor.

Anyone injured by a needle must complete an accident report to be filed in the Division Assistant'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. The library has an extensive online database available to all students. The database includes e-books, academic journals, and many other resources. Students may access the online database both on and off campus through the college website.

**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.

**NURSING PINS**

During the final semester of the program, students have the opportunity to purchase nursing pins. Pins are a symbol of graduation from the Nursing Program. Purchase of the nursing pin is optional. If a student purchases a pin but does not graduate, the student will not receive the pin and will not be eligible for a refund.

**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 Director of Nursing 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.

**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. *Note: If required to perform skill off-site, the student can receive special permission from the course instructor.
5. Students will only be allowed to recap needles when practicing drawing up medications under the supervision of the Faculty or Skills Lab personnel. Students must demonstrate current 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. Please inform the staff in the lab if there is equipment or software not working properly. If the lab staff is not present, provide in writing a detailed description of the malfunction and email it to lab staff. **No items will be loaned from the Nursing Lab.**

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 Administrative Assistant. 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 expected 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. 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).

**Late Work Policy**

In all nursing courses, students are expected to complete work in a timely manner and by assigned deadlines. Failure to do so is unprofessional. When a student fails to submit an assignment by the due date, 0.5 points will be deducted for each calendar day that the assignment is late. All assignments must be attempted and submitted, even if late submission will end with no points as a result of half point deductions. *Failure to complete assignment requirements will result in an "I" in the associated course.

**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 Tristate Homepage Channel 11 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.

**HENDERSON COMMUNITY COLLEGE**
**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, 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 the designated deadline. The deadlines are set by the HCC Nursing Program.
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 the completed Readmission Packet to the Director of Nursing or designee by the designated deadline.
    b. Request in writing an evaluation and recommendation for re-admission from two nursing faculty members. Letters must be from course faculty to be repeated.
    c. Meet current guidelines for admission.

5. If more than three years have elapsed since initial enrollment in any RN Program, the applicant must 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 219, 229 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.
10. Students seeking readmission who have been unsuccessful (assigned a D, E, F or W) in any nursing course will be considered on a case-by-case basis and not by general point ranking alone.

In order to qualify for the Henderson Community College Associate Degree Nursing Program, a student must have an academic record free of disciplinary action. Students with disciplinary violations in any college within the KCTCS system or who have transcripts from other colleges indicating conduct violations will be considered ineligible for the program.

**Henderson Community College ADN Program Readmission Application**

Student Name:
Student ID #:
Student Address:

Student Phone #

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 September 1 if planning to enroll for the subsequent Spring 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.
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 219, 229 or 230 (and relative practicing corresponding courses) 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 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 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.
10. Students seeking readmission who have been unsuccessful (assigned a D, E, F or W) in a nursing course will be considered on a case-by-case basis and not by general point ranking alone.
11. In order to qualify for the Henderson Community College Associate Degree nursing Program, a student must have an academic record free of disciplinary action. Students with disciplinary violations in any college within the KCTCS system or who have transcripts from other colleges indicating conduct violations will be considered ineligible for the program

**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 ☐
6-12 ☐
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. A student is only exempt from this requirement if the student is unable to gain endorsement due to retirement or other separation of employment that prohibits the student from gaining these letters. The student may also be required to interview with members of the Nursing Admissions Committee.

Please give this page to the Nursing faculty member to complete. The faculty member should return it to the Director of Nursing.

**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.

_____

**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

_____

**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**

| Student name: | Password: | Assigned computer: |
|---|---|---|
| Course: | Test name: | |

1. Students will be asked to sign a confidentiality statement prior to each test.
2. Students should use Mozilla Firefox to sign on to Blackboard. No other programs should be running during the testing time.
3. 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.
4. 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. A faculty or staff member will monitor to ensure the student only utilizes restroom facilities and does not leave the area.
5. 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.
6. 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 hallways of the 3rd floor of the STC and A/T Buildings**.**
7. 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. Inspection of body extremities may be requested.
8. 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.
9. Students are expected to open and minimize the computer calculator prior to opening their test. Students will utilize the computer calculator for testing purposes.
10. 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.**

Signature_____ Date_____

Please record your score and return this sheet before leaving the test center.
**Score:_____out of _____= _____%**

**Hard Copy Answer Sheet**

Student's Name/Date/Test_____

| | | | |
|---|---|---|---|
| 1. | 31. | 61. | 91. |
| 2. | 32. | 62. | 92. |
| 3. | 33. | 63. | 93. |
| 4. | 34. | 64. | 94. |
| 5. | 35. | 65. | 95. |
| 6. | 36. | 66. | 96. |
| 7. | 37. | 67. | 97. |
| 8. | 38. | 68. | 98. |
| 9. | 39. | 69. | 99. |
| 10. | 40. | 70. | 100. |
| 11. | 41. | 71. | |
| 12. | 42. | 72. | |
| 13. | 43. | 73. | |
| 14. | 44. | 74. | |
| 15. | 45. | 75. | |
| 16. | 46. | 76. | |
| 17. | 47. | 77. | |
| 18. | 48. | 78. | |
| 19. | 49. | 89. | |
| 20. | 50. | 80. | |
| 21. | 51. | 81. | |
| 22. | 52. | 82. | |
| 23. | 53. | 83. | |
| 24. | 54. | 84. | |
| 25. | 55. | 85. | |
| 26. | 56. | 86. | |
| 27. | 57. | 87. | |
| 28. | 58. | 88. | |
| 29. | 59. | 89. | |
| 30. | 60. | 90. | |

**NAME _____DATE _____**

**SKILL TESTING POLICY**

**SKILL TESTING**

Emphasis will be placed on preparing students for the first skill test. Each skill will be demonstrated by faculty at a designated time followed by lab practices required by the instructor(s). Students will be encouraged to utilize the resources of the nursing lab when open and available.

HCC student scrub uniform is required for skill testing.

If a student does not complete their required practices prior to the scheduled skill test day, it will constitute as an automatic failure of the skill.

If tardy (> 5 minutes but < 15 minutes late) for scheduled time on skill test day, the student will be rescheduled at the instructor's availability. If absent (> 15 minutes late), it will count as a failed skill and the re-skill procedure will ensue.

An ISBARR format report and incident report may be required following a skill failure by the instructor(s) discretion. A reflective paper, including the appropriate disclosure of the error and potential legal implications may also be required and will be due prior to the scheduled second attempt. The instructor(s) will designate mandatory re-mediation before re-testing a skill.

All second attempts of skill testing will be evaluated by two instructors. If a student fails an essential skill on the second attempt, he/she will no longer continue in the nursing course. The student will be required to withdraw with a "W".

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 and will be given a jeopardy. The student repeating the skill test will be provided two attempts for success.

A minimum of one week and a maximum of 2 weeks shall not 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.

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_____

Date when skill must be completed _____

Additional instructions: _____

**HENDERSON COMMUNITY COLLEGE NURSING PROGRAM**

**Jeopardy Form**

Student Name _____ Date and place incident occurred _____

Instructor Name _____

Detailed description of incident:

Remediation required:

Remediation instituted:

Student Comments:

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

Student Signature _____Date _____

Instructor's Signature _____Date _____

Henderson Community College
Associate Degree Nursing Program
Health-Related Event Form

***(Name)***_____was**/**is under care on**/**from **(*Date*)** _____ for an acute illness or a change from their previous state of health.

Please review the *Technical Standards* found below. By signing this form, you are indicating the student is able to meet all the technical requirements of a Nursing Student at HCC with no restrictions (*including weight / lifting restrictions*).

***Technical Standards:*** Nursing at the technical level involves the provision of direct care for individuals and is characterized by the application of verified knowledge in the skillful performance of nursing functions. All students should possess:

- Sufficient visual acuity, such as is needed in preparation and administration of medications, and for the observation necessary for patient assessment and nursing care;
- Sufficient auditory perception to devices such as cardiac monitors, stethoscopes, IV infusion pumps, fire alarms etc.;
- Sufficient gross and fine motor coordination to respond promptly and to implement the skills, including the manipulation of equipment required in meeting health needs;
- Sufficient communication skills (speech, reading, writing**)** to interact with individuals and to communicate their needs promptly and effectively, as may be necessary in the individuals interest;
- Sufficient intellectual and emotional functions to plan and implement care for individuals.

Additional Comments:

Health Care Provider's Name (Print):_____

Health Care Provider's (Signature): _____

Date: _____ Phone Number: _____

**By signing below, I agree that I have read and understand the Henderson Community College Nursing Student Handbook, the KCTCS Code of Student Conduct, HCC Student Handbook, my course syllabus(i) and all Henderson Community College Nursing Program policies, including but not limited to policies related to criminal background checks and drug screening, KBN and convictions, technical standards, accommodations, professionalism and expectations, confidentiality, required immunizations and lab testing, CPR, accidental exposures, attendance, Chain of Command, as well grading and evaluation of students. I agree to comply with the standards of the Henderson Community College Nursing Program and attest to my knowledge that failure to comply will result in disciplinary action – *which may include up to dismissal from the program with ineligibility for readmission*.**

Student Name (print) _____
Student Name (signature)_____
Date: _____

1. **I hereby give the Henderson Community College and its faculty and staff permission to utilize my:**
De-identified information for reporting (accrediting and regulating agencies) purposes and institutional research
2. Information and references for release to healthcare agencies, potential employers, institutions of higher learning as they pertain to my performance as a nursing student when applicable
3. Release pertinent documentation to clinical agencies (immunization records, CPR certification, TB skin test, criminal background check, drug screening, etc.) as required to qualify for clinical placement
4. Audiotaped, videotaped, or photographed image for educational purposes or during educational / service learning activities
5. I understand that I may withdraw permission at any time but it is my responsibility to inform my instructor and the Director of Nursing in writing

**Student Name (print)** _____
**Student Name (signature)**_____
**Date:** _____

I understand that clinical assignments are based on site availability. I understand that clinical facilities require specific vaccinations and screening. In the event I am restricted from attending an assigned clinical facility, for any reason by the facility itself, I will not be able to fulfill my program requirements and will be asked to withdraw from the program.

I am aware that this document will be placed in my Student File to be viewed at a later date, if necessary.

**STATEMENT OF UNDERSTANDING**

| | |
|---|---|
| Student Name: | |
| Program: | |
| College: | |

**As a Student of this program, I agree to the rules, regulations, policies and procedures as stated below.**

1. The program requires a period of assigned, guided clinical experiences either in the college or other appropriate facility in the community.
2. For educational purposes and practice on "live" models, I will allow other Students to practice procedures on me, and I will practice procedures on them under the guidance and direct supervision of my instructor. The nature and educational objectives of these procedures have been fully explained to me. No guarantee or assurance has been given to me by any representative of the college as to any problem that might be incurred as a result of these procedures. I understand and voluntarily assume the risks involved, and I hereby agree to defend, indemnify, and hold harmless the School, its agents and employees, and other Students for any injury, loss, or damages I may suffer arising from or in connection with my participation in this activity.
3. These clinical experiences are assigned by the instructor for their educational value and thus no payment (wages) will be earned or expected.
4. I understand that I will be a Student within the clinical facilities that affiliate with my college and will conduct myself accordingly. I will follow all required and published personnel policies, standards, philosophy, and procedures of these agencies. I will agree, at my own expense, to obtain all health screenings, immunizations, criminal background checks, and drug screenings as required by the Facility.
5. I have been provided a copy of, read, and agree to adhere to the college's policies, rules, and regulations related to the program for which I am applying.
6. I understand that information regarding a patient or former patient is confidential and may be used only for clinical purposes within an educational setting according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
7. I understand the educational experiences and knowledge gained during the program do not entitle me to a job nor guarantee that I will get a job in this occupation; however, if all educational objectives and licensure requirements are successfully attained, I will be qualified for a job in this occupation.
8. I understand any action on my part inconsistent with the above understandings may result in suspension of training.
9. I understand that I am liable for my own medical and hospitalization expenses.
10. I understand that I will be accountable for my own actions; therefore, I will carry a minimum

$1,000,000/$3,000,000 limited professional liability insurance during the clinical phase of the program.

**I have read and understand each term above, and agree to abide by this statement of understanding.**

_____

To be signed by legal guardian if applicant is a minor.
**As the legal guardian of the Student named above, I agree to the above conditions.**

_____