STEVENSON
MEMORIAL HOSPITAL

Information for Clinical Instructors and Students

Guidelines for Clinical Placement

September 2020/Revised 2024

Stevenson Memorial Hospital (SMH) in collaboration with Community Colleges and Universities has developed the following guideline for the clinical placement of nursing students. It is the expectation that students participating in a clinical experience at SMH will function within these standards at an acceptable level. The staff at SMH will assist the student meet these standards of excellence through encouragement, support and guidance. We encourage the student to enhance their growth through our innovative, patient focused environment. The goals of our facility are to foster the student's acquisition of sound knowledge and skill, and to generate knowledge needed to enhance expert nursing practice.

The Nursing Student Standards at SMH:

The student will;

1. Learn to promote, restore and support health, prevent illness and to relieve suffering.
2. Provide safe, competent and compassionate care.
3. Be respectful of the patient and family values, culture and religion.
4. Strive to establish a therapeutic, trustworthy and caring relationship.
5. Deliver patient and family centered care, showing excellence through nursing practice.
6. Work to enhance the quality of health of the individuals, families and community in a "holistic" manner.
7. Maintain client and family confidentiality at all times.
8. Strive to develop his/her own interpersonal skills and to develop leadership qualities.
9. Work with the facility to build strong partnerships to meet the challenges of the health care environment.
10. Develop a higher level of problem solving skills
11. Use evidence-based knowledge.

The nursing student represents the nursing profession therefore the student has an obligation to know and appreciate the professional's values and to incorporate them into his/her own practice. The student should understand the Canadian Nurses Association Code of Ethics of Nursing and the College of Nurses of Ontario Guidelines for Ethical Behavior in Nursing.

Purpose of Booklet

The intention of this booklet is to give you introduce you to SMH and provide information on skills that you might be required to perform. It is not our intention to teach the skills but to make you aware of the aspects that are unique to SMH.

As per the practice guidelines from the College of Nurses of Ontario, every nurse is accountable for his/her own practice. This means that a nurse will not perform a skill that she/he does not have the knowledge, skill and judgment to perform.

Pre-clinical Placement Recommendations

Staff at SMH is committed to ensuring the student clinical program is a positive experience for all involved (students, clinical instructors, placement coordinators and SMH staff). To begin this experience on a positive note, Instructors are encouraged to contact SMH's Student Placement Coordinator prior to arriving with students for an introduction to the clinical area.

Confidentiality Agreements

SMH has a *Zero Tolerance* policy on any violation of confidential information concerning patients, hospital personnel and hospital business. Audits will be conducted on a regular basis to ensure confidentiality is maintained and violations are addressed. All employees/physicians/volunteers/students and staff from external agencies who have access to confidential information, as defined in the Policy

Statement, are required to sign the Confidentiality Agreement. This Agreement acknowledges that any violation of the confidentiality policy will be grounds for disciplinary action, up to and including dismissal.

What does this mean?

1. You must not divulge confidential information within or outside SMH unless required in the performance of your duties.
2. You must not share your access codes, e.g. your computer password. Your password can and will be used to track accessing of confidential information.
3. You must not leave any confidential information exposed for others to view, e.g. computer screen or patient record or discuss confidential information in public areas.
4. You must not use the information systems to search for any confidential information that is not required to do your job.

The original signed copy of this Agreement must be submitted to the Student Placement Coordinator on the first day of clinical placement.

Name Badges

Students and Instructors are required to wear the School issued Student ID badge, and crest on your sleeve or front pocket that clearly identifies you as a student.

Parking

Parking is available to all students in the staff parking area. A parking pass will be available for you, please see the Student Placement Coordinator on your first day to obtain your pass.

It is highly recommended that students car-pool as parking spaces are limited.

Surge Learning

All pre-grad/consolidation students are required to complete educational modules on our electronic learning system. Surge Learning can be accessed by any computer, anywhere. Modules are to be completed prior to your first practicum. You will be notified via email by the Student Placement Coordinator when your access has been established. The Student Placement Coordinator should be contacted if you have any issues with accessing the system.

www.surgelearning.com
Student login information: smh. (First initial and last name) i.e. smh.jdoe
Password: smh(or the year of your practicum)

Uniforms

Students as well as all staff should wear their street clothes to work and bring a clean uniform with them to wear while on duty. Uniforms should not be worn back and forth from work. Professional looking nursing uniforms should be worn at all times. Name tags and/or school badges must also be worn at all times while in the facility.

Infection Prevention & Control

Students and Instructors are expected to follow and practice basic infection control practices, and follow precautions accordingly.

IPAC principles are paramount in protecting patients, yourself, and other members of the team. Students must respect the principles of donning and doffing PPE, and should be monitored when

doffing. Any student who breaches IPAC protocols is expected to self-disclose to their instructor. The instructor is to determine if this needs to be shared with the Clinical Coordinator for further follow-up or action.

Students who are unwell are not to come to clinical. They are to follow the School's protocol for reporting sick and missing clinical.

SMH has the right to send any student, or a group of student home, if they are unwell, or do not follow IPAC protocols.

Students with a Preceptor

Students must contact their assigned preceptor at least one week prior to starting their clinical placement to discuss their scope of practice (i.e. RPN/RN) student year, expectations, number of patients, and complexity of patient, learning plan and goals. You will be given your preceptor's contact information and unit extension number at the time you receive your preceptor's name.

Note: If you are unable to contact your preceptor, please contact the Student Placement Coordinator to assist you in arranging the above meeting.

Standard Order-sets

Standard order-sets were developed for use in the corporation based on best evidence. The physician customizes the orders for the patient by ticking off the box for the order that applies to the patient. The physician must sign the standard orders. The health care team then initiates them.

Pre-Clinical Placement Recommendations

- All students are expected to arrive on the unit 20 minutes prior to the start of their shift, in scrubs, to allow time for students to review their patient assignment and the nursing Kardex.
- All precepted students are required to provide a learning plan to SMH staff. This learning plan will enhance the delivery of appropriate and rewarding learning experiences.

Communication with SMH

- Confirmation of Clinical Placements: Students will be contacted by their school's nursing placement coordinator/instructor regarding the status of their request.
- All communication must occur between the school's placement coordinator and the Student Placement Coordinator at SMH. Students are not to contact SMH staff directly. This will help to minimize miscommunication.

SMH medication delivery system

SMH uses Accudose as an automated dispensing unit (ADU), along with patient specific medications in a locked cabinet. The Accudose house medications available to each unit for their specific client population. The ADU requires a Bio ID to enter into the machine. This is a multi-step process that requires each student and instructor to complete the Surge Learning module on Accudose prior to start of their practicum. Once the Surge Learning Module is completed, print of the completion certificate and submit to the Student Placement Coordinator in order to complete the pre-registration process. Students are not to access the Accudose with their preceptors Bio ID or password.

eMAR (Electronic Medication Administration Record)

In-patient care units at SMH use the electronic MAR and BMV (bedside medication verification). Orders are to be scanned to pharmacy in order for them to appear on the patient's Accudose profile and eMAR.

Documentation and when to write a note

SMH uses MEDITECH Expanse. All inpatient charting is electronic. Online tutorials are available on Surge Learning.

The CNO standards for documentation should guide the nurse and student when documenting in the patient chart.

When to Write a Note: As a nurse, and as you document, you are a HISTORIAN & a JOURNALIST. You report retrospective data because you never document before the act or event except for the Nursing Plan of Care.

1. Admission/Transfer/Discharge
2. Patient Condition: Your note should show deterioration, improvement, no change, problem resolved or adverse reactions. A complete assessment should be performed and documented on, at a minimum of once per shift. Your documentation should include key findings related to the chief medical concern (for example, a patient being treated for CHF – edema, breathing, chest sounds, etc.)
    a. Deterioration: may lead to a new Nursing Diagnosis.
    b. Improvement: Chart as patient's condition improves.
    c. No Change: Indicating neither, improvement or deterioration since last note but still following the problem.
    d. Problem Resolved: problem has been resolved e.g. State no further symptoms of problem but you will continue to watch for any other signs of reoccurrence.
    e. Adverse Reactions - A pt involved with medical tests or treatments is at risk for developing complications. An adverse reaction to a test or procedure must be identified, treated, monitored and charted.
3. Refusal of Treatment: Document what the patient is refusing and why. The pt's physical and mental status, your efforts to educate the pt and/or family, your communication with the Dr. and a clear statement that treatment was not provided because of pt and/or family refusal.
4. Patient Injury: You must indicate clearly what happened. Do not make a judgment or assumption. Give a complete description of all injuries noted and reported.

Tips for documentation

- Make your documentation patient-centered
- Make sure the time of the occurrence is correct
- Organize your thoughts before writing
- Make notes unbiased and non-judgmental
- Make yourself and other team members the narrator of the story
- Use complete sentences to convey meaning clearly
- Use brief, clear, concise statements of the facts
- Document your patient's subjective data followed by your objective data and your actions
- Document the care you provided
- If you have to deviate from the standards of care, document why you deviated

Consent to Treatment Act, 2001

Nurses no longer witness consents at the SMH, BUT Nurses must still ensure that the patient gave an informed consent. Consents are required for:

- diagnostic procedures

- operative procedures
- administration of blood and blood products

Health Care Consent Act

This Act states: Except in an emergency, a health practitioner must make reasonable steps to ensure that a treatment is not administered unless the patient is capable and has given consent.
OR
If the patient is incapable, consent must be obtained from a substitute decision maker or POA.

Treatment: This is “anything done to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purpose.” Treatments that pose little or no risk of harm to the persons are exempted from this definition.

Responsibility: It is now the total responsibility of the physician proposing the treatment to inform the patient about the procedure, obtain and witness the consent.

Procedure: The proposer M.D. informs the patient of the procedure and at the same time discusses if the potential administration of blood products may be necessary. If the patient does not wish to receive blood products, they sign the back of the consent form, which is “Refusal to Consent to a Blood Transfusion”.