

Skills Assessment

The goal of the orientation shift is to:

- Review unique needs of patient population on the unit.
- Identify how to access commonly used equipment and supplies on the unit.
- Review the skills within the scope of practice of an Instructor.
- Access resources that support patient care.



Resources

Instructions

This unit orientation competencies must be completed and submitted, as directed by student placement, by *at least one week prior* to the clinical rotation start date. Student placement will send a request to upload orientation record at that time.

- The information I submit is complete (with dates), true, and accurately reflects my work and abilities to function as a clinical instructor on the designated unit.
- I know and will exhibit the following CREDO Behaviors in my role as a clinical instructor: I make those I serve my highest priority, I respect privacy and confidentiality, I communicate effectively, I conduct myself professionally, I have a sense of ownership, and I am committed to my colleagues.

Clinical Instructor Name: _____

Clinical Instructor Signature: _____ Date _____

Preceptor's Name: _____ Preceptor's Signature: _____ Initials: _____

Preceptor's Name: _____ Preceptor's Signature: _____ Initials: _____

VUMC ID and VUMC Email Password Issues

- Call VUMC Help Desk 615-343-HELP for password reset assistance.

eStar Login Issues

- Notify student.placement@vumc.org about any issues. Do not contact the Help Desk or submit a PegasusTicket.
- While being resolved, observe charting with peers or other appropriate staff for learning purposes.

Omnicell Access Issues

- Call VUMC Help Desk 615-343-HELP for password reset assistance
- Notify student.placement@vumc.org about any further issues.

Competency Documentation

VUH Quality Guidelines (vumc.org)	Performed (P)	Observed (O)	Reviewed (R)
<p>Tracheostomy care/suctioning</p> <ul style="list-style-type: none"> • Demonstrates tracheostomy care utilizing sterile technique • Demonstrates appropriate room set-up for trach patient (Resuscitation bag; end tidal CO2 detector; identical #/size replacement tracheostomy tube; obturator; #6 endotracheal tube (ETT); airway compromise algorithm posted at head of bed (HOB); suction equipment such as oral and tracheal catheters) • Verbalizes/demonstrates steps to take for a compromised airway in a patient with a trach • Demonstrates assessment for a patient with a trach • Identifies problems associated with the trach that warrant provider notification • Demonstrates steps involved with trach suctioning maintaining sterility • Assesses for or verbalizes indications for trach suctioning <p>Policy Tech: Tracheostomies: Management of Care</p>			
<p>CAUTI guidelines (Foley insertion, care and removal)</p> <ul style="list-style-type: none"> • Applies guidelines on CAUTI Prevention in providing care to a patient with an in-dwelling catheter • Performs catheter care utilizing CHG wipes and document application in the EHR. 			
<p>Gastrostomy tube care and feeding</p> <ul style="list-style-type: none"> • Administration of Enteral Feeding via a Dobhoff, NGT, PEG tube or J Tube • Reviews Provider order for the formula, rate, volume, route and frequency. • Obtains correct supplies and demonstrates programming of feeding pump and flush according to Provider order. • Ensure patient HOB elevated at 30 to 45 degrees during intermittent and continuous enteral feeding administration, after a bolus or intermittent feeding, and after a continuous feeding was stopped for any reason. • Monitors patient for s/s of feeding intolerance. • Documents all feeding intake and water flushes. <p>Policy Tech: Nasogastric Tube (NGT) for Administration of Medications or Nutrition Insertion Protocol</p>			
<p>Operating Alaris Pump (IV Management)</p> <ul style="list-style-type: none"> • Assess IV for patency at minimum once per shift if saline locked and q2 hours if continually infusing. • Demonstrates aseptic technique when accessing IV site. • Applies guidelines on CLABSI prevention in implementing CLABSI prevention nursing interventions • IV tubing labeled, appropriately capped when not in use, changed according to policy, and verbalizes the importance of not wrapping the IV site in Coban. • Utilizes the guardrails in the IV pump by selecting the appropriate level of care <p>Policy Tech: Intravenous Therapy: Peripheral Vascular Access- Adult & Pediatrics Policy Tech: Administration of Intravenous Intermittent Infusions Policy Tech: Injectable Medication Preparation: Outside of Pharmacy</p>			
<p>Omniceil</p> <ul style="list-style-type: none"> • Employs safe medication pulling practices (pulling medications for one patient at a time, distraction free zones) 			

Competency Documentation

<i>Emergency Response</i>	P	O	R
<p>Emergency Equipment/Response:</p> <ul style="list-style-type: none"> ● Recognize patient deterioration or change in patient condition. ● Activate an RRT or STAT and remain with the patient until the RRT team arrives to triage the patient. <p>a. Location of Crash Cart b. STAT/RRT 11111 c. Philips monitor</p> <p>Policy Tech: Rapid Response Team Activation - Adult</p> <p>Policy Tech: Change in Patient Condition - Escalation/Physician Notification</p>			
<p>Communication</p> <p>a. Change of shift handover b. Communication of students' assignments</p> <p>Policy Tech: Clinical Handover Communication (SOP)</p>			
<p>eStar Documentation</p>			
<p>Medication administration</p> <ul style="list-style-type: none"> ● Demonstrates the ability to look up unfamiliar medications prior to administration utilizing Lexicomp and Micromedex ● Employs the 5+ Rights of Medication Administration ● Utilizes barcode scanner when administering medications ● Documents medication administration according to VUMC policy, including if dose is delayed or retimed ● Administers medication in a timely manner based on ordered frequency ● Utilizes second RN to complete double independent verification of all high alert medications ● Monitors patient's clinical status after administration of high alert medication <p>Policy Tech: Medication Administration</p>			
<p>Co-signing student entries</p> <p>a. Vital Signs, I/Os, and ADLs</p> <ul style="list-style-type: none"> ● Accurately and timely escalates abnormal values and assessment findings to nursing staff ● Demonstrates and documents daily bath and linen change completion ● Demonstrates and documents ambulating, turning, and repositioning patients utilizing provider order and patient movement equipment appropriately 			
<p>Documenting in flowsheets</p> <p>a. Pain Management b. LDAs c. Safe Patient Handling Equipment such as slippery sheets, lifts, etc. (Fall Prevention) d. Labs</p> <ul style="list-style-type: none"> ● Labels IV site with gauge, date, and initials of RN who inserted. Charts IV site in LDA. ● Anticipates the need for safety devices based on strength assessment and has them readily available ● Demonstrates transport handover ● Demonstrates aseptic technique when performing venipuncture or accessing CVAD ● Demonstrates use of barcode scanning to collect the labs and appropriately labels ● Verbalizes distinction between STAT and ROUTINE labs <p>PolicyTech: Pain Management</p> <p>Policy Tech: Intravenous Therapy: Peripheral Vascular Access - Adult & Pediatrics</p> <p>Policy Tech: Falls Prevention- Adult</p> <p>Policy Tech: Transport of Patients- Adult</p> <p>Policy Tech: Labeling of Laboratory Specimens</p>			