Clinical Expert to Adjunct Faculty: Mastering the Art of Nursing Education

A Webinar Series for Clinical Adjunct Faculty

A NYSNA FACULTY Program

Comprehensive Reference & Reading List

Journal Articles: Transitioning to Nursing Education

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Culleiton, A.L., & Shellenbarger, T. (2007). Transition of a bedside clinician to a nurse educator. *MedSurg Nursing,16*(4), 253-257.

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Forbes, M.O., Hickey, M.T., & White, J. (2010). Adjunct faculty development: Reported needs and innovative solutions. *Journal of Professional Nursing*, *26*(2), 116-124.

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Schriner, C. (2007). The influence of culture on clinical nurses transitioning into the faculty role. *Nursing Education Perspectives*, *28*(3), 145-149.

Skiba, D. J. & Barton, A. J. (2006). Adapting your teaching to accommodate the NET generation of learners. *OJIN: Online Journal of Issue in Nursing, 11*(2). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume112006/No2May06/tpc30_416076.aspx

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Suplee, P. D., & Gardner, M. (2009). Fostering a smooth transition to the faculty role. *The Journal of Continuing Education in Nursing*, *40*(11), 514-520.

Young, P. & Diekelmann, N. (2002). Learning to lecture: Exploring the skills, strategies, and practices of new teachers in nursing education. *Journal of Nursing Education*, *41*(9), 405-412.

Zavertnik, J. E., Huff, T. A., & Munro, C. L. (2010). Innovative approach to teaching communication skills to nursing students. *Journal of Nursing Education*, *49*(2), 65-71.

Textbooks

Bastable, S. B. (2008). *Nurse as educator: Principles of teaching and learning for nursing practice* (3rd ed.).Sudbury, MA: Jones & Bartlett Publishers.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating Nurses: A call for radical transformation.* San Francisco, CA: Jossey-Bass.

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Diekelmann, N. L. (Ed.). (2003). *Teaching the practitioners of care: New pedagogies for the health professions*. Madison, WI: The University of Wisconsin Press.

Finkelman, A., & Kenner, C. (2009). *Teaching IOM: Implications of the institute of medicine reports for nursing education* (2nd ed.). Silver Spring, MD: American Nurses Association.

Gaberson, K. B., & Oermann, M. H. (2006). *Clinical teaching strategies in nursing* (2nd ed.). New York: Springer Publishing Co.

Keating, S. B. (2006). *Curriculum Development and Evaluation in Nursing.* Philadelphia, PA: Lippincott Williams & Wilkins.

O'Connor, A. B. (2006). *Clinical instruction and evaluation: A teaching resource* (2nd ed.). Sudbury, MA: Jones & Bartlett Publishers.

Oermann, M. H., & Gaberson, K. B. (2005). *Evaluation and testing in nursing education* (2nd ed.). New York: Springer Publishing Co.

Penn, B. K. (2008). *Mastering the teaching role: A guide for nurse educators*. Philadelphia, PA: F. A. Davis.

Zager, L., Herman, J., & Manning, L. (*in press). Leading learning: The eight-step approach to clinical teaching*. Dahlonega, GA: I Can Publishing.

Professional Resources

American Association of Colleges of Nursing (AACN). (2008). The essentials of baccalaureate education for professional nursing practice. Retrieved from http://www.aacn.nche.edu/education/pdf/baccessentials08.pdf

American Nurses Association and National Nursing Staff Development Organization (2010). *Nursing professional development: Scope and standards of practice*. Silver Spring, MD: American Nurses Association.

QSEN: Quality and Safety Education for Nurses

Brown, R., Feller, L., & Benedict, L. (2010). Reframing nursing education: The quality and safety education for nurses initiative. *Teaching and Learning in Nursing, 5,* 115-118.

Quality and Safety Education for Nurses. (n.d.). Faculty resources. Retrieved from http://www.qsen.org/faculty_resources.php

Additional Websites

Hansen M2H Nursing (from Margaret Hansen at the University of San Francisco) @ www.m2hnursing.com.

Unit Orientation Checklist (Scavenger Hunt)

Name: _____ Title: _____ Unit: _____ Date: _____

Introduction to Unit	Date Completed Initials	Comments
Overview of Unit:		
Patient Rooms		
DRG's		
Average LOS		
Personnel:		
Leadership Team		
Care Team members		
Daily Routines:		
Assignment sheet/board		
Interdisciplinary team (IDT) rounds		
Patient Rounds		
Competencies		

Environment	Date Completed Initials	Comments
Forms/Requisitions		
Managers Office		
Medication room/cart		
Narcotic cabinet		

Environment	Date Completed Initials	Comments
Emergency drug box		
Med. Refrigerator		
References:		
Clinical Reference Book		
Disaster Manual		
Infection Control Manual		
Language Bank		
Patient Care Manual		
Medication information resources		
Radiology Manual		
Unit Manual		
Supply room(s)		
Staff Lounge		
Sharps containers		
Telephone system/paging system		
Treatment room		
Tube System		
Utility Room(s) Clean Dirty		

Equipment	Date Completed Initials	Method of Validation*			
		D	Demo	Educ	NA
Addressograph machine					
Bandaids					
Bed, patient					
Bedside equipment:					
Blood drawing equipment					
Call Bell/intercom					
Computer					
Drains: Gomco suction Hemovac Jackson pratt Nasogastric tube Urinary drainage system		 ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐
Doppler (for pulse identification)					
Dressings for wounds 4x4's Sterile dressings		 ☐ ☐	 ☐ ☐	 ☐ ☐	 ☐ ☐
Dynamap BP machine					
EKG machine					
Emergency:					
Ambu bag (bag-valve-mask)					
CAC/1-2-6 Cart/Cardiac Arrest					
Defibrillator					
Fire Extinguishers					
Oxygen shut off valves					
Air Shut off valves					
Fax Machine					

Equipment	Date Completed Initials	Method of Validation*			
		D	Demo	Educ	NA
Feeding tubes					
Food service trucks					
Geri-chair					
Glucose monitoring					
Holter Monitor					
Hoyer Lift					
Hypo/hyperthermia blanket					
Incentive spirometer/Tri-flow respiratory apparatus					
IV fluids/tubing					
IV infusion pumps					
Linen room/cart					
Mechanical Ventilator (if appropriate)					
Medication carts					
Monitoring Equipment:					
Bedside					
Central					
Transport					
Negative pressure room & control					
Ostomy equipment					
Oxygen delivery systems					
PCA pumps					
Pleurevac chest drainage system					

Equipment	Date Completed Initials	Method of Validation*			
		D	Demo	Educ	NA
Pulse oximeter					
Pyxis System					
Restraints, Physical					
Scales:					
Sequential compression device (SCD)					
Specialty beds (Therapeutic support service)					
Stretchers					
Suction equipment					
Syringes					
Thermometers (electronic, other)					
Traction: Bucks; Cervical					
Wheelchairs					
Other:					

Patient Care	Date Completed Initials	Method of Validation			
		D	**Demo**	**Educ**	**NA**
Admission					
Critical Pathways					
Dietary					
Discharge					
Documentation					
Emergency Procedures/Numbers					
Escalation Process/Personnel					
Medication administration/documentation					
Patient Treatment Schedule/log					
Physician On-call schedule					
OR Schedule					
Orders: Transcription of (if not CIS system)					
Orders: Review of					
Patient Education					
Transfer					
Unit routines: weights, heights, vital signs, etc.					

OPEN and review all equipment on the crash carts. Assemble the laryngoscope

*Method of Validation Codes: Check all that apply	
D	Discussed and reviewed policy and procedure and or protocol with appropriate personnel in clinical area and/or documented accurately
Demo	Demonstrated skill accurately and successfully in clinical area under supervision
Educ:	Attended or challenged an educational session to acquire knowledge or skill or successfully challenged evaluation method.
NA:	Experience not applicable or available for current assignment

Associates Signature: _____ Date: _____

Preceptor/Validator's Signature: _____Date: _____

Weekly Clinical Conference Record

Name: _____ Date: _____

Clinical Unit/Institution: _____

Purpose: The purpose of the weekly clinical conference record is to allow students to document weekly activities within the clinical area and to reflect on the learning experience. In addition to **reflecting on the experience**, the student is to **identify goals and plans for achieving the goals** for enhanced learning.

1. Accomplishments: What type of patients did you care for? What procedures did you perform or learn? What information did you learn about the system in which the experience occurred?

   _____
   _____
   _____
   _____

2. Goals for learning experience Identify at least one goal that will enhance your clinical experience and learning:

   _____
   _____
   _____
   _____

3. Plan of Action: _____

   _____
   _____

4. Comments: Please comment on your experience for the day/week; include any concerns that you may have. The clinical faculty will also add comments and feedback regarding the experience.

   _____
   _____
   _____

Clinical Faculty Comments:

_____
_____

Date of Meeting: _____

Signature of Student: _____

Signature of Clinical Faculty: _____

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QSEN Clinical Assessment Tool

Patient

_____Patient name outside of room
_____Wrist band: Name verified with patient and DOB
_____Correct names/dates on whiteboard inside patient room

Tubes and Lines – follow each line from patient to device, look at connections, amount of room to move, secured in place, and labels

Oxygen
_____Nares – any skin breakdown
_____Source – flow rate_____, ordered flow rate_____

Feeding tubes (DH)
_____Nares – any skin breakdown
_____Source– label on bag_____, dated_____
_____Irrigation set-up – clean/dated_____

Abdominal tubes
_____Type: G-tube (input) Biliary tube (output)
_____Site – described in pathway_____, labeled_____, bag attached_____

Chest tube
_____Site – described in pathway_____, dressing intact_____
_____Tubing – no kinks_____, tight connections_____
_____Pleurovac – check fluid levels and movement of fluid in
_____Suction chamber
_____H_2O chamber
_____Drainage chamber
Drainage
Amount noted on chamber_____

Tracheostomy
_____Description of trach and size written on pathway
_____Suction catheters available in room
_____Extra trach tube available in room
_____Obturator in sight
_____Sterile water at bedside for trach care? Dated if opened_____

Foley

_____Date of original insertion noted on pathway
_____Tubing – dependent and without loops
_____Drainage bag – below level of bladder

IV's

_____Site – inspect for redness, swelling, warmth, tenderness, drainage
_____Follow tubing to solution – check connections_____, label_____
_____Solution – Correct drug_____, time_____, dose_____, route_____
Compare all of above to MAR/admin RX
_____Pump: Green light_____ Plugged in to wall socket_____

Environment

_____Side rails – necessary?
_____Bed in low position
_____Call light working and within reach
_____No obstacles/clutter at bedside or in route to bathroom
_____No obstacles in route to sink
_____No obstacles at bedside
_____Patient assistive devices within reach – i.e. glasses, hearing aids
_____Correct date/nurse name on white board in patient room
_____Water pitcher or glass available and clean
_____Urinal at bedside
_____Bathroom or Bedside commode emptied
_____Trash receptacle available and within easy reach

Questions for patient (5 minute sit-down)

What would you like to see happen today?

How would you describe your hospitalization – Is there anything that could be done to make it better?

What should nursing students know about what it's like being a patient in the hospital?

Assessment Tool completed by_____and reviewed by_____RN

Dmg2/05/08

THE GUIDELINES

NYSNA/NYONE

Guidelines Regarding Utilization of Licensed Nurses (RNs and LPNs) and Unlicensed Assistive Personnel (UAP) in the Delivery of Nursing Care

Introduction

These guidelines outline the appropriate utilization of registered professional nurses (RNs), licensed practical nurses (LPNs), and unlicensed assistive personnel (UAPs) in the delivery of nursing care. The guidelines focus on the responsibilities of the RN in supervising LPNs and UAPs. These guidelines are intended to be used as a standard and should be utilized by all healthcare organizations in the design and delivery of patient care throughout New York State.

I. Organizational Responsibilities

Healthcare organizations are responsible for maintaining a working knowledge of regulations that pertain to the appropriate scope of practice for licensed practitioners and unlicensed workers working within the agency. The organization's delivery system must be designed to meet the needs of its patient population through:

- Ensuring that professional staff members provide care within their approved scopes of practice
- Evaluating the intensity and complexity of activities to establish the appropriate skill mix and staffing levels
- Conducting systematic evaluations of the effectiveness of the care delivery system and making appropriate adjustments

Responsibilities of the organization include:

- Developing appropriate position descriptions
- Recruiting qualified individuals
- Determining initial competency
- Providing appropriate education and training to maintain competency
- Communicating employee competencies to RN supervisors
- Providing the necessary time and reduced assignment load for preceptor RNs
- Preparing RNs to perform supervision and evaluation
- Providing the appropriate time for supervision
- Providing adequate orientation and cross-training for staff members who are floated to unfamiliar units
- Conducting ongoing evaluations of staff members at all levels
- Taking corrective action for substandard performance

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II. RN Scope of Practice in New York State

The Nurse Practice Act, Article 139 of the New York State Education Law, defines the practice of the RN as "*diagnosing and treating human responses to actual or potential health problems through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed physician, dentist or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations." (Nursing Guide to Practice,* July 2003). Registered nurses are independent practitioners and do not require supervision when they provide nursing care to individuals or groups of people. RNs are prepared by education and clinical experience to assess, diagnose, plan, implement, and evaluate nursing care in all settings.

"Casefinding" includes but is not limited to:

- Identification of epidemiological trends
- Client abuse assessment
- Early identification of emergent complications

"Health teaching" includes but is not limited to:

- Patient teaching regarding possible side effects of medications
- Patient teaching regarding the disease process and management of disease in relation to the patient's life situation, including factors related to culture and ethnicity
- Health care promotion, such as disease prevention, accident prevention, and normal child growth and development

"Health counseling" includes but is not limited to:

- Mental health counseling
- Addiction counseling
- Health counseling related to management of chronic diseases

"Care restorative of life and well being" includes but is not limited to:

- Rehabilitation services such as bowel/bladder training and ostomy/wound care
- Triage and continuous assessment for early signs and symptoms of post-operative complications, leading to timely intervention
- Ongoing surveillance and nursing intervention to rescue chronically ill persons from development of negative effects and secondary results of treatment

"Care supportive of life and well being" includes but is not limited to:

- Hospice and palliative care
- Chronic pain management through non-pharmacological nursing measures such as ergo dynamic techniques, therapeutic touch, and rational-emotive therapy (RET)
- Public health care including elder care, well-baby care, school nursing, and industrial nursing

(State Board for Nursing [SBFN], September 2005)

Nursing diagnosis is defined in the Education Law as "*the identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regime. Such diagnostic privilege is distinct from a medical diagnosis."* The SBFN further defines nursing diagnosis to include the "*collection and interpretation of patient clinical data, the development of nursing care goals, and subsequent establishment of a nursing care plan.*"

Advanced Practice Registered Nurses

Article 139 of the New York State Education Law recognizes only nurse practitioners as Advanced Practice Registered Nurses (APRNs) and describes their scope of practice as "*the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician qualified to collaborate in the specialty provided*." Nurse practitioners practice in accordance with written practice agreements and practice protocols.

In addition to nurse practitioners, NYSNA recognizes other categories of APRNs, including nurse anesthetists, clinical nurse specialists, and nurse midwives. These are RNs who have met advanced educational and clinical requirements beyond those required for all RNs and are experts in specialized areas of practice.

III. LPN Scope of Practice in New York State

Licensed practical nurses (LPNs) are dependent practitioners and must practice under the supervision of an RN, physician, dentist, or other approved health care practitioner such as a nurse practitioner, physician assistant, or podiatrist. The Nurse Practice Act defines the practice of a LPN as "*performing tasks and responsibilities within the framework of casefinding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered nurse or licensed physician, dentist, or other licensed health care provider legally authorized under this title and in accordance with the commissioner's regulations*." (*Nursing Guide to Practice*, July 2003).

"Under the direction of a registered nurse" is understood to mean that a registered nurse is present on the premises or immediately available by telephone when professional services are rendered by a LPN. The degree of supervision shall be appropriate to the circumstances. LPNs receive specific education and training through an accredited institution that has met the state's requirements and standards for excellence and quality. The National League for Nursing characterizes the LPN's practice as caring for patients with common illnesses and providing basic therapeutic and preventive nursing procedures.

Specific activities within and beyond the LPN scope of practice:

- The LPN can delegate and supervise other LPNs in the delivery of care within the LPN's legal scope of practice and level of competency.
- The LPN can supervise unlicensed assistive personnel.
- While LPNs can do data collection, they cannot do patient assessments.
- LPNs cannot independently develop the nursing care plan.
- LPNs cannot administer IV chemotherapy; however, bladder instillation of chemotherapy is permissible.

- LPNs cannot administer any direct IV push medications, except for saline and heparin flushes. They cannot administer an IV fluid bolus for plasma volume expansion, except in the outpatient chronic hemodialysis setting.
- Except in outpatient chronic hemodialysis settings, LPNs cannot access any form of central line, or venous chest or arm port line device.
- LPNs cannot do triage, case management, or mental health teaching.
- When an LPN is delivering home care, the RN must be immediately available by telephone.
- In long term care settings, an RN must be on-site at least eight hours out of the day and immediately available by telephone at all other times.

IV. Unlicensed Assistive Personnel (UAP) Role and Responsibility

Certain categories of unlicensed health care providers, such as operating room technicians, dialysis technicians, and nuclear medicine technicians, have been permitted in a limited manner to perform some activities that fall within the nursing scope of practice. The supervising RN, nurse practitioner, or physician, must remain responsible for the patient assessment, as that professional responsibility cannot be delegated to a UAP. Licensed practitioners in other healthcare professions, such as respiratory therapists, pharmacists, midwives, or physician assistants, may perform some nursing activities within their legally protected scopes of practice.

Under most circumstances, a UAP is a specifically trained individual who serves as an "extra pair of hands" to assist licensed nurses with *non-nursing functions* and *health-related activities* in delivering direct care to patients or clients. Non-nursing functions are generally classified as housekeeping, clerical, transportation, and dietary tasks. Health-related activities are direct patient care activities that are not within the legally protected scope of nursing practice and can be assigned to UAPs who have demonstrated competency. A health-related activity is one that does not require professional judgment or critical thinking and can be completed using a standard procedure.

Activities that can be assigned to UAPs:

- Assisting with activities of daily living (feeding, bathing, ambulating, turning and positioning, grooming, toileting, etc.)
- Measuring vital signs
- Applying clean dressings
- Performing basic intake and output
- Providing oral suctioning and mouth care
- Delivering care of nails, hair, and skin

With additional training and demonstrated competency, UAPs may also be permitted to:

- Taking EKGs
- Using a glucometer
- Performing phlebotomy
- Caring for external catheters

- Assist with placement of braces and prostheses

Activities that cannot be assigned to UAPs:

- Assessing, evaluating, or problem solving
- Developing a nursing care plan
- Performing sterile or invasive procedures or techniques
- Inserting urinary catheters
- Delivering nasogastric or gastrostomy tube feedings
- Administering oxygen
- Performing tracheal suctioning, tracheostomy care, or respiratory care
- Administering medications, immunizations, or blood or blood products

V. Delegation, Assignment, and Supervision

In New York State, LPNs and UAPs are dependent members of the healthcare team who must be supervised by an RN or other authorized licensed professional. Supervision is defined as "*the active process of directing, guiding, and influencing the outcome of an individual's performance of a task and should not be construed to be managerial supervisors on behalf of the employer*" (American Nurses Association, 2005). RNs can *delegate* nursing tasks to other RNs or LPNs, and LPNs can *delegate* to other LPNs. Delegation is the transfer of professional responsibilities to another person who is qualified by training, experience, and licensure to perform them. Health-related activities and non-nursing tasks can be *assigned* to UAPs, but the UAPs' training and competence to perform the tasks must be made known to the supervising RN.

In New York State, it is considered unprofessional conduct to delegate a nursing task to an unlicensed person. Part 29.1 (b) (10) of the *Rules of the Board of Regents* states that unprofessional conduct shall include "*delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, by experience, or by licensure to perform them.*" Violations of this law should be reported to the State Education Department for investigation.

The education, skill, and time needed for an adequate assessment may vary from one patient to another, and subtle clinical clues may be missed when too many direct care activities are delegated or assigned. The RN must determine how much time can be spent away from the bedside. The RN must also consider how many people will interact with a particular patient and the effect of those interactions on the patient.

Factors to consider when deciding to delegate or assign activities:

- **Potential for harm:** What is the particular activity's potential for harm? Certain nursing activities, particularly more invasive ones, carry a greater risk for patient harm. The greater the potential for harm, the more necessary it may be for a professional nurse to render care. The RN must determine how much risk the activity carries for the individual patient.
- **Complexity of task:** What psychomotor and cognitive skills are required to perform a particular activity? Activities involving more complex psychomotor skills and requiring expert nursing assessment and judgment should only be performed by a professional nurse. Support

personnel may learn to perform activities ranging from custodial to direct patient care. But as the required skills increase in complexity, greater consideration must be given to the support person's prior training and demonstrated competency.

- **Problem solving and innovation required:** If a problem is suspected, does it require individualized problem solving to achieve a successful outcome? An otherwise uncomplicated activity may require special adaptation and innovative approaches for a particular patient. Adapting such an activity and evaluating its outcome are the responsibility of the professional nurse.
- **Unpredictability of outcome:** How predictable are the outcomes of an activity? When a patient's individual response pattern to an activity has been established, assigning that activity to qualified support personnel may be considered. When a patient's response is unpredictable or unknown, it is advisable to delegate the activity to an RN or LPN.
- **Required coordination and consistency of care:** Will assigning or delegating a health-related activity increase or decrease the amount of time a professional nurse can spend with a particular patient and that patient's family? The nurse's ability to effectively plan, coordinate, and evaluate a patient's care is restricted when support personnel engage in most of the direct patient contact. (Adapted from the American Association of Critical-Care Nurses, 2004)

VI. Title Protection

As of July 26, 2007 the state Nurse Practice Act reflects the passage of an amendment to Section 6903 protecting the practice of nursing and the use of title "registered professional nurse" or "licensed practical nurse." This law forbids individuals who are not licensed either as a registered professional nurse (RN) or licensed practical nurse (LPN) from portraying themselves as nurses or using the title "nurse" or any abbreviation or reference thereof. Current titles such as Certified Nurse Aide (CNA) are not affected by this law. Individual cases of suspected abuse should be reported to the State Education Department Office of the Professions.

Title protection is a way to assure the public that the individual providing care has met the standards for licensure by New York State and is guided in practice and quality of those professional services by the *Scopes and Standards* and *Code of Ethics* developed by the American Nurses Association.

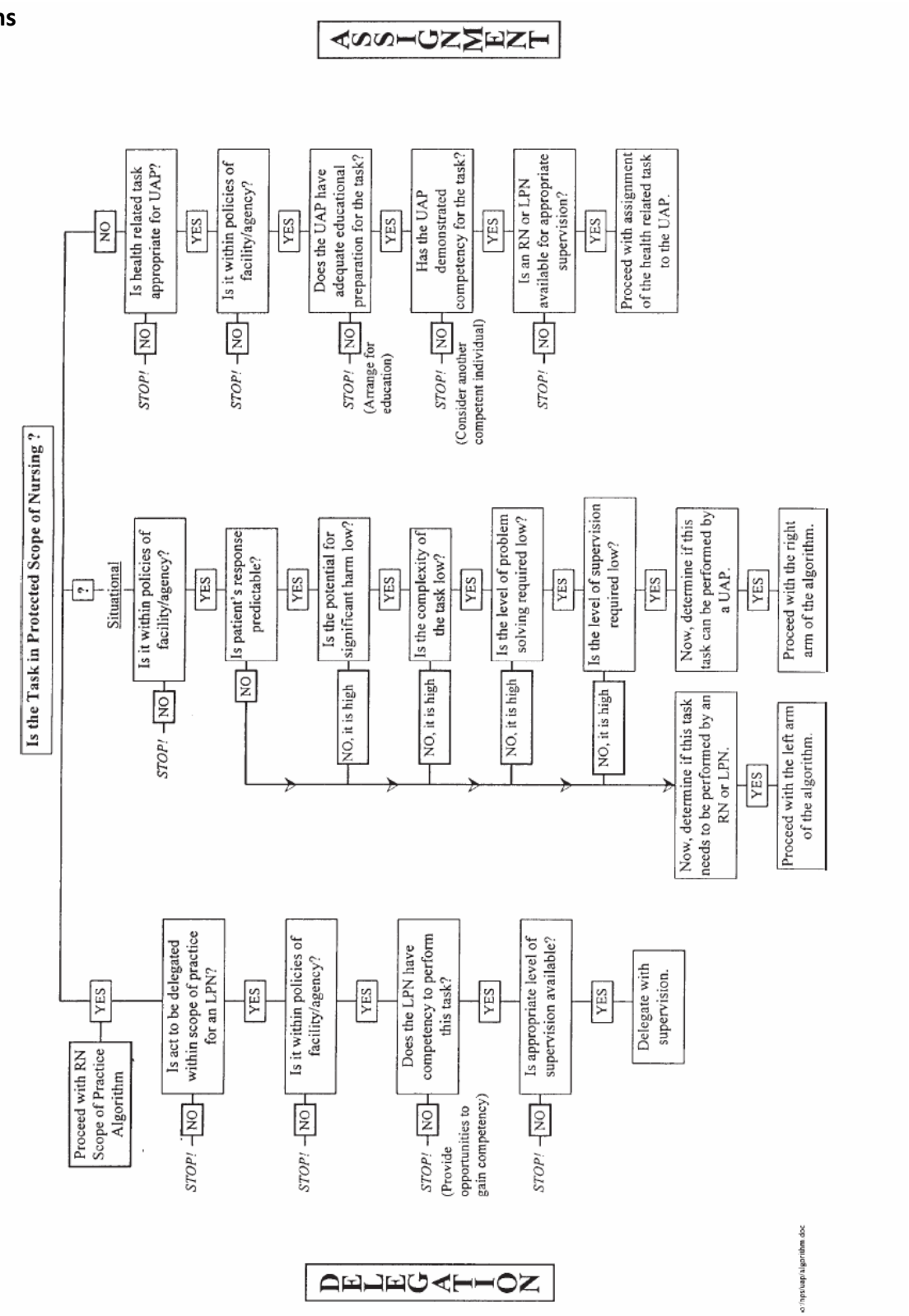
Whether or not a title is appropriate can be determined by analyzing whether the title would lead the public to believe that the individual holds professional licensure. For example, the proliferation of a **new** title, such as "nurse extender," would lead the public to believe that this could be an advanced nursing position. **Existing** titles that contain the word "nurse" or "nursing" and contextually assist the RN are appropriate and can continue to be used by facilities.

This law is enforceable only if the public understands it. To ensure continued protection and respect for the title of "nurse," NYSNA urges all nurses to educate and enlighten the public and healthcare organizations to this important amendment in the New York State Education Law.

Examples of Appropriate and Inappropriate Uses of the Title "Nurse"

Appropriate	***Inappropriate***
Nursing Assistant	Baby Nurse
Nurse Aide	Nurse Extender

VII. Algorithms



ALGORITHM ON RN SCOPE OF PRACTICE
NEW YORK STATE NURSES ASSOCIATION

*If unsure of answer, move along algorithm until you come to a definite stop.
**In New York State Civil Rights Law, Section 79, an individual's right to conscience is addressed and permits one to refuse to assist in an abortion if certain criteria are met.
The Nurse Practice Act in New York State is Article 139 of the Education Law.

This algorithm was developed under the direction of the Executive Committee of the NYSNA Functional Unit of Nurse Administrators and Managers.

Additional Resources and References:

Delegation, Assignment, and Supervision, NYSNA brochure, 2006

NYSNA Position Statement: *Protecting Nursing's Scope of Practice* http://www.nysna.org

NYSNA Position Statement: *Registered Professional Nursing's Utilization of Unlicensed Assistive Personnel* http://www.nysna.org

The Scope of Practice of Licensed Practical Nurses, memo from the NY State Education Department, September 2005 http://www.op.nysed.gov/

The Practice of IV Therapy by Licensed Practical Nurses in Acute Care Settings, memo from the NY State Education Department, September 2004 http://www.op.nysed.gov/

The Practice of IV Therapy by Licensed Practical Nurses in the Long Term Care Settings, memo from the NY State Education Department, September 2004 http://www.op.nysed.gov/

SBAR report to physician about a critical situation

S	**Situation** **I am calling about** <patient name and location>. **The patient's code status is** <code status> **The problem I am calling about is** _____. I am afraid the patient is going to arrest. **I have just assessed the patient personally:** **Vital signs are**: Blood pressure _____/_____, Pulse _____, Respiration_____ and temperature _____ **I am concerned about the:** Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual Pulse because it is over 140 or less than 50 Respiration because it is less than 5 or over 40. Temperature because it is less than 96 or over 104.
B	**Background** **The patient's mental status is:** Alert and oriented to person place and time. Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation. **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm **The patient is not or is on oxygen.** The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**Assessment** **This is what I think the problem is:** <say what you think is the problem> **The problem seems to be cardiac infection neurologic respiratory _____** **I am not sure what the problem is but the patient is deteriorating.** **The patient seems to be unstable and may get worse, we need to do something.**
R	**Recommendation** **I suggest or request that you** <say what you would like to see done>. transfer the patient to critical care come to see the patient at this time. Talk to the patient or family about code status. Ask the on-call family practice resident to see the patient now. Ask for a consultant to see the patient now. **Are any tests needed:** Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others? **If a change in treatment is ordered then ask:** How often do you want vital signs? How long to you expect this problem will last? If the patient does not get better when would you want us to call again?

Guidelines for Communicating with Physicians Using the SBAR Process

1. Use the following modalities according to physician preference, if known. Wait no longer than five minutes between attempts.
    1. Direct page (if known)
    2. Physician's Call Service
    3. During weekdays, the physician's office directly
    4. On weekends and after hours during the week, physician's home phone
    5. Cell phone

    Before assuming that the physician you are attempting to reach is not responding, utilize all modalities. For emergent situations, use appropriate resident service as needed to ensure safe patient care.

2. Prior to calling the physician, follow these steps:
    - Have I seen and assessed the patient myself before calling?
    - Has the situation been discussed with resource nurse or preceptor?
    - Review the chart for appropriate physician to call.
    - Know the admitting diagnosis and date of admission.
    - Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me?
    - Have available the following when speaking with the physician:
        - Patient's chart
        - List of current medications, allergies, IV fluids, and labs
        - Most recent vital signs
        - Reporting lab results: provide the date and time test was done and results of previous tests for comparison
        - Code status

3. When calling the physician, follow the SBAR process:
    (**S) Situation:** What is the situation you are calling about?
    - Identify self, unit, patient, room number.
    - Briefly state the problem, what is it, when it happened or started, and how severe.

    (B) Background: Pertinent background information related to the situation could include the following:
    - The admitting diagnosis and date of admission
    - List of current medications, allergies, IV fluids, and labs
    - Most recent vital signs
    - Lab results: provide the date and time test was done and results of previous tests for comparison
    - Other clinical information
    - Code status

(A) Assessment: What is the nurse's assessment of the situation?

(R) Recommendation: What is the nurse's recommendation or what does he/she want?
Examples:

- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

4. Document the change in the patient's condition and physician notification.