

2017



Respiratory Care
Program
Whitesburg Campus

Clinical Instructor
Handbook

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Mission Statement

The mission of the Respiratory Therapy program is to provide the instruction and resources necessary to enable individuals to develop the knowledge, skills, and attitudes that will allow the student to become a successful and competent professional Respiratory Therapists.

Vision

It is the desire of the program faculty to continue to develop a Respiratory Care program whose graduates and faculty enjoy a reputation for excellence.

Purpose & Goals

- Provide instruction necessary to enable graduates to function as competent Respiratory Therapists who have competence in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains of Respiratory Care as performed by registered Respiratory Therapists.
- To help satisfy the need in the local and regional communities for competent Respiratory Therapists.

Philosophy

The Faculty of the Respiratory Care Program believes that:

- the purpose of the program is to serve students who wish to become respiratory therapists; and that by so doing, the program serves the future patients of these students;
- knowledge, skills, behavior and attitude are of equal importance in the development of respiratory care practitioners;
- the graduates of the program should possess competence at the level of the advanced practitioner, with adequate knowledge in the scientific foundation; critical thinking skills; and strong ethical principles;
- the program faculty and students hold sacred the dignity and worth of all people regardless of race, creed, sex, disadvantage, handicap, or social status;
- becoming a professional respiratory therapist is a noble objective worthy of intense effort.

AARC Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles.

Respiratory Therapists shall:

Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals. Actively maintain and continually improve their professional competence, and represent it accurately.

Perform only those procedures or functions in which they are individually competent and which are within the scope of accepted and responsible practice.

Respect and protect the legal and personal rights of patients they care for, including the right to informed consent and refusal of treatment.

Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty or required by law.

Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.

Promote disease prevention and wellness.

Refuse to participate in illegal or unethical acts, and refuse to conceal illegal, unethical or incompetent acts of others.

Follow sound scientific procedures and ethical principles in research.

Comply with state and federal laws which govern and relate to practice

Avoid any form of conduct that creates a conflict of interest, and shall follow the principles of ethical business behavior.

Promote health care delivery through improvement of the access, efficacy, and cost of patient care.

Refrain from indiscriminate and unnecessary use of resources.

Description of the Respiratory Care Profession

Respiratory Care is a profession involved in supporting cardiopulmonary health, rehabilitation, therapeutics, and life support. Therapists are also extensively involved in cardiopulmonary diagnostic testing, patient evaluation and care planning. They work with patients of all ages from pre-mature infants to the elderly. They work in a variety of healthcare settings such as hospitals, clinics, and home care. Therapists use knowledge of patient physiology, and advanced technology in planning and delivery of respiratory care. Most states require licensure certification and/or registry by the National Board of Respiratory Care.

Respiratory Care Scope of Practice

The practice of Respiratory Care encompasses activities in: diagnostic evaluation, therapy, and education of the patient, family and public. These activities are supported by education, research, and administration. Diagnostic activities include but are not limited to: (1) obtaining and analyzing physiological specimens; (2) interpreting physiological data; (3) performing tests and studies of the cardiopulmonary system; (4) performing neurophysiological studies; and (5) performing sleep disorder studies.

Therapy includes but is not limited to application and monitoring of: (1) medical gases (excluding anesthetic gases) and environmental control systems; (2) mechanical ventilator support; (3) artificial airway care; (4) bronchopulmonary hygiene; (5) pharmacological agents related to respiratory care procedures; (6) cardiopulmonary rehabilitation; and (7) hemodynamic cardiovascular support.

The focus of patient and family education activities is to promote knowledge of disease processes, medical therapy and self-help. Public education activities focus on the promotion of cardiopulmonary wellness.

Technical Standards

Purpose

To provide students/applicants with an understanding of the physical demands, communication skills and cognitive level required for the program. These standards are based on tasks which are performed by Respiratory Therapists on a regular basis.

Standard	Issues	Examples of Required Activities
Critical Thinking Skills sufficient to make clinical judgment.	Critical thinking.	Assess patients' physical and psychosocial needs in a variety of clinical settings by utilizing interpretation of written, verbal and sensory observations to determine appropriate therapies for patient care.
Problem solving skills appropriate to adjust therapies in response to patient needs	Problem Solving.	Adjust therapeutic interventions to meet the needs of patients in a variety of settings
Interpersonal skills sufficient to allow appropriate interaction with individuals and groups from a variety of cultural and socioeconomic backgrounds.	Interpersonal Relationships	Interacting with patients, families, co-workers and others to create and maintain professional relationships
Written and verbal communication that is appropriate to create clear and concise dialogue in a clinical setting	Communication	Communicate effectively with patients, physicians, families and other staff members to assure appropriate patient care.
Physical abilities appropriate to maneuver in small spaces while maneuvering equipment	Mobility	Move safely in a patients' room. Safely maneuver equipment and apply equipment to patients in a variety of situations, often in confined spaces. Perform CPR including chest compressions and intubation

Standard	Issues	Examples of Required Activities
Gross and fine motor skills appropriate to perform patient care procedures to national standards which include safety and efficiency	Motor Skills	Safely care for patients by manipulating machine controls and equipment. Occasionally crouching, squatting or bending to obtain/evaluate equipment and patients; assist patients from lying to sitting and or standing positions; hand eye coordination sufficient to perform an arterial blood gas puncture and suctioning
Appropriate physical strength and endurance to be able to access patient as well as perform therapies on patients for extended periods of time	Strength and Endurance	Transporting patients and equipment within a facility; standing or being mobile in clinical settings for 10 hours or more; strength to perform intubation; and assist in moving of patients in beds, on stretchers and wheelchairs. Constant standing, walking and lifting of up to 25 pounds
Auditory ability sufficient to monitor and assess health care needs of patients	Hearing	Hear monitor alarms, equipment audible alarms, voices with background noise, and through protective equipment, calls for help
Tactile ability appropriate for assessment of physical health conditions	Tactile	Be able to palpate patient pulses. Perform didactic and therapeutic percussion, and physical assessment of the chest
Ability to deal effectively with stressful situations, and maintain a professional and positive interactions with others	Temperament	Perform procedures on patients who maybe in pain due to a variety of reasons. Maintain a sense of professional behavior when under stress

THE ROLE OF THE CLINICAL INSTRUCTOR

You, as a clinical instructor have been given one of the most important roles in the education of future Respiratory Care practitioners. Each clinical instructor brings to students a set of unique clinical experiences. These shared experiences can add a tremendous amount of practical information to the students' growing knowledge base. In the clinical setting, the instructor provides a vital bridge from the classroom to the patient.

The clinical instructor plays more than one role when working with students. Students see an instructor as a **TEACHER** who imparts knowledge and/or skills; a **LEADER** who guides them; a **TEAM MEMBER** who is associated with them in a joint effort or action; a **ROLE MODEL** who sets a professional standard for imitation; a **CONSULTANT** who advises them; and last but not least, the clinical instructor is viewed as a **FACILITATOR** who makes good experiences happen.

Everyone at some time in their training has benefited from experienced clinical instructors; and all have been influenced by their association with clinical instructors during their training. You now have an opportunity as a clinical instructor, to pass on the knowledge and experience you have gained. Your part in the education of competent dedicated practitioners helps ensure a bright future for our profession.

CRITERIA FOR APPOINTMENT AS A CLINICAL INSTRUCTOR

The individual who is considered for selection as a clinical instructor in the Respiratory Care Program must:

1. Express interest in teaching.
2. Display enthusiasm.
3. Be knowledgeable.
4. Demonstrate communication skills necessary to accomplish teaching.
5. Meet with approval of the Medical Director, the Program Director and the Director of Clinical Education and the Director of the Respiratory Care Department in which they work.
6. Attend scheduled clinical instructor meetings and workshops.
7. Submit faculty curriculum vitae.
8. Complete required instructor training to assure inter-rator reliability.
9. Maintain a minimal rating of satisfactory on employee evaluation.

FERPA

- Family Educational Rights and Privacy Act, 1974
- Protects the privacy of a student's educational records
- Applies to all educational agencies or institutions that receive funds under any program administered by the Secretary of Education

What are Educational Records?

- Records - handwriting, print, computer, videotape, audiotape, film, microfilm, or e-mail
- Contain information directly related to the student
- Are maintained by an agency or institution or party acting in its behalf
- KCTCS lists the following as records maintained by the colleges
- Academic records from schools previously attended
- Scores / results on standardized tests and interest inventories
- Degrees awarded
- Current academic work completed
- Grades and other faculty evaluations
- Applications for admissions
- Applications and other data related to financial aid
- Applications for employment
- Class rolls
- Letters of recommendation
- Academic advisor notes
- Attendance data
- Biographical and identifying information
- Medical data
- Current student status
- Accounts relating to fees
- Academic offenses
- Disciplinary offenses
- Counseling notes

When Can Information Be Released Without Student Consent?

- The law allows disclosure without consent to:
 - School employees who have a legitimate educational interest
 - Other schools, upon request, in which a student is intending to, enroll
 - Appropriate parties in connection with financial aid to a student to determine eligibility, amount or conditions of financial aid, or to enforce the terms and conditions of aid
- Certain government officials of the U. S. Department of Education, the Comptroller General, and state and local educational authorities, in connection with an audit, authorized representatives of the U. S. Attorney General for law enforcement purposes or state or federally supported education programs
- Individuals who have obtained a judicial order or subpoena
- School officials who have a need to know concerning disciplinary action taken against a student
- Appropriate parties who need to know in cases of health and safety emergencies when necessary to protect the health and safety of the student and / or others
- State and local authorities, within the juvenile justice system, pursuant to specific state law

- Alleged victim of a crime of violence the results of a disciplinary proceeding with respect to that crime
- Parent or legal guardian of a student under the age of 21, information regarding any violation of university policy or state, federal or local law, governing the use or possession of alcohol or a controlled substance

VARIOUS ROLES AND METHODS IN TEACHING

DEMONSTRATION	Showing and explaining a process or procedure.
ASSISTING	Supporting and helping with procedures.
SUPERVISING	Directing or overseeing a procedure.
CONSULTING	Acting as a resource person (pointing out unusual procedures, patients, etc.)
FACILITATING	Organizing and arranging beneficial clinical experiences.

TEACHING METHODS USED IN EACH SEMESTER

CLINICAL PRACTICE 1 (RCP 150)	Demonstration; Observation, Assisting
CLINICAL PRACTICE 2 (RCP 175)	Demonstration; Assisting; Supervising; Evaluation
CLINICAL PRACTICE 3 (RCP 200)	Demonstration; Directing; Assisting; Supervising; Consulting; Facilitating
CLINICAL PRACTICE 4 (RCP 275)	Some Assisting, but mostly Supervising of procedures; Demonstration in Intensive Care Areas; Consulting and Facilitating
CLINICAL PRACTICE 5 (RCP 250)	Supervising, Consulting, and Facilitating

CLINICAL GUIDELINES

Attendance in Clinical Areas:

- Students are expected to attend **all** scheduled clinical sessions.
- Clinical time sheets are used for tracking attendance. Each student is responsible for signing themselves in/out and having clinical instructor verify and sign time sheet. No other student is to sign another student in or out. Falsifying time sheet information will be considered academic dishonesty and treated as such in the disciplinary process.
- If a student fails to sign in/out on a clinical day he/she may receive a written warning and a 5% grade reduction for each offense.
- Students may not leave the clinical facility during clinical hours without first obtaining permission from the clinical instructor.
- The Respiratory Care Program **requires** students who are assigned to a clinical site to inform the **Clinical Site first** and then the Director of Clinical Education if he/she is going to be tardy or absent. The student should call no less than 30 minutes before clinical assignments begin. Students are to leave a detailed voice message for the Director of Clinical Education If the Director of Clinical Education cannot be reached.
- Since punctuality and reliability are essential for success in your career, and a characteristic sought by all employers, students who are late for clinical assignments will receive **a 10% grade reduction** on their evaluation.
- Tardies are defined as >10 minutes late. (If the student arrived on time but was unable to sign in the clinical instructor should document arrival time in the comment section on the evaluation form.)
- Students who are **absent** from a clinical assignment without notice will receive a zero (**0**) for that rotation. **Two (2) absences without notice will result in dismissal from the program.**
- Absences that are deemed **excessive** by the Director of Clinical Education/Program Faculty will result in an incomplete for the course. The student will be required to make up the missed time with a reduction in grade. The Director of Clinical Education/Program Faculty, may require the student to repeat the entire course if it is not feasible to make up the missed time.

Delineation between Clinical Time and Clinical Site Employment

While enrolled in an attending the Respiratory Care program many students are employed at various clinical sites. There must remain a clear distinction between the student and employee roles; and to that end:

- Students must not be utilized at facilities to substitute for clinical instruction, or administrative staff.
- Students must not complete clinical coursework while working in an employee status at any clinical site.
- Students may not receive/accept remuneration in exchange for work performed at or during their clinical education, course work, and experiences.

EMERGENCY CALLS

Students are expected to respond to all emergency situations that arise in the following manner

Students will respond to the area of the emergency. At the discretion of the clinical instructor students will remain and take part in the emergency operation. Those students NOT assigned will immediately return, to their previously assigned duties, unless otherwise instructed by their instructor. An equal opportunity to gain experience in emergency patient care will be provided, whenever possible.

For all other emergency announcements the student will remain with their assigned instructor. The student will assist in patient care and other needed tasks at the discretion of their instructor.

USING THE TELEPHONE SYSTEM

1. Students may not use hospital telephones for personal business.
2. Student may receive **ONLY EMERGENCY CALLS** from outside the hospital!
3. The use of cellular phones in the clinical setting is strictly prohibited.

LUNCHES AND BREAKS

An assigned lunch break will not be made, but may be taken at a time when the assigned duties are completed or at the discretion of the assigned clinical instructor. Breaks are to be taken at the discretion of the instructor and are limited to 15 minutes in length.

NOTE: From time to time situations arise when a break will not be allowed due to emergencies or other extenuating circumstances; however, every effort should be made to ensure that all students receive their break whenever possible.

MEDICAL RECORDS

Students are allowed access to patient medical records and with this privilege comes the responsibility for maintaining PATIENT CONFIDENTIALITY.

- Medical records may not be removed from a nursing station or from the Medical Records Department at any time.
- Medical records may not be reproduced at any time, in any form, for any purpose.
- Tape recorders or lap top computers are not allowed in the Medical Records Department.

STUDENT IDENTIFICATION

1. Students are required to wear their Southeast Kentucky Community and Technical College I.D. badges at all times, when on clinical assignment. These badges cannot be defaced.
2. No other type of I.D. badge may be worn when on duty as a student (i.e. No hospital employee badges may be worn.)

HEALTH AND SAFETY

School Related Accidents and Incident Reports.

- A student who becomes ill or is injured at the clinical site must report to the assigned instructor and/or the Director of Clinical Education/Program Faculty as soon as possible. She/he will determine if it is necessary for the student to be seen by the employee health nurse or the Emergency Department.
- The student is required to fill out an incident report at the school and the facility in the event of an injury or incident. An incident report is written documentation of the facts concerning injury to the patient or student.
- An Incident Form should be completed as soon as possible, regardless of how trivial the incident may appear at the time. The form must be completed within 24 hours of the accident or incident.
- A copy of the form will be kept in the student's program file.
- Personal injuries and illness requiring medical treatment are the financial responsibility of the student.
- If the student is required to have continuing medical treatment for a limiting disability or condition, the student is responsible for notifying the program faculty as soon as it is known to the student.
- It is recommended that the student maintain individual health insurance coverage.

DRESS CODE

Students must adhere to the established dress code for Respiratory Care Program (see "Dress Code Guidelines" for complete explanation).

STUDENT CONDUCT

The student is expected to adhere to the standards of ethical professional behavior as set forth in the AARC State of Ethics and Professional Conduct for Respiratory Therapists.

Students are expected to conduct themselves in a professional manner at all times, and to treat every patient, physician, all instructors and every other member of the health care team with respect and courtesy.

Students enrolled in this course of training are expected to demonstrate a high level of MOTIVATION, RELIABILITY, and DEDICATION to the practice of their chosen profession.

EVALUATION AND RECORD OF CLINICAL ACTIVITIES

Each clinical day the student is responsible for submitting Clinical Check Off sheets and a Record of Procedures Performed for clinical instructor review and validation.

At the end of each clinical rotation the student is responsible for submitting a clinical evaluation, to be completed by the assigned instructor. Also, the student must submit a daily clinical time sheet to be validated by the assigned instructor.

If a student feels that they have been unfairly evaluated by an instructor they should contact the instructor or the Director of Clinical Education/Program Faculty to discuss the issue. The instructor or Director of Clinical Education/Program Faculty will promptly investigate the issue and provide feedback to the student within 10 school days.

CLINICAL STANDARDS OF APPEARANCE AND ATTIRE

Because people form impressions, usually within the first 15 - 30 seconds after being introduced, it is important that you give an appropriate, visual impression. If, in the patient's eye, the student does not look professional, it may affect the student's ability to interact with the patient. Standards of clinical appearance and attire are set and enforced by the faculty of the Respiratory Care Program. Failure to abide by these standards will result in the student being sent home to correct the problem, and deduction of points on the semester professional evaluation.

Basic Grooming - Meticulous personal hygiene is required!

Hair: Must be clean and off the face. Long hair must be managed so that it does not fall forward when attending to the patient. Conservative hair color and professional style required and must meet the approval of the faculty. Male students' hair should be no longer than collar length.

Beards & Mustaches: Beards and mustaches are permitted; however they must be kept short, neatly trimmed and clean. If a male student wishes to grow a beard, he must notify clinical faculty. Otherwise the student is expected to be clean-shaven at all times.

Nails: Fingernails must be kept short, trimmed and clean. No nail polish. **Absolutely no acrylic, artificial or nail overlays allowed.**

Make-up: Conservative application of make-up is allowed, with a light shade of lipstick.

Deodorant: Deodorant should be applied daily, and reapplied throughout the day as needed.

Fragrance: COLOGNE, PERFUME, SCENTED BODY WASH, LOTIONS OR SCENTED AFTER SHAVE ARE NOT ALLOWED! Many of our patients have severe allergic reactions to these "triggers". Many other patients who are nauseated experience exacerbation of the nausea when exposed to these offenders.

Tattoos: All tattoos must be completely covered.

Jewelry: The only jewelry allowed is as follows:

Rings - a wedding band and/or engagement ring *ONLY* are permitted (rings of *any kind* may NOT BE PERMITTED to be worn in the NICU).

Watches - A watch with a second hand is required.

Earrings -- only small post earrings may be worn for pierced ears. Only one **matched pair** of earrings may be worn. Excessive ear piercings are not permitted.

Hair accessories – Accessories that are worn in the hair should be appropriate in style, color (gold, silver, white or the color of your hair). Large hairpieces are not allowed. **All accessories are to be solid in color.**

Body Piercing – Body piercing **CANNOT** be visible to patients. This includes eyebrows, nose, lip, and tongue piercing.

The clinical facilities and SKCTC will not be responsible for jewelry worn in the clinical area. The best policy is to leave your jewelry at home. You may be asked to remove anything from your person during clinical assignments, if it is deemed unprofessional.

Chewing gum is not allowed in any facility during clinical rotations!

CLINICAL ATTIRE

Scrubs: Required uniform are to be worn.

Shoes: Shoes must have heels and toes enclosed and should be white in color. Leather athletic shoes or support type shoes are appropriate and recommended. Basketball shoes ("high tops"), sandals, sling backs, ladies shoes with high heels are NOT acceptable.

Clinical attire must be worn to and from the clinical facility!

- School name badge, stethoscope and clinical notebook are considered part of your clinical attire. The student is responsible for having each of these items with them at all times when in the clinical area.
- Student Respiratory Therapists will present a neat and tidy appearance at all times.
- Clinical attire must be clean, neatly pressed and fit properly.
- Students are responsible for furnishing and laundering their own clinical attire.
- Smoking or the use of any tobacco products is not permitted in any clinical facility.
- Special areas may require specific dress attire and students will adhere to the institution/area dress code.

Please note: Any student who reports for clinical assignment and does not meet the above standards will be dismissed from the clinical area, and sent home to rectify the problem. Failure to abide by these standards will also result in the deduction of points on the student's semester professional evaluation

Clinical Task Performance Evaluation System

Task performance evaluations are used to evaluate clinical competency. The student may elect to perform a task performance evaluation after the following criteria are met:

- Completion of the didactic coursework for a specific skill.
- Simulation or task evaluation and check off in the laboratory setting.
- Observing and assisting the clinical instructor in the procedure.
- Performing task several times.

It is the student's responsibility to determine when he/she feels ready to be evaluated on a specific skill. Students must request to attempt the evaluation and provide the instructor with the skill performance evaluation form prior to the task is performed. The instructor will observe the student perform the entire task unassisted.

The instructor records the evaluation of the student's performance on the provided form. Failure when performing a clinical skill does not imply an end to the clinical experience. The student may attempt the task again when he/she has reviewed the procedure and feels prepared. Successful completion of the evaluation does NOT imply an end to the performance of that skill. Students are required to routinely perform the skill in order to maintain a competent level of proficiency.

A list of the required performance tasks is included in this handbook. The evaluations must be performed in the clinical setting before completion of the program will be recognized.

In the event a student has not completed the required evaluations at the time of graduation, the faculty will evaluate the student's clinical records to determine if sufficient opportunities were available for the student to perform the required evaluations on an actual patient. If lack of opportunities is established, the student will be allowed to demonstrate task performance through simulation.

THE STUDENT MUST:

- Students must complete the Record of Procedures Performed, recording all activities for that clinical day.
- Give the instructor the completed form before the end of the clinical day.

THE CLINICAL INSTRUCTOR WILL:

- Review the student's performance on a 0 – 4 scale on the applicable evaluation on
- Validate the Record of Procedures Performed completed by the student as well as any tasks performed.
- The Program Faculty believe if when the student is evaluated as anything other than “average” it is critical to the student's learning experience to have full documentation of the behaviors that placed their performance in a higher or lower category. The instructor will:
- Submit the completed evaluation.

The Program Faculty believes it is critical for the student to take the opportunity to ask the instructor questions about any area of the evaluation that is unclear.

TASK PERFORMANCE EVALUATIONS:

- All performance evaluations are to be handled following the steps listed above.
- When Task Performance Evaluations are completed and Signed by the clinical instructor.
- All hard copies of clinical forms are to be reviewed by the Director of Clinical Education/Program Faculty.
- Clinical evaluations are to be turned in to the Director of Clinical Education and will be reviewed with the student. The student will then sign the evaluation acknowledging they have seen and reviewed the evaluation. If they do not agree with the evaluation the DCE and student will meet with the instructor to review it.

Whitesburg Consortium for Respiratory Care Education
Performance Evaluation Summary Record

Abbreviated Procedure Summary	Class
Vital Signs (Pulse, respiratory rate, arterial blood pressure)	RCP 150
Patient Assessment	RCP 150
Oxygen Administration	RCP 150
Bronchial Hygiene	RCP 150
Aerosolized Medication	RCP 150
MDI	RCP 150
Incentive Spirometry	RCP 150
Chest Physical Therapy	RCP 150
EKG	RCP 150
Adult Routine Ventilator Check	RCP 175
Endotracheal Suctioning	RCP 175
Arterial Line Sampling	RCP 175
ABG Sampling Puncture	RCP 175
Extubation	RCP 175
Vent Monitoring Adult	RCP 175
Aerosolized Medication on Vent- Adult	RCP 175
Adult Ventilator Setup	RCP 175
Pulmonary Mechanics	RCP 175
Taping ET Tube/Tube Holders	RCP 175
Intubation	RCP 175
Setup and Ventilation Via Endotracheal Tube	•
Aerosol/Tent Therapy	•
Nasotracheal Suctioning	•
IPPB Therapy	•

- As Procedure is available.

Example Outline - NT Suction Procedure Performance

EQUIPMENT AND PATIENT PREPARATION

1. Evaluates indication for procedure based on patient's inability to clear secretions with best cough and presence of audible secretions
2. Reviews patient chart for significant findings and data
3. Identifies and gathers the necessary equipment (gloves, suction catheter, water based lubricant, nasopharyngeal airway if appropriate, sterile water & container, manual resuscitator, appropriate sized mask, oxygen source, vacuum source & tubing)
4. Applies 3 or more mL of an alcohol-based hand rub to palm and rub hands together covering all surfaces of each hand until hands are dry (**Caution: should take at least 15 seconds for hands to become dry**); or if hands are visibly dirty or contaminated perform hand wash using a vigorous rubbing action for at least 10 seconds; and uses appropriate isolation precautions
5. Introduces self to the patient, stating name, department; confirms patient identification.
6. Explains the purpose of the procedure, including risks and safety precautions
7. Confirms patient and/or family understanding of the procedure

IMPLEMENTATION OF PROCEDURE

1. Checks function of manual resuscitator (proper gas outlet and flow, corrects leaks as necessary and adjusts vacuum pressure.
2. Position patient's head/neck in mild extension (sniffing position)
3. Selects proper size of suction catheter
4. Puts on protective gloves using sterile technique; connects suction catheter to vacuum source; adjusts vacuum pressure; suctions sterile water to confirm operation
5. Assess need for supplemental oxygen (e.g. pulse oximeter, heart monitor) and pre-oxygenate as appropriate for more than 30 seconds
6. Monitors oxygenation status prior to, during, and after the suctioning event.
7. Lubricate catheter and gently insert through nasal passage directing the catheter towards the septum and the floor of the nasal passage, if resistance is encountered gently twist while advancing the catheter
8. Continues to advance catheter through oropharynx and into the trachea while evaluating position to reduce incidence of esophageal placement, speech should become hoarse or whisper like with correct tracheal placement
9. Advance catheter until patient coughs or resistance is met
10. Apply negative pressure while the catheter is being withdrawn; duration of each suctioning event should be approximately 10-15 seconds; assess need for subsequent suction events before removing the catheter from the nose
11. Assess need for supplemental oxygen (e.g. pulse oximeter, heart monitor) and hyper-oxygenate as appropriate for more than 1 minute following each suction event
12. Repeat cycle only as indicated (cycle consists of assessing patient response, evaluating oxygenation status, and suctioning event)

13. Monitors patient response (i.e. breath sounds, oxygen saturation, respiratory rate and pattern, heart rate and rhythm, sputum characteristics, presence of bleeding, level of pain, cough, and ICP)

14. Responds to hazards or complications as appropriate (e.g. mechanical trauma, misdirection of catheter, desaturation, dysrhythmias, bronchospasm, changes in hemodynamic status, elevated ICP)

FOLLOW-UP

1. Evaluate outcome of suctioning procedure (positive outcomes may include: improved breath sounds, removal of secretions, and improved SpO₂)
2. Decontaminates hands with an alcohol-based hand rub or performs a 15 second hand wash
3. Records relevant data in patient chart and appropriate departmental records

DEMONSTRATES KNOWLEDGE OF FUNDAMENTAL CONCEPTS

1. Identifies indication for suctioning
2. Identifies potential complications associated with suctioning
3. Identifies indication for nasopharyngeal airway
4. Identifies appropriate vacuum pressures

CLINICAL COMPETENCY PERFORMANCE CRITERIA

1. Displays rational judgment and is able to explain the relationship between theory and clinical practice.
2. Performs procedure in a reasonable time frame and with attention to appropriate detail
3. Maintains aseptic technique and takes appropriate safety precautions
4. Communicates clearly, and in a courteous manner

Additional Comments: include errors of oversight or sequence, strengths and weaknesses during procedure (i.e. knowledge, communication skills, and patient interaction skills)

Summary performance evaluation Please use the following criteria:

Performs Unassisted - ready for clinical application with minimal supervision. Performed procedure accurately, or was able to correct performance without injury to the patient or decreasing effect of therapy being given.

Performs Assisted – Needs to review fundamental concepts, requires practice and re-evaluation of minor deficiency(s) (ex. forgets to wash hands during the follow-up stage. Must be re-evaluated on this step not the whole procedure).

Unable to Perform- Unsatisfactory: requires additional supervised clinical practice and complete re-evaluation of the procedure.

Clinical Competency (Performance Evaluation Final Check-Off) - ready for clinical application with minimal/no supervision. Performed procedure accurately, or was able to correct performance without injury to the patient or decreasing effect of therapy being given. Was able to answer pertinent questions about procedure including, indications, contraindications, and hazards.

REQUIRED: Summary Performance Evaluation

Evaluating the proficiency that a student demonstrates when performing clinical skills should include not only the ability to perform the task according to acceptable standards of practice and hospital policy but also the ability to answer some basic questions in relation to rationale for therapy as well as trouble shooting and discussion of situations that the student might encounter.

Included here are some sample questions for your convenience.

ABG PUNCTURE

Questions:

1. Describe the procedure for an Allen's test and tell what criteria would indicate that the patient should NOT have a radial stick performed in that arm.
2. What is the minimum amount of time that you should hold the site following an arterial stick?
3. Following an arterial stick, what do you do with the needle in order to prevent sticking yourself or anyone else from an accidental needle puncture?
4. If you received the following arterial blood gas results, what would you do? pH = 7.21, PaCO₂ = 58mmHg, PaO₂ = 47mmHg, HCO₃ = 23 on room air.
5. What would you do if a patient refused to let you perform an arterial puncture?
6. What would you do if you accidentally dropped the syringe containing blood and blood spilled on the floor? (Where would you get the materials you need for handling this situation?)
7. How will an air bubble in the sample affect the results on a patient who is breathing 40% oxygen?

AEROSOL / HUMIDITY THERAPY

Questions:

1. What would you do if you entered a patient's room to set up an aerosol mask and the patient appears to be sleeping?
2. If a nebulizer is set at 70% and the oxygen flow meter is set at 10L/min, what is the total flow of gas to the patient?
3. What would you do if a patient refused to keep his aerosol mask on because it kept getting his face wet?
4. What are the results if the total flow to the patient does not exceed his/her inspiratory demands?
5. What will happen to the FIO₂ if enough water accumulates in the large-bore tubing to impede flow to the patient? Why does this happen?
6. How would you set up a T-piece if the physician's order specified exactly 75% O₂ to be delivered?

ARTIFICIAL AIRWAY CARE

Tracheotomy Questions:

1. A patient needs suctioning prior to tracheotomy care. During the procedure, how would you clear the secretions that lodge above the cuff?
2. You are about to practice tracheostomy care on a patient for the third time. Your instructor is in the hall outside the room. A nursing student walks in and asks if he can help. What would you do?
3. During tracheostomy care the patient coughs just as you're changing the ribbon and the entire tracheostomy tube comes out. What would you do?
4. A physician comes into the room while you're cleaning the tracheostomy tube. She begins handling the tracheostomy site, but she is not wearing gloves. What would you do?
5. While cleaning the tracheostomy site, you accidentally cut the pilot balloon to the cuff. What should you do?

ETT

Questions:

1. While preparing to tape the ET tube you notice the cm marking at the teeth is 18. It was previously 23 cm. What is the potential problem and what would you do?
2. A nurse comes to assist you during a re-taping procedure. The nurse has not washed her hands and is not gloved. How would you handle this situation diplomatically?
3. You are re-taping a tube on a patient. A physician tells you "You're doing that all wrong. Get someone who can do it right." What would you do?
4. While removing the old tape, the pilot balloon is accidentally cut. What would you do?
5. A patient with severe facial burns has an oral endotracheal tube in place. How can you secure the tube?
6. You check the x-ray and notice that the tip of the tube is below the level of the second rib anteriorly. What would you do?
7. When measuring cuff pressure you find that it's 45 cm H₂O. The cuff pressure is reduced to 25 cm H₂O. Original VT was 700 ml. VT now is 300 ml. How can this be corrected?
8. Prior to doing a minimal leak technique, you inflate the cuff and listen over the trachea. Even with inflation, there is a loud audible leak during inspiration. What should you do?
9. A patient's cuff pressure with a minimal leak technique is at 35 cm H₂O. The physician in charge of the patient wants you to reduce the pressure. You're afraid of an excessive lose in VT from the ventilator. What would you do?
10. You go to perform a minimum leak technique and the nurse frantically shouts to you "Don't touch his tube. He might extubate himself and the doctor said not to let him extubate himself". What would you do?
11. You complete a minimal leak technique and cuff pressure measurement on an ICU patient. As you leave the room the nurse yells at you "You forgot to put the side rails up." What would you do?

ASSESSMENT OF VITAL SIGNS

Questions:

1. The blood pressure cuff will not pump up. What would you do?
2. You are unable to palpate a left brachial pulse. What action can you take?
3. What is normal BP?
4. You are in a patient's room checking Mr. M's BP, he becomes angry and demands to know what you want with his BP. Are you a doctor and, if not, why are you in his room? What would you do?
5. What do you do with the value you obtain? What if BP is significantly different from what is in the chart?

CHEST PHYSIOTHERAPY

Questions:

1. You are performing CPT on a patient and the initial BP is 180/95. The patient is to receive CPT to the right lower lobe. In what position would the patient be placed? During the treatment the patient begins to complain of a headache and the BP now is 200/102. What action is required?
2. A patient who is receiving CPT has emphysema. The physician has ordered CPT to the lower lobes, but the patient will not allow you to place him in Trendelenburg. How would you handle this problem?
3. The physician has ordered CPT with vibrations to a patient who has multiple rib fractures. The patient complains of pain during the treatment. You call the physician but the physician requests that you continue to perform the CPT. What is the proper recourse to resolve the problem?
4. You are in a patient's room checking Mr. M's BP, he becomes angry and demands to know what you want with his BP. Are you a doctor and, if not why are you in his room? What would you do?
5. You are giving CPT a patient who has cystic fibrosis. She is watching you very closely and she makes several comments that you are not giving CPT to her child properly. The mother states that she does not want you to come back and that she is going to call her doctor and report you. How would you handle this situation?

CPAP THERAPY

Questions:

1. List four hazards associated with CPAP therapy.
2. What precautions must be taken if CPAP therapy is used on a patient on a general floor (not ICU)?
3. What would you do if a family member continually takes the CPAP mask off the patient to give him ice chips because his mouth is dry?

CPR/INTUBATION

Questions:

1. What is the proper placement of the Macintosh and Milers blades to visualize the vocal cords?
2. What is the purpose of the stylet?
3. When would you use the curved laryngoscope blade rather than the straight blade?
4. What should you do if, following the proper insertion of the ETT, the patient begins to vomit?
5. What would you do if you have the sneeze while in the process of intubating a patient?

EVALUATION OF THE CHEST FILM

Questions:

1. What would you do if viewing the x-ray with your medical director, you disagree with his diagnosis?
2. Name four characteristics of an x-ray of a COPD patient.
3. List the four radiographic densities from most radiopaque to most radiolucent.
4. Why does the heart appear slightly larger than actual size on an AP film?
5. What would you do if, during patient rounds the patient asks you what would be your interpretation of his chest x-ray?

EXTUBATION

Questions:

1. What is the appropriate therapy to treat post-extubation stridor?
2. What are some hazards of long-term intubation?
3. What would you do if a physician orders extubation for a patient that you do not feel is ready to be extubated?
4. What criteria are used to determine success post extubation?

INCENTIVE SPIROMETRY THERAPY

Questions:

1. What is the indication for incentive spirometry?
2. Explain what a valsalva maneuver is and the effect it can have on the patient (include clinical signs).
3. What are contraindications of incentive spirometry?
4. Ms. White is a quadriplegic patient. Would she be a good candidate for IS? Why or who not?

MDI THERAPY

Questions:

1. What are the hazards of MDI therapy?
2. What are the indications of MDI therapy?
3. What side effects might be encountered with MDI therapy?
4. You are called to start a MDI on patient in the ER. The patient is an eighty five old male and has sensorium dementia. The patient is not able to understand your directions. What measure would you do to rectify the problem?
5. You are administering an MDI to a patient and the patient cannot properly administer the MDI. The patient has a poor inspiration and does not have an inspiratory hold. What measure would you use to rectify the situation?

NEBULIZER THERAPY

Questions:

1. What are the hazards and possible side effects of nebulizer therapy?
2. What are the indications of hand held nebulizer therapy?
3. A physician orders a nebulizer treatment with 2 cc 10% MUCOMYST. What possible complications should you watch for?
4. You are called to initiate SVN therapy with a bronchodilator. You review the chart and notice that the physician has ordered 3 mls Albuterol. What action would be appropriate?
5. You are giving a treatment to patient with a bronchodilator and your beeper goes off. You answer the beep and are called to ER for a stat treatment. Meanwhile you leave the patient still taking the treatment. When you come back to the room the patient is diaphoretic, heart rate is 30 times higher than the baseline, and when the patient is dizzy. Explain what has happened to the patient and why it happened?

OXYGEN THERAPY

Questions:

1. While doing O2 rounds you find a patient dusky in color with respiratory distress and his O2 mask is on the floor. What do you do?
2. You assess a patient and find evidence of hypoxia, but the patient is on his oxygen exactly as it was ordered. What do you do?
3. You are called to assess a patient. On arrival you notice the patient is disoriented and confused. She yells at you to “stir the beans before they burn”. How do you handle this situation?
4. Your patient has been on a cannula at 2 L/m for 4 days. He has not signs of respiratory distress and his O2 saturation is 98% on room air. What should you do?

NASAL CANNULA/SIMPLE MASK

Questions:

1. Explain what will happen to the FIO₂ to the patient if the patient's ventilatory status changes.
2. If the patient has COPD with CO₂ retention, will a change in the ventilatory status be hazardous to the patient and why or why not?
3. You are doing oxygen rounds and the patient is on two liters of oxygen and is smoking in the room. The patient has been informed of the hospital's rules about not smoking in the hospital and the "No Smoking" signs are posted. The patient refuses to put out the cigarette and request that you leave the room. What would be the appropriate steps in this situation?
4. You go into a patient's room and find the patient in the bathroom without the patient's nasal cannula. The patient is very dyspneic and cyanotic. The patient refuses to use the bedpan or the bedside commode. How would you rectify this problem?
5. What is the lowest liter flow at which this mask should be run and why?
6. While doing oxygen rounds, you enter the room of a comatose patient and notice that they have vomited into their simple mask. What would you do first?
7. A patient complains that the mask hurts their face. How could you remedy this problem?

NON-REBREATHING MASK

Questions:

1. What is the appropriate flow rate for a non-rebreathing mask?
2. Why should the reservoir remain 1/3 full throughout the breathing cycle?
3. What follow-up assessment would be appropriate for a patient on a partial rebreathing O₂ mask?
4. What would you recommend if the patient could not tolerate having the partial rebreathing mask on (the patient gets a "smothering" feeling with the mask properly in place).

MISCELLANEOUS O2

Questions:

1. What would you do if the pop-off alarm was sounding on a bubble device?
2. How do you explain to a patient why they are using oxygen and what safety precautions need to be taken?
3. What would you do if you saw a pack of cigarettes on the bed stand next to a patient on oxygen?

VENTURI MASK

Questions:

1. What is the total flow to the patient if a venture mask is running at 8lpm while set on 35%?
2. What is the effects of the FIO₂ of the venture mask if the patient tucks their covers up around their neck, covering the entrainment port?
3. How will a change in the patient's respiratory pattern affect the FIO₂ deliver of this device?
4. A patient ordered to wear a 28% venture mask is complaining of becoming SOB while eating. How could you remedy the problem?
5. The physician orders you to set up a 60% venture mask. What would you do?

SPUTUM COLLECTION

Questions:

1. How is TB spread? What type of isolation precautions would you use?
2. How would you protect yourself when collecting a sputum specimen from an active TB patient?
3. What instructions do you give the patient to collect sputum in the cup?
4. The patient states he is now on antibiotics and has not been coughing up anything for three days. Is it appropriate to continue to try to collect sputum at this time?

SUCTIONING

Questions:

1. Prior to sectioning procedure you are explaining the procedure to the patient. The patient pleads with you not to perform the procedure. He says he feels like he's suffocating. What should you do?
2. While suctioning a patient, the patient suddenly turns blue and their pulse oximetry drops to 40%. What should you do?
3. While trying to advance the catheter in the nose you meet a resistance and the catheter won't move forward. What should you do?
4. During NT suctioning the patient begins to gag. What is causing this?
5. You are helping another RCP to suction a patient. You notice the RCP accidentally touches the catheter tip on the bed sheets but looks as if they are going to continue the procedure. What would you do?
6. You are called to suction a patient on the ventilator in the ICU area. The patient is hyperoxygenated and ventilated but the patient continue to exhibit hypoxemia and develops arrhythmias. What steps should you follow to maintain a patient airway despite suctioning?
7. You are suctioning a patient and the patient develops cardiac arrhythmias and becomes hypotensive. What protocol should you follow at this time?
8. What will happen if the suction canister vacuum and patient lines are reversed during suctioning?
9. What would you do when you have to suction the patient, but the patient's family is in the room and requests that you do not suction the patient? The patient is in need of suctioning. What would be the appropriate action in this situation?
10. You are watching your supervisor suctioning a patient and the supervisor breaks sterile technique. What would you do in this situation?

MANUAL VENTILATION

Questions:

1. While testing the bag you noticed the air vents, and the bag will not build up pressure before delivery, what action can you take?
2. During bagging you notice a sudden change, and the patient is much more difficult to ventilate. How do you correct this problem?
3. While bagging you hear a leak (large to massive) and the patient is talking to you. What do you do?
4. Your patient complains he is dizzy. Explain how this could happen.
5. You are bagging a patient during transport to the x-ray department, the patient is intubated orally. If the tube comes out during transport, how could you ventilate the patient? What extra equipment would you need?

VENTILATOR THERAPY

Questions:

1. A patient has a minute ventilation of 20L/min with an IMV rate of 20/min and $VT = 1000\text{cl}$. The flow rate is 40L/min. The patient appears to be “fighting” the ventilator, is using accessory muscles to breath and is in distress. What would you do?
2. You are caring for a 72 year old patient on mechanical ventilatory support who has a history of severe mental retardation and metastatic cancer. A family member comes into the room and asks you to disconnect the patient and let him die. What would you do?
3. You are about to perform a ventilatory check. A physician in the room says “What are you doing? Only a therapist is allowed to do that.” What would you do?
4. If the peak pressure is 28 cm H₂O, what should the low and high pressure alarm settings be?
5. After placing the patient on the ventilator, you notice that the patient’s exhaled tidal volume is 325 ml less than the set tidal volume. What could cause this?
6. What would you do if you disagreed with the physician’s ordered ventilator settings for a patient?
7. While setting up the ventilator, the patient mouths to you that they do not want to be placed on any life support system. What would you do?
8. The machine you are checking will not pass a leak test. Your supervisor tells you “that’s ok; we need it on a patient.” What would you do?

9. The ventilator you are checking keeps giving you a “vent.in-op” alarm and “system failure” message. You are alone on evening shift. You need another ventilator. What would you do?
10. Trace gas flow through the circuit and identify the exhalation valve.
11. What is the purpose of the leak check?
12. A patient on a ventilator appears dyspneic and is combative. The patient’s chest wall is moving but breath sounds are difficult to assess. What can you do?

VENTILATOR PROBLEM SOLVING

Case One:

During a 4 day period, a mechanically ventilated patient on +10 PEEP has gained 3 kg. Fluid intake measures about 3000 ml/day and output is 1550/day. The peak pressure reading has increased from 28 to 40 cm H₂O. Lung compliance has decreased from 35 to 26 ml/cm H₂O. Breath sounds reveal bilateral fine crackles. What is the cause of these changes and how would you correct the situation?

Case Two:

A 60 kg patient is being mechanically ventilated following acute MI. Ventilator settings are V_t of 900 ml, frequency of 12 and FIO₂ of 0.40. ABG’s were Pa CO₂ of 30 torr, pH of 7.50, and PaO₂ of 110. What changes might be appropriate?

Case Three:

Following surgery, a patient is kept temporarily on mechanical ventilatory support. The patient’s peak inspiratory pressure rises from 25 to 58 cm H₂O in a 90 minute period of 100% oxygen. Chest wall movement is asymmetrical with movement greater on the right side. Breath sounds are distant on the right and absent on the left. The left side is dull to percussion and the right side is resonant. The trachea is deviated to the left. What is the problem and the best solution?

Case Four:

While monitoring a patient on mechanical ventilation, the therapist notes that the peak inspiratory pressure and the plateau pressure have increased significantly over the past hour. The trachea is deviated to the left. Breath sounds are diminished on the left and absent on the right. The right side is hyperresonant to percussion. What is the problem and how should it be corrected?

Case Five:

A patient on mechanical ventilation in the assist/control mode has the following ABG results: pH 7.61, PaCO₂ of 23 torr, PaO₂ on FIO₂ of 0.35. The V_t is 900 ml and the rate is 20/min. What is an appropriate immediate action?

Case Six:

The minute ventilation on a ventilated patient is 8.4lpm. The PaCO₂ is 30 torr, the pH is 7.51, and the PaO₂ is 110 torr on an FIO₂ of 0.24. What would you recommend for this patient?

Case Seven:

A mechanically ventilated patient had the following arterial blood gases and ventilator parameters: PaO₂ of 74 torr, PaCO₂ of 39 torr, pH of 7.41, PEEP of +3, SIMV of 3 with a spontaneous rate of 12, pressure support +5 above PEEP. The patient's spontaneous V_t is 470 ml and the FIO₂ is 0.35. The patient's NIF is -38 cm H₂O and their vital capacity is 18 ml/kg ideal body weight. What changes would you make at this time?

Case Eight:

Auscultation over the trachea during positive pressure ventilation reveals a slight audible leak in the area at peak inspiration. Cuff pressures are currently 18 cm H₂O. What would be your next action?

Clinical Instructor Acknowledgement Statement

I have read and understand the information contained in the Clinical Instructor handbook. I realize I am responsible for guiding the student in professional and educational aspects of their clinical rotation. Should questions arise I will contact Lori Johnson or Wendy Wright for clarification.

Date: _____ Signature: _____