CUESTA COLLEGE

ASSOCIATE DEGREE NURSING PROGRAM

RN STUDENT HANDBOOK

Dear Registered Nursing Student,

Welcome to the Cuesta College Associate Degree Registered Nursing (RN) program. It is our hope that your education inspires you to embrace the nursing role and implement the highest standards of care for your patients. Our curriculum will provide the general knowledge and skills necessary for you to take the national exam for licensure as an RN (NCLEX-RN) and begin your career as an entry-level nurse.

The program is comprised of dedicated faculty and staff members who work as a team to facilitate your successful completion of the program. However, this is a full-time, demanding, and rigorous program. Additional hours of study, research, preparation, and review time outside of class will be necessary to ensure your success.

We are proud of our RN program and value student feedback. We have a long-standing history of our graduates passing their NCLEX-RN and obtaining gainful employment. Students are given formal and informal opportunities throughout the four semesters of the program to provide feedback about the quality of education and how it prepares them for a career in nursing. Your responses are very important to us and will be used to guide future curriculum revisions.

The RN Student Handbook contains program policies and useful information about our program. Please review the handbook thoroughly and keep it available for reference. The forms at the back of the handbook are to be read and signed after the incoming student orientation session, indicating your agreement to adhere to the policies throughout the program. The signed forms will be placed in your student file, along with all required certifications and student progress reports, during the program. Every intent is to ensure that these policies are current; however, policies may change during the duration of the program due to unforeseen circumstances or regulatory changes.

The faculty, staff and I look forward to working with you to make this a valuable and meaningful educational experience that provides a solid foundation for your registered nursing career.

Respectfully,

Director of Nursing

TABLE OF CONTENTS

SECTION I
COLLEGE & NURSING PROGRAM GOVERNANCE

COLLEGE & NURSING PROGRAM GOVERNANCE

CUESTA COLLEGE GOVERNANCE

Cuesta College is governed by the San Luis Obispo County Community College District. The District's Board of Trustees and college organizational charts are located on the Cuesta College Leadership webpage: http://www.cuesta.edu/about/leadership/

CUESTA COLLEGE MISSION

Cuesta College is an inclusive institution that inspires a diverse student population to achieve their educational goals.

We effectively support students in their efforts to improve foundational skills, earn certificates or associate degrees, transfer to four-year institutions, and advance in the workforce.

Through innovative and challenging learning opportunities, Cuesta College enhances lives by promoting cultural, intellectual, personal, and professional growth. We prepare students to become engaged citizens in our increasingly complex communities and world.

CUESTA COLLEGE VISION

Cuesta College is dedicated to accessible, high-quality education for the support and enhancement of student success, professional development, and the community we serve.

CUESTA COLLEGE VALUES

Access - Success - Excellence

NURSING PROGRAM MISSION STATEMENT

Educate nursing students to provide safe, ethical, high quality, evidence-based, collaborative, patient-centered nursing care that incorporates clinical judgment and informatics at the entry-level in an increasingly complex healthcare environment.

NURSING PROGRAM PURPOSE & GOALS

1. Students can obtain RN licensure and pursue a career in nursing.
2. Students facilitate optimal health for individual patients, families, and communities.

NURSING PROGRAM CHAIN OF COMMAND

The Nursing Department adheres to the principles of direct communication. Student concerns are directed to faculty first. If resolution is not achieved, the student should follow the chain of command by then speaking with the nursing program director, followed by the dean.

NURSING PROGRAM COLLEGE COLLABORATION AND SUPPORT

The nursing department collaborates with the college administration and departments across campus to maintain a strong and respected nursing program. These include the Nursing Selection Committee, Student Services, Institutional Research, Counseling, Disabled Student Programs & Services (DSPS), Foundation, Financial Aid, and the library to provide a positive educational opportunity for our students.

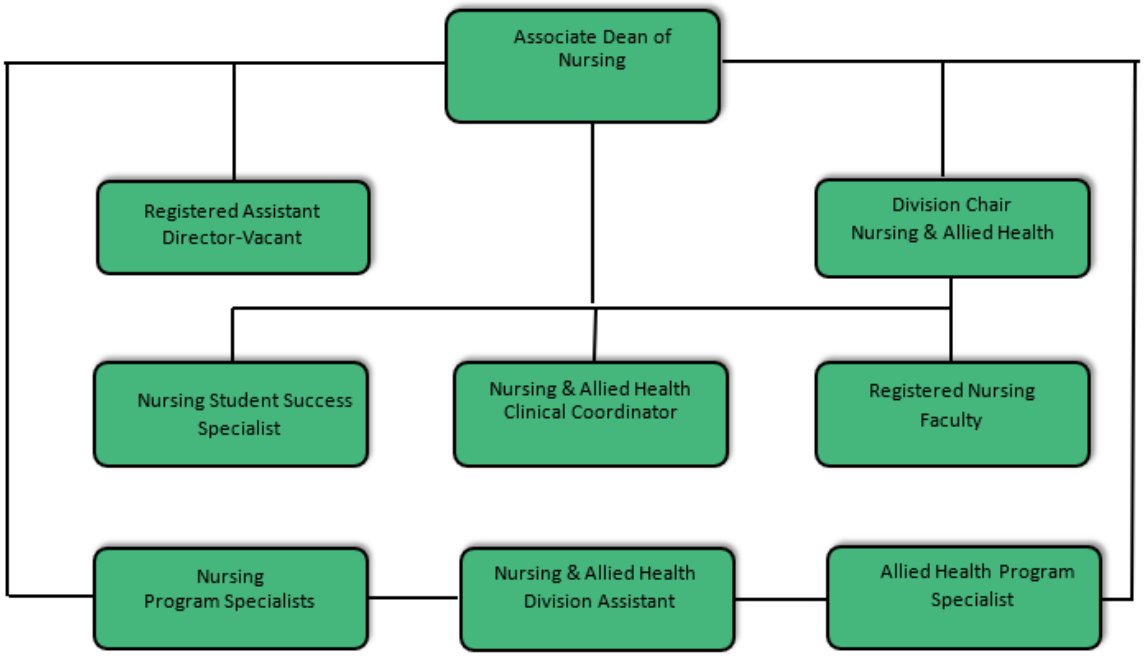
NURSING PROGRAM COMMUNITY COLLABORATION AND SUPPORT

The nursing department holds strong partnerships with community members and clinical agencies. Community Advisory Meetings are held twice a year with healthcare agency administration. The nursing program benefits greatly from generous educational opportunities and financial support from community members and healthcare agencies.

NURSING DIVISION ORGANIZATIONAL CHART

CUESTA COLLEGE

CUESTA COLLEGE NURSING DIVISION ORGANIZATIONAL CHART



SECTION II

NURSING PROGRAM HISTORY, PHILOSOPHY & CURRICULUM

CUESTA COLLEGE NURSING DEPARTMENT HISTORY

1967 The Associate Degree Nursing program (ADN) was approved by the California State Board of Registered Nurses (BRN) under the leadership of Juanita Booth. College Board Trustee, Carolyn Ragsdale, RN, was a strong voice to bring the program to our county. The nursing division received Joslyn Foundation donations to use for equipment and library holdings.

1981 A satellite program was opened to allow an additional 12 LVN to RN students to be admitted. The Caring Curriculum was developed by nursing faculty through a grant from Mrs. Ada Callahan Irving. The original Caring Curriculum was developed by Regina DePue, Edith Hall, Colleen Ehrenberg, Malcolm MacDonald, Anita Oschner, Mary Parker and Fely Platou.

1989 Cuesta College collaborated with Allan Hancock College to begin an LVN to RN program on the Hancock campus. The Cuesta LVN-RN satellite was discontinued.

1994 The Ada Callahan Irving Caring Endowment allowed for the initial ground breaking of the new Nursing Allied Health building (2500). Ada was a nurse, and her husband, Harold, was a chemistry teacher at Cuesta. Ada's dream to financially support the preservation of Cuesta as a top-quality nursing program for the community.

2003 The ADN class was expanded to 46 students in response to the local nursing shortage.

2005 ADN admission was further expanded to 56 students utilizing a Chancellor's Enrollment Growth Grant and Work Investment Act (WIA) grant and six community hospital partnerships.

2009 The RN class selection transitioned from a qualified applicant pool/waitlist to a combination merit based/qualified applicant pool. The last students admitted from the waitlist entered Fall 2009. A moratorium on applications was in place from 2007 to 2009 to complete the wait list.

2009 The RN simulation program began in fall 2009 with one high fidelity manikin purchased with grant funding from the Chancellor's Office. Simulation was incorporated into all four semesters.

2010 The use of multi-criteria Selection became the admission process into the RN program in fall 2010. Class size was decreased to 46 due to the premature loss of the WIA Grant 2 years into the 5-year grant, balanced with market need in our community.

2013 The Advanced Placement LVN to RN application was formalized, reserving three spaces for LVNs to enter the 2nd semester of the program.

2016 The RN simulation lab was remodeled with two high-fidelity manikins to provide prioritization and multiple patient care scenarios. One of the manikins is adaptable to provide maternal health scenarios. The simulation lab was created with initial donations by James and Karen Clarke.

2014 - 2017 The RN program had a stellar 4-year run with 1st-time NCLEX pass rates at 100%.

2018 Recipient of the Chancellor Office Gold Star Award for economic mobility: increase in earnings by 50% or more, attainment of the regional living wage by 70% or more, and employment in field of study by 90% or more.

2018 Ranked #1 in the 2018 Best RN Programs in California by Registerednursing.org, with #2 ranking in 2019 and 2020.

2018 Highlighted for successful NCLEX pass rates and retention in the California Community College Chancellor's Office Nursing Educational Programs Report to Governor Edmund Brown for its success.

2020 COVID-19 pandemic forced a stay-at-home order and a 1-week transition to virtual classrooms and clinicals. Faculty and students were commended for their ability to be flexible, focused, and maintain program quality throughout the pandemic.

2021 The Cuesta College RN program has educated over 2040 Associate Degree Nursing (RN) graduates since the first class graduated in 1969.

2022 The Novice to Expert Philosophy and student learning outcomes is put into place. This curriculum was developed from the collaborative efforts of Marcia Scott, Program Director, Monica Millard, Division Chair, Beth Johnson, Assistant Director, current full-time faculty members Rick Staley, Michalyn Maddelein, Darby Axelrod, Genevieve Lidoff, and recently retired full-time faculty members Ann Miller, Antonia Torrey, and Linda Harris.

2022 Marica Scott's retirement after 34 years of service to the nursing program was a big change. Beth Johnson, who served as the Assistant Director of the program, became the Interim Director of Nursing in June 2022.

2023 Beth Johnson RN, MSN was named the new Associate Dean of Nursing & Allied Health. This is the first time in the Cuesta College RN Program history that the nursing director became an Associate Dean. The class size was increased to a total graduating RNs of 50 students. An LVN to RN Pathway of 30 students for a total of 80 RN student graduates for Cuesta College ADN Program.

Cuesta College RN Program Philosophy and Conceptual Framework: Novice to Expert

The Novice to Expert Philosophy and Conceptual Framework is founded on Dr. Patricia Benner's theory for the acquisition and development of skills as a student pass through the five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. The framework embraces the belief that nurses acquire knowledge and skills from experiential learning to develop clinical competence. This framework is adapted to address the growth and development of nursing students across the four semesters of the program in preparation for entry-level nursing employment. The stages identified for students to achieve clinical competency for nursing practice are novice, advanced beginner, competent, and proficient.

The 'novice' student nurse has no experience in the situations in which they are expected to perform and seek concrete information to understand patients' current conditions. Students in this stage seek to perform tasks and are governed by rules to guide their performance.

The 'advanced beginner' student nurse has experienced real situations and through those experiences, learned components that are meaningful in their nursing care practice. Students know how to perform certain skills however, need assistance identifying priorities and operating on general guidelines. At this level, their prior experiences help students achieve a more global nursing perspective.

The 'competent' student nurse begins to recognize meaningful patterns in their clinical practice. The student at this level can rely on a plan and have improved their organizational skills to deal with the contingencies of clinical nursing. Students are feeling more organized and have improved their decision-making abilities.

The 'proficient' student nurse can see situations as a whole rather than in parts. Students at this level have learned from their experiences and can identify as well as modify their plans in response to different events.

Each clinical competency has been incorporated into ten concepts that have been identified as integral in all nursing behaviors. Each concept has been leveled from a novice to proficient competency to identify the goals that nursing students should be achieving at each level as they move across semesters in the program.

These ten (10) concepts within the nursing program framework are Caring, Lifespan/Cultural Care, Collaboration, Communication, Informatics, Nursing Process, Evidence-Based Practice/Quality, Safety, Confidentiality, and Patient Teaching/Nurse Learning. These concepts are threaded throughout the curriculum by aligning course objectives and clinical assessment tools to the concepts.

The ten (10) concepts are defined as follows:

Caring requires the nurse to demonstrate advocacy and provide nursing care that promotes trusting relationships. Courtesy and respect are demonstrated with recognition of patients' dignity and individuality. This concept promotes and incorporates accountability, responsibility, and self-directed behaviors in nursing practice while maintaining a professional and positive nursing image.

Lifespan/Cultural Care requires the nurse to provide patient-centered care, recognizing age, development, language, mental health status, culture, ethnicity, gender identity, spirituality, and patient

(individual, family, community) preferences. This concept also involves sensitivity and respect for the diversity of human values and experiences.

Collaboration is a function within nursing and interprofessional teams to achieve quality patient care utilizing communication, mutual respect and shared decision-making. Incorporate leadership roles and conflict resolution into nursing practice.

Communication is multi-faceted and includes verbal/non-verbal communication skills as well as documentation. This concept requires the nurse to communicate with the patient, family, community, and interprofessional team. The nurse needs to demonstrate therapeutic communication across the lifespan and support the attainment of desired outcomes by providing encouragement, support, and compassion. The nurse is also required to document events and activities that demonstrate comprehensive patient centered-care and incorporate appropriate medical terminology by utilizing written/electronic documentation that effectively communicates patient care activities.

Informatics requires the nurse to utilize information technology to communicate, manage knowledge, promote the safe practice, and support clinical judgment. The nurses must identify potential changes in practice to improve patient outcomes and recognize the necessity to pursue lifelong learning of information technology skills.

Nursing Process requires the nurse to collect assessment data (physical, psychosocial, lab, diagnostics, medications, and medical history) to plan, prioritize, implement, and evaluate the patient's plan of care. The nurse will need to use and interpret assessment data to guide clinical reasoning and decision-making skills to achieve clinical judgment and desired patient outcomes. Medical orders will need to be implemented based on patient assessment and plan of care, and effectively time manage to provide care to multiple patients.

Evidence-Based Practice/Quality is the use of evidence-based practice resources to develop patient-centered care. The nurse is required to participate in quality improvement methods to improve patient care outcomes.

Safety is maintaining and promoting physical and psychological safety for patients, families, and communities by adhering to established policies, procedures, and scope of practice.

Confidentiality is the protection of patient health care information in which the student adheres to patient confidentiality of healthcare information and advocates appropriately if confidentiality is breached.

Patient Teaching/Nurse Learning is a process that facilitates an exchange of knowledge between the patient and nurse to foster optimal outcomes. The nurse is required to implement patient-centered teaching plans to facilitate the acquisition of knowledge, skills, and attitudes to promote optimal health as well as evaluate the effectiveness of teaching. Nurse learning is a process in which the nurse takes accountability for their knowledge acquisition, and is engaged in learning that is self-directed, self-motivated, and life-long. The nurse will identify learning needs to achieve one's highest learning potential and will demonstrate evidence of competence, coordination, and continued growth in both cognitive and psychomotor skills.

Unifying Theme

Novice to Expert (Benner) is our philosophical unifying theme to identify how nursing students acquire

competency for clinical nursing practice. This unifying theme describes the nursing student and expectations for progression from semester to semester in our program. This theme informs and is used to develop program outcomes, course sequencing, and performance competencies.

Faculty and students work collaboratively to promote motivation for self-actualization in achieving maximum learning potential.

We embrace that knowledge happens sequentially, simple to complex, through experiential learning and guided situational simulation in a safe and welcoming learning environment.

The learning environment encompasses the classroom, skills laboratory, simulation laboratory, and community healthcare settings.

The patient (individual, family, and community) is defined as the recipient of nursing care.

Nursing care is defined as a continuum that begins with entry into the healthcare system and encompasses a safe discharge.

Mission Statement

Educate nursing students to provide safe, ethical, high quality, evidence-based, collaborative, patient-centered nursing care that incorporates clinical judgment and informatics at the entry-level in an increasingly complex healthcare environment.

Goals

1. Students can obtain RN licensure and pursue a career in nursing.
2. Students facilitate optimal health for individual patients, families, and communities.

ACQUIRED COMPETENCIES FOR CLINICAL PRACTICE

Benner's novice to expert theory identifies how nurses acquire competency for clinical nursing practice. We have adapted Benner to describe the nursing student and expectations for progression through each level in our program.

Novice (1st semester) – no situational experience; must be given rules to guide performance

Advanced-beginner (2nd semester) – limited situational experience; demonstrates beginning-ability to recognize expected norms and deviations.

Competent (3rd semester) – establishes perspective; ability to forecast and prioritize based on situational experience

Proficient (4th semester/Preceptorship) - recognize the whole situation and anticipates events based on experience; demonstrates beginning ability to manage unexpected events. No longer relies solely on rules or guidelines to guide practice and connect understanding to appropriate action

EXPECTATIONS FOR PROGRESSION

Students' progress through the program at various stages of competence as they encounter different content areas of nursing. For example, a second-year student may be functioning at the competent level in Medical-Surgical performing at the novice level in Psychiatric settings.

Level 1 – Progresses from novice to advanced beginner student

Level 2 – Progresses from advanced beginner to competent student

Level 3 – Progresses from competent to proficient student

Level 4 – Progresses in proficiency to enter the nursing profession as an entry-level nurse

PROGRAM CONCEPTS AND LEVEL COMPETENCIES/OUTCOMES

I. Caring - Demonstrate advocacy. Provide nursing care that promotes trusting relationships. Demonstrate courtesy and respect with recognition of patients' dignity and individuality. Promote and incorporate accountability, responsibility, and ethical and self-directed behaviors in nursing practice while maintaining a professional and positive nursing image.

1. Obtain a basic understanding of the advocacy role of the registered nurse. Present a professional appearance and calm therapeutic demeanor.
2. Recognize how the registered nurse advocates for the patient and their family.
3. Participates in the advocacy role for the patient and family needs with greater autonomy.
4. Integrates advocacy role of the registered nurse and advocates for patient needs.

II. Lifespan/Cultural Care - Provide patient-centered care that recognizes age, development, language, mental health status, culture, ethnicity, gender identity, spirituality, and patient (individual, family, community) preferences with sensitivity and respect for the diversity of human values and experience.

1. Provide nonjudgmental nursing care that considers patient needs, preferences, values, and beliefs with a focus on adult and geriatric patients.
2. Integrate patient needs, preferences, values, and beliefs into nursing care including maternal-child and pediatric populations.
3. Analyze and adapt nursing care to meet patient needs, preferences, values, and beliefs.
4. Advocate with the interprofessional team to meet patient needs, preferences, values, and beliefs.

III. Collaboration – Function within nursing and interprofessional teams to achieve quality patient care utilizing communication, mutual respect, and shared decision-making. Incorporate leadership roles and conflict resolution into nursing practice.

1. Recognize the role of the nurse as a member of the interprofessional team and identify self in that role.
2. Provide pertinent and timely patient information to members of the interprofessional team to help develop the plan of care. Recognize situations where delegation supports patient-centered care.

3. Participate with the interprofessional team when providing patient care including appropriate delegation to unlicensed staff. Expand communication to the interprofessional team to identify and develop a comprehensive plan of care.
4. Assume a leadership role as the coordinator of patient care. Assign, supervise and evaluate the effectiveness of interprofessional patient care relationships.

IV. Communication - Encompass verbal and non-verbal communication skills with a patient, family, community, and interprofessional team interactions. Documentation records events and activities that demonstrate comprehensive patient-centered care. Incorporates appropriate medical terminology.

A. Verbal/Nonverbal - Demonstrate therapeutic communication with the patient, family, and community across the lifespan. Support attainment of desired outcomes by providing encouragement, support, and compassion. Adapt techniques to compensate for sensory deficits and communication barriers.

1. Apply therapeutic communication that conveys information effectively, demonstrates empathy, and establishes rapport. Provide timely patient care updates that reflect patient condition, care priorities, and interventions with nurse and nursing instructor.
2. Demonstrate and evaluate therapeutic communication to include maternal-child and pediatric populations.
3. Implement therapeutic communication to build trusting relationships and foster well-being in more complex patient care situations.
4. Utilize communication techniques that foster mutual respect and shared-decision making with multiple patients. Provide clear instructions and validates completion of delegated tasks.

B. Documentation – Utilizes written/electronic documentation to effectively communicate patient care activities across the lifespan.

1. Demonstrate timely and accurate documentation of assessment and nursing care activities.
2. Document with increased depth and detail acknowledging the differences within patient populations.
3. Prioritize relevant documentation for multiple and more complex patients.
4. Implement self-directed, comprehensive documentation for an increased number of patients.

V. Informatics – Utilize information technology to communicate, manage knowledge, promote safe practice, and support clinical judgment Identify potential changes in practice to improve patient outcomes. Recognize the necessity to pursue lifelong learning of information technology skills.

1. Identify valid electronic resources of healthcare information to foster knowledge and support clinical judgment to develop a plan of care.
2. Analyze the importance, significance, and implications of technology that support clinical judgment, and promote safe practice.

3. Incorporate and communicate information from valid resources with the interprofessional team to provide safe quality patient care.
4. Utilize information technology to support clinical judgment and improve patient outcomes with greater independence and accuracy.

VI. Nursing Process – Collect assessment data (physical, psychosocial, lab, diagnostics, medications, and medical history) to plan, prioritize, implement, and evaluate the patient's plan of care. Use and interpret assessment data to guide clinical judgment to achieve desired patient outcomes. Implement medical orders based on patient assessment and plan of care. Effectively use time management to provide care to multiple patients.

1. Gather pertinent information to establish a thorough perspective of the patient and apply the nursing process to patient situations. Identify priorities of care with recognition of basic needs to promote optimal health. Perform accurate assessments, differentiating normal from abnormal findings. Revise plan of care based on assessment and evaluation of patient status.
2. Apply the nursing process to develop and individualize care for patients across the lifespan. Demonstrate increasing ability to prioritize care with multiple patients. Anticipate changes in patient status and implement appropriate interventions to the plan of care.
3. Implement clinical judgment with greater independence and efficiency for more complex patients.
4. Demonstrate growing independence as the patient care coordinator to direct and prioritize the plan of care.

VII. Evidence-Based Practice/Quality – Use evidence-based practice resources to develop patient-centered care. Participate in quality improvement methods to improve patient care outcomes.

1. Identify appropriate resources to develop patient-centered care.
2. Apply evidenced-based concepts to simple structured patient-care situations and recognize quality improvement activities.
3. Analyze and integrate relevant data to support decision-making for the plan of care. Promote quality improvement in patient-care situations.
4. Utilize nursing research to promote the best patient outcomes.

VIII. Safety – Maintain and promote physical and psychological safety for patients, families, and communities by adhering to established policies, procedures, and scope of practice.

1. Identify safety standards in patient-care situations by understanding policies, procedures, and scope of practice.
2. Apply safety standards by utilizing established policies and procedures within the scope of practice.
3. Advocate for safety standards in patient care situations and environments.
4. Implement safety standards in patient situations with increased independence.

IX. Confidentiality – Protection of patient health care information.

1-4. Adhere to patient confidentiality of healthcare information and advocate appropriately if confidentiality is breached.

X. Patient Teaching/Nurse Learning – Patient teaching facilitates the exchange of knowledge between the patient and nurse to foster optimal outcomes. Nurse learning is a process in which the nurse takes accountability for their knowledge acquisition.

A. Patient Teaching– Implement patient-centered teaching plans to facilitate the acquisition of knowledge, skills, and attitudes to promote optimal health. Evaluate the effectiveness of teaching.

1. Individualize teaching plans and apply them to adult and geriatric patient education situations.
2. Implement patient teaching plans to be inclusive of maternal-child and pediatric populations.
3. Collaborate with the interprofessional team to individualize the patient plan of care.
4. Establish holistic teaching plans to promote optimal health in anticipation of discharge needs.

B. Nurse Learning - Engage in learning that is self-directed, self-motivated, and life-long. Identify learning needs to achieve one's highest learning potential. Cognitive and psychomotor skills demonstrate evidence of competence, coordination, and continued growth.

1. Actively participate in learning opportunities that expand knowledge utilizing instructor, and interprofessional team. Manage and perform psychomotor skills safely within a reasonable period.
2. Assume greater responsibility for participation in learning opportunities while managing care for more patients. Increase efficiency, coordination, and confidence while performing psychomotor skills.
3. Establish self-directed learning to develop competencies and promote best practices.
4. Engage in learning experiences to transition into entry-level nursing.

RN Program Learning Outcomes and Objectives

Upon completion of the RN Program, the student will be able to:

1. Demonstrate advocacy. Provide nursing care that promotes trusting relationships. Demonstrate courtesy and respect with recognition of patients' dignity and individuality. Promote and incorporate accountability, responsibility, and ethical and self-directed behaviors in nursing practice while maintaining a professional and positive nursing image.

2. Provide patient-centered care that recognizes age, development, language, mental health status, culture, ethnicity, gender identity, spirituality, and patient (individual, family, community) preferences with sensitivity and respect for the diversity of human values and experience.

3. Function within nursing and interprofessional teams to achieve quality patient care utilizing communication, mutual respect, and shared decision-making. Incorporate leadership roles and conflict resolution into nursing practice.

4. Encompass verbal and non-verbal communication skills with a patient, family, community, and interprofessional team interactions. Documentation records events and activities that demonstrate comprehensive patient-centered care. Incorporates appropriate medical terminology.

5. Utilize information technology to communicate, manage knowledge, promote safe practice, and support clinical judgment. Identify potential changes in practice to improve patient outcomes. Recognize the necessity to pursue lifelong learning of information technology skills.

6. Collect assessment data (physical, psychosocial, lab, diagnostics, medications, and medical history) to plan, prioritize, implement, and evaluate the patient's plan of care. Use and interpret assessment data to guide clinical judgment to achieve desired patient outcomes. Implement medical orders based on patient assessment and plan of care. Effectively use time management to provide care to multiple patients.

7. Use evidence-based practice resources to develop patient-centered care. Participate in quality improvement methods to improve patient care outcomes.

8. Maintain and promote physical and psychological safety for patients, families, and communities by adhering to established policies, procedures, and scope of practice.

9. Protection of patient health care information.

10. Patient teaching facilitates the exchange of knowledge between the patient and nurse to foster optimal outcomes. Nurse learning is a process in which the nurse takes accountability for their knowledge acquisition.

SECTION III
PROGRAM REQUIREMENTS & POLICIES

Code Conduct for Students in the Associate Degree Nursing Program	BP 5500.2

The Board of Trustees determines that the following policies govern the participation of the impaired student affected by chemical dependence or mental illness in the Associate Degree Nursing Program.

1. The nursing program, in addition to offering an academic program, includes clinical course work. The safety of patients under the care of student nurses must be assured. The instructor and the Director of Nursing Program may take immediate corrective action to remove a student impaired by chemical dependence or mental illness from the clinical program if the student demonstrates by his/her conduct and performance in the clinical setting that he/she is a danger to the health and safety of patients under his/her care.

2. After evaluation and due process, students considered by the Director of Nursing Programs to be impaired by chemical dependence or mental illness will be allowed to continue their studies, including clinical course work, as long as they are adhering to the provisions of a contract between the college and the student for the student's retention.

3. Information on the student's condition is confidential and will not be disclosed except when necessary to protect the safety of patients under the care of student nurses.

4. An individual contract of retention will be developed by the student, rehabilitation therapist, and the Director of Nursing and shall specify:

    a. That the student must participate in an approved chemical and/or mental treatment rehabilitation program for the duration of his/her nursing program studies.
    b. That evidence of satisfactory attendance and progress will be provided to the college on a regularly scheduled basis.
    c. That the student will consent to periodic random drug screening as part of the treatment and rehabilitation program.
    d. That the impaired student will give all medications under direct supervision and that the student will not have access to keys to medications.
    e. That if the student fails to adhere to the conditions of the contract for retention, the same procedure will be followed as with any other student on probation; the circumstances of the violation will be reviewed by the nursing faculty as a whole; and recommendations for the retention or dismissal will be made to the Director of Nursing Programs, who will then make the decision after advising the Dean of Student Services.

5. Information on the student's dismissal from the nursing program will be reported to the Board of Registered Nursing when such information is requested by the Board of Registered Nursing. (Formerly BP 6202)

STUDENT CODE OF CONDUCT (LINK)

The Student Code of Conduct is a statement of the Cuesta College District expectations regarding student standards of conduct, both academic and non-academic. Students are expected to obey all laws and district policies and regulations. Students shall be subject to discipline for violation of these laws, policies, and regulations. Student misconduct may also be subject to other regulations of the district, including but not limited to regulations regarding complaints of harassment and discrimination. The Office of the Assistant Superintendent/Vice President of Student Success & Support Programs, College Centers has the responsibility to uphold the Student Code of Conduct to impose disciplinary action as appropriate and to assure the implementation of the Student Conduct and Due Process Procedures. The following conduct violations shall constitute good cause for disciplinary action. Good cause includes, but is not limited to, the following offenses:

1. Violation of district policies, procedures, or regulations.
2. Failure to comply with directions of district officials acting in the performance of their duties; disrupting, obstructing, or interfering with instructional, administrative, disciplinary, or other functions or activities of the district.
3. Cheating, plagiarism (including plagiarism in a student publication), or engaging in other academic dishonesty.
4. Unauthorized use of a personal electronic device in an instructional or testing environment (such as smart watch, cell phone or tablet).
5. Dishonesty, forgery, alteration or misuse of college documents, records or identification; or knowingly furnishing false information to the district.
6. Causing, attempting to cause, or threatening to cause physical injury to another person.
7. Possession, sale or otherwise furnishing any firearm, knife, explosive or other dangerous object, including but not limited to any facsimile firearm, knife, or explosive, unless, in the case of possession of any object of this type, the student has obtained written permission to possess the item from a district employee, which is concurred in by the college president.
8. Unlawful possession, use, sale, offer to sell or purchase, or furnishing, or being under the influence of, any controlled substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the California Health and Safety Code, an alcoholic beverage, or an intoxicant of any kind; or unlawful possession of, or offering, arranging or negotiating the sale of any drug paraphernalia, as defined in California Health and Safety Code Section 11014.5.
9. Committing or attempting to commit robbery or extortion.
10. Causing or attempting to cause damage to district property or to private property on campus.
11. Unauthorized possession or use of any personal property or equipment of the district.
12. Stealing or attempting to steal district property or private property on campus, or knowingly receiving stolen district property or private property on campus.
13. Willful or persistent smoking (including electronic cigarette devices) in any area smoking has been prohibited by law or by regulation of the college or the district.
14. Committing sexual harassment as defined by law or by district policies and procedures.

15. Engaging in harassing or discriminatory behavior based on disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other status protected by law.
16. Engaging in intimidating conduct or bullying against another student through words or actions, including direct physical contact; verbal assaults, such as teasing or name-calling; social isolation or manipulation; and cyber bullying; "bullying" means any severe or pervasive physical or verbal act or conduct, including communications made in writing or by means of an electronic act, directed toward one or more students that has or can be reasonably predicted to have the effect of one or more of the following:
    a. Placing a reasonable student or students in fear of harm to that student's or students' person or property;
    b. Causing a reasonable student to experience a substantially detrimental effect on his or her physical or mental health;
    c. Causing a reasonable student to experience substantial interference with his or her academic performance;
    d. Causing a reasonable student to experience substantial interference with his or her ability to participate in or benefit from the services, activities, or privileges provided by the district.
17. Engaging in intimidating or bullying against district personnel through words or actions. Disruptive behavior, willful disobedience, habitual profanity or vulgarity, or the open and persistent defiance of the authority of, or persistent abuse of, district personnel.
18. Willful misconduct which results in injury or death to a student or to college personnel or which results in cutting, defacing, or other injury to any real or personal property owned by the district or on campus.
19. Lewd, indecent, or obscene conduct on district-owned or controlled property or at district-sponsored or supervised functions.
20. Engaging in expression which so incites students as to create a clear and present danger of the commission of unlawful acts on college premises, or the violation of lawful district administrative procedures, or the substantial disruption of the orderly operation of the district.
21. Persistent, serious misconduct where other means of correction have failed to bring about proper conduct.
22. Unauthorized preparation, giving, selling, transfer, distribution, or publication, for any commercial purpose, of any contemporaneous recording of an academic presentation in a classroom or equivalent site of instruction, including but not limited to handwritten or typewritten class notes, except as permitted by any district policy or administrative procedure.
23. Unauthorized entry upon or use of district facilities.
24. Sexual Assault, defined as actual or attempted sexual contact with another person without that person's consent, regardless of the victim's affiliation with the community college, including, but not limited to the following:
    a. Intentional touching of another person's intimate parts without that person's consent or other intentional sexual contact with another person without that person's consent.

b. Coercing, forcing, or attempting to coerce or force a person to touch another person's intimate parts without that person's consent.

c. Rape, which includes penetration, no matter how slight, without the person's consent of either of the following:

i. The vagina or anus of a person by any body part of another person or by an object.

ii. The mouth of a person by the sex organ of another person.

25. Sexual exploitation, defined as a person taking sexual advantage of another person for the benefit of anyone other than that person without that person's consent, regardless of the victim's affiliation with the community college, including, but not limited to, any of the following:

a. Prostituting another person.

b. Recording images, including video or photograph, or audio of another person's sexual activity, intimate body parts, or nakedness without that person's consent.

c. Distributing images including video or photograph, or audio of another person's sexual activity, intimate body parts, or nakedness, if the individual distributing the images or audio knows or should have known that the person depicted in the images or audio did not consent to the disclosure and objected to the disclosure.

d. Viewing another person's sexual activity, intimate body parts, or nakedness in a place where that person would have a reasonable expectation of privacy, without that person's consent, and for the purpose of arousing or gratifying sexual desire.

26. Any act which is defined as a felony, misdemeanor or infraction under the laws of the State of California.

STUDENT NURSE CODE OF CONDUCT

Cuesta College nursing students are expected to conduct themselves in a professional manner. Cuesta College bases its policies on the philosophy, objectives, and statutes contained in the California BRN Nurse Practice Act and the American Nurses Association Code of Ethics. Students will meet the standards and conduct themselves in a manner consistent with the Nurse Practice Act and Code of Ethics found below:

California Code of Regulations,
Title 16. Professional and Vocational Regulations
Division 14. Board of Registered Nursing
Article 4, Standard 1443.5. Standards of Competent Performance found at
http://www.rn.ca.gov/pdfs/regulations/npr-i-20.pdf

§ 1443.5. Standards of Competent Performance.
A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

Note: Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2725 and 2761, Business and Professions Code.

American Nursing Association Code of Ethics for Student Nurses and Nurses found at:
http://nursingworld.org/codeofethics

The ANA House of Delegates approved these nine provisions of the Code of Ethics for Nurses at its June 30, 2001, meeting in Washington, DC. In July 2001, the Congress of Nursing Practice and Economics voted to accept the new language of the interpretive statements, resulting in a fully approved revised Code of Ethics for Nurses with Interpretive Statements. This code of ethics was revised and published in 2015 to reflect changes in the practice environment following an extensive formal review process established by the ANA. The nine interpretive statements form the Code of Ethics are as follows:

1. The nurse practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.
3. The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.
4. The nurse has the authority, accountability, and responsibility for nursing practice; makes decisions, and take action, consistent with the obligation to promote health and provide optimal care.
5. The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character, and integrity, maintain competence, and continue personal and professional growth.

6. The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.
7. The nurse in all roles and settings advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.
8. The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.
9. The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

Relationships with Colleagues and Others

Respect for persons extends to all individuals with who the nurse interacts. Nurses maintain professional, respectful, and caring relationships with colleagues and are committed to fair treatment, transparency, integrity-preserving compromise, and the best resolution of conflicts. Nurses function in many roles and settings, including direct care provider, care coordinator, administrator, educator, policy maker, researcher, and consultant.

The nurse creates an ethical environment culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect. This standard of conduct includes an affirmative duty to act to prevent harm. Disregard for the effects of one's actions on others, bullying, harassment, intimidation, manipulation, threats, or violence are always morally unacceptable behaviors, Nurses value the distinctive contribution of individuals or groups as they seek to achieve safe, quality patient outcomes in all settings. Additionally, they collaborate to meet the shared goals of providing compassionate, transparent, and effective health service.

Program Etiquette

1. Arrive to class and return from breaks on time.
2. Returning to the classroom late from a break will count as a tardy.
3. Disturbances in class that distract the instructor or classmates will not be tolerated. Cell phones are to be silenced. Violators will be asked to leave class.
4. Electronic devices are not to be used for purposes other than instruction. Violators will be asked to leave class.
5. Faculty, staff, and classmates will be treated with respect.
6. Guest lecturers will be treated with gratitude and respect.
7. Students are considered guests in clinical agencies and are to act professionally, respectfully, and politely.
8. Hydration is allowed in the classroom. No food is to be eaten during the lecture. Trash is to be disposed of in outside trash bins.

CUESTA COLLEGE RN STUDENT DRESS CODE

1. Cuesta College RN Students are to adhere to an approved dress code.
2. Cuesta College student nurse photo identification badge and hospital photo identification are always worn above the waist when in a clinical agency.

3. Failure to maintain a professional appearance as a representative of Cuesta College RN Program will result in being asked to leave the clinical area, resulting in an absence.
4. Instructions to obtain the required uniform, specific brand, and styles will be given to admitted students at the incoming student orientation.
5. The uniform is professional dress and should be worn for clinical simulation and when in the clinical setting to perform patient research for clinical preparation.
6. Infection control practices require that your uniform not be worn in public settings, such as the grocery store. If you are outside of the clinical setting, your uniform should be covered.

The clinical dress code of the Cuesta College RN Student Nurse will be:

7. White top with sleeves.
8. Cuesta green scrub/uniform pants.
9. White scrub jacket may be worn with the uniform.
10. White shoes. Shoes must be clean, with low heel, closed or strapped heel and closed toe.
11. Socks should match your uniform pants or plain white colored socks could be worn.
12. Uniform in good repair and clean.
13. Facial makeup will be conservative.
14. No scented perfume, essential oil, aftershave, lotion, or cigarette smoke. Reliable deodorants should be used.
15. No jewelry except a watch, wedding band, and single pair of stud or discrete earrings. No gauge earrings. No necklaces.
16. Trimmed and cleaned fingernails. No acrylic nails or nail polish.
17. No artificial eyelashes.
18. Hair clean and controlled so it will not fall forward while performing nursing care.
19. Long hair pulled back and secured (kept out of patient care area)
20. Facial hair (moustaches & beards) allowed if kept clean and neatly trimmed
21. Tattoos - cover if professionally inappropriate (If you have questions regarding appropriateness, speak with your instructor or Associate Dean)
22. Pants NOT touching floor.
23. No gum chewing except for medical exception.

Clinical professional dress code for patient research:

24. Photo identification badge and white student nurse uniform are to be worn for patient research.
25. Faculty will determine situations that would allow professional dress with photo identification badge.
26. Students will not wear jeans, shorts, or sleeveless shirts in situations of professional dress code. Students found to be wearing inappropriate attire will be asked to leave and will have an absence.
27. Students may be given specific dress code guidelines for alternate clinical sites such as psychiatric, community health or pediatric settings.

PHYSICAL REQUIREMENTS & FUNCTIONAL ABILITIES

Certain functional abilities are essential for the delivery of safe, effective nursing care. These abilities are essential in the sense that they constitute core components of nursing practice, and there is a high probability that negative consequences will result for patient/patients under the care of nurses who fail to demonstrate these abilities. Programs preparing students for the practice of nursing must attend to these essential functional abilities in the education and evaluation of its students.

The nursing faculty at Cuesta College has identified functional abilities considered essential to nursing. These abilities are reflected in course objectives and clinical evaluation tools, which are the basis for teaching and evaluating all nursing students.

Applicants seeking admission into the nursing program who have questions about the functional abilities and appropriate reasonable accommodations are invited to discuss their questions with one of the nursing program faculty or the program director. Reasonable accommodation will be directed toward providing an equal educational opportunity for students with disabilities while adhering to the standards of nursing practice for all students.

The practice of nursing requires the following functional abilities with or without reasonable accommodations:

1. Visual acuity is sufficient to assess patients and their environments and to implement the nursing care plans developed from such assessments.
   Examples of relevant activities:
   - Detect changes in skin color or condition.
   - Collect data from recording equipment and measurement devices used in patient care.
   - Detect a fire in a patient area and initiate emergency action.
   - Draw up the correct quantity of medication into a syringe.
2. Hearing ability sufficient to assess patients and their environments and to implement the nursing care plans developed from such assessments.
   Examples of relevant activities:
   - Detect sounds related to bodily functions using a stethoscope.
   - Detect audible alarms within the frequency and volume ranges of the sounds generated by mechanical systems that monitor bodily functions.
   - Communicate clearly in telephone conversations.
   - Communicate effectively with patients and other members of the healthcare team.
3. Tactile ability sufficient to assess patients and implement the nursing care plans developed from such assessments.
   Examples of relevant activities:
   - Detect changes in skin temperature.
   - Detect unsafe temperature levels in heat-producing devices used in patient care.
   - Detect anatomical abnormalities, such as subcutaneous crepitus, edema, or infiltrated intravenous fluid.
4. Strength and mobility sufficient to perform patient care activities and emergency procedures.
   Examples of relevant activities:
   - Safely transfer patients in and out of bed.
   - Turn and position patients as needed to prevent complications due to bed rest.
   - Hang intravenous bags at the appropriate level.
   - Accurately read the volumes in body fluid collection devices hung below bed level.
   - Perform cardiopulmonary resuscitation.
   - Ability to lift 50 pounds repetitively and unaided.

5. Fine motor skills sufficient to perform psychomotor skills integral to patient care.
   Examples of relevant activities:
   - Safely dispose of needles in sharps containers.
   - Accurately place and maintain the position of the stethoscope for detecting sounds of bodily functions.
   - Manipulate small equipment and containers, such as syringes, vials, ampules, and medication packages, to administer medications.

6. Ability to speak, comprehend, read, and write in English at a level that meets the need for accurate, clear, and effective communication.
   Examples of relevant activities:
   - Verbally communicate patient care needs to members of the healthcare team.
   - Verbally communicate teaching plans to patients.
   - Comprehend medical orders to implement care without the assistance of an interpreter.
   - Document legal records of patient care.

7. Physical endurance sufficient to complete assigned periods of clinical practice.

8. Emotional stability to function effectively under stress, adapt to changing situations, and follow through on assigned patient care responsibilities.

9. Cognitive ability to collect, analyze, and integrate information and knowledge to make clinical judgments and management decisions that promote positive patient outcomes.

INJURY & PHYSICAL STATUS CHANGES POST-ADMISSION PHYSICAL EXAM

If your physical status changes since the admission physical exam to enter the program, the student must inform the faculty immediately to investigate possible clinical accommodation(s). In the event of an injury that may impact or restrict the student's

*Continuing students unable to maintain functional abilities with reasonable accommodation will be withdrawn from the program. In the event of an injury, students must provide a formal statement from a physician, nurse practitioner, or certified physician assistant detailing the nature of the injury, a treatment plan, and a clear timeline for return to academic and clinical activities. The statement must also outline any physical limitations or accommodations to ensure student and patient safety during clinical rotations.

Students will not be permitted to return to class or clinical assignments until the required documentation has been submitted and reviewed. Any necessary adjustments to clinical participation will be determined in coordination with faculty and clinical site requirements.

Failure to provide the required medical documentation may result in a delay in program participation.

The Cuesta College associate degree nursing program follows the guidelines established within each clinical facility regarding restricted activity.

Example: you fracture your ankle and must wear an ankle boot to ambulate. In this case, we will need clearance from the clinical agency and a release note from your physician, nurse practitioner, or certified physician assistant detailing the nature of the injury, a treatment plan, and a clear timeline for

return to academic and clinical activities (with or without limitations) to admit you into clinical. Failure to notify the program may be considered academic dishonesty.

CUESTA COLLEGE REGISTERED NURSING PROGRAM

Performance Standards

I. Purpose: To define elements of patient care/skills essential to ensure patient safety when performed in clinical throughout all semesters of the RN program.

II. Policy: All students will perform safe and competent patient care adhering to the Performance Standards, Cuesta College Student Handbook, Course Syllabus, Clinical Objectives, Level Competencies, and Clinical Facility Policy and Procedure Manuals. Students will adhere to Performance Standards from previous levels as they progress through the program's four levels.

III. Level specific student scope of practice: The student nurse can perform the patient care/skill in the clinical setting after the following instruction, practice, and competency verification has occurred:

a. Taught in a theory class
b. Practice in the skills lab
c. Competency check-off completed, if required
d. Perform with faculty member in the clinical setting
e. Reassess with faculty to assure continued competence and status to perform independently
f. Adhere to program policies to perform skills

BRN Regulation 2729 – Nursing services may be rendered by a student when these services are incidental to the course of study and the student is enrolled in a board-approved nursing program.

The faculty determines the amount of supervision to provide to any individual nursing student. When determining the appropriate level of supervision, faculty considers the severity and stability of the assigned patient and the patient's condition, the types of treatments, procedures, medications required for the patient, and the student's competency and ability to adapt to the changing situations in the clinical setting. When engaged in the clinical learning experience, the nursing student is supervised by the clinical faculty and the RN in the facility. Both the clinical faculty and the RN in the clinical facility are responsible for the quality of care delivered by students under their supervision.

IV. OVERRIDING PERFORMANCE STANDARDS – SEMESTER 1 - 4

1. Caring and Advocacy for the patient

a. Introduce self and student role; obtain permission prior to care
b. Explain procedures and patient role when planning for the day
c. Obtain patient consent prior to patient care/skill and procedures
d. Perform procedures/assessments on time/within allotted time
e. Ensure privacy
f. Maintain professional caring role
g. Perform/assist with patient's ADLs, including hygiene
h. Act as the patient advocate

2. Standard Precautions

a. Protect self from contamination.
b. Protect patient from contamination.
c. Dispose of contaminated material in designated containers.
d. Dispose of all syringes/medications per OSHA guidelines.
e. Confine contaminated material per OSHA guidelines.

3. Safety

a. Validate all procedures/medications/assessments/interventions with medical order
b. Identify/verify the patient using at least two corroborating identifiers, as designated by facility policy, before providing care, performing treatments, or administering medications
    i. Ask the patient to state (not confirm) name and one other patient identifier, (i.e., date of birth).
    ii. Verify the patient's name and second patient identifier by matching the patient identification band against the medical record.
    iii. For non-verbal patients, verify the patient's name and second patient identifier by matching the patient identification band against the medical record.
c. Validate patient allergies
d. Maintain a safe facility environment; use and handle equipment safely and appropriately
e. Communicate abnormal findings and alert staff of emergency situations
f. Adhere to level specific student scope of practice

4. Communication (Verbal)

a. Incorporate *Caring and Advocacy Standards*
b. Effectively inform level-specific scope of practice to staff RN and pertinent healthcare team members
c. Explain procedure and patient's role
d. Communicate timely assessment/data/order updates to instructor, staff RN, and/or appropriate interdisciplinary team members

5. Communication (Written Documentation)

a. Document assessments, procedures, interventions, and reassessments in the patient medical record accurately and timely
b. Adhere to legal principles of documentation, facility policy and student scope
c. Develop and updates nursing care plans/plan of care based on assessment and reassessment

6. Teaching/ Learning

a. Perform independent research sufficiently to understand the topic
b. Provide teaching based on patient learning needs
c. Assess barriers to learning and provides appropriate options
d. Evaluate patient response and documents
e. Record in patient medical record

7. Assessment

a. Perform a baseline physical assessment/reassessment on all patients

b. Perform vital signs specific to level of care and facility policy
c. Perform assessments appropriate to each patient's status and care needs
    i. Adult/geriatric physical assessment (level I) novice
    ii. Adult/geriatric/pediatric/newborn/neonate physical assessment (level II) advanced beginner
    iii. Adult/geriatric physical assessment (level III) competent
    iv. Adult/geriatric/mental health physical assessment (level IV) proficient

8. Plan of care

a. Assess patient and their response to healthcare problems; formulate nursing diagnosis
b. Formulate a plan of care
c. Identify outcomes that reflect prevention, reduction, or resolution of problem
d. Plan interventions to achieve identified outcomes and develop an individualized plan of care
e. Implement plan of care
f. Evaluate patient response to care and the effectiveness of the plan of care

LEVEL I PERFORMANCE STANDARDS – SEMESTER 1

1. Medical Record Documentation

    a. Observe legal requirements of documentation
    b. Apply nursing process in documentation
    c. Record information pertinent to the patient's condition and nursing care
    d. Adhere to facility policy and procedure for documentation requirements
        i. Documentation is accurate and timely
        ii. Reassessments, interventions, and outcomes relate to the plan of care
        iii. Changes in condition/new orders that impact nursing interventions
        iv. Procedures performed at the bedside
        v. Time patient leaves the unit and returns to unit for tests, procedures, surgery
    e. Adhere to facility policy when using electronic medical record for maintaining confidentiality

2. Medication Administration Standards
    a. Perform three checks for each medication against medication administration record prior to administration
    b. Verify drug incompatibilities and allergies
    c. Identify correct landmarks
    d. Accountable for proper medication handling
        i. Don gloves when hand to medication contact is anticipated
        ii. Maintain visual control of medications throughout administration process
    e. Utilize the Rights of Medication Administration:
        i. Right medication
        ii. Right dose
        iii. Right patient
        iv. Right time
        v. Right route
        vi. Right documentation promptly after medication administration
    f. Verbalize name of drug, indication, therapeutic effects, pertinent pre-assessments, anticipated side effects, drug interactions, safe dose range, and nursing implications *before* administration

g. Calculate weight-based calculations as appropriate
h. Scan patient armband, confirms patient identifiers and correct EMAR
i. Scan each medication before administration
j. Complete dose verification with two licensed nurses for High-Risk medications per facility protocol
k. Perform pertinent patient teaching prior to administration
l. Document post-administration assessments
m. Dispose medication waste in appropriate container following OSHA and HIPAA standard
n. Accountable for specialized knowledge and policies when caring for patients receiving chemotherapeutic and antineoplastic agents
o. All students who are pregnant, attempting to become pregnant, or breast feeding should exercise caution when caring for patient receiving these agents
    i. Handling of bodily fluids requires double gloving, wearing of goggles and covering the toilet with a low permeability barrier during flushing of waste
    ii. Washing hands after touching patient, bodily fluids, and removing PPE
    iii. Only linen which is soiled with body fluids within 48hrs of chemotherapy drugs needs to be placed in the yellow chemo precaution laundry bags
    iv. Report any spills or exposures to RN, clinical faculty, and environmental services

3. IV Therapy: Fluid Administration

a. Perform IV site assessment per facility policy and as needed
b. Verify patency
c. Prime tubing maintaining sterility of relevant tubing parts
d. Change and labels solution and tubing per facility policy
e. Secure catheter with a sterile dressing per facility policy
f. Adhere to *Medication Administration Standards*
g. Assure correct solution, additives, and rate

4. Discontinuing a peripheral IV access site

a. Perform assessment prior to discontinuing IV
b. Utilize techniques to minimize discomfort while removing dressing
c. Remove catheter smoothly, visualizing site during removal
d. Achieve hemostasis before application of dressing
e. Inspect catheter for integrity and reports irregularities
f. Document procedure

5. Intake and Output

a. Monitor
b. Assess
c. Document
d. Reports irregularities

6. Mobility

a. Assess patient's mobility status
b. Assess need for adaptive devices to assist with patient mobility
c. Maintain proper body alignment of self when moving patient
d. Observe safety standards when moving or positioning patient

7. Enteral Tubes

   I. Nasogastric tube placement and decompression
      a. Verbalize rationale for type of tube and references medical order
      b. Verify order and uses source document
      c. Place gastric tube and assures placement
      d. Verify correct suction and setup
      e. Assess skin integrity and abdomen
      f. Secure tube
      g. Assess for migration by noting tube measurement at nares
      h. Flush as ordered to maintain patency

   II. Enteral feeding
      a. Assess tube placement
      b. Check residuals
      c. Secure tube
      d. Assess skin integrity and abdomen
      e. Verify tube feeding formula and rate
      f. Change tubing in accordance to open and closed system and per facility policy

   III. Medication administration
      a. Adhere to *Medication Administration Standards*
      b. Assess for placement
      c. Flush tube before medication administration
      d. Crush medications appropriately
      e. Flush tube after medication administration

8. Oxygenation

   a. Assess respiratory status of patient.
   b. Position patient to facilitate oxygenation.
   c. Assure correct oxygen delivery.
   d. Apply basic oxygenation devices correctly
   e. Assess oxygen saturation

9. Skin Care

   a. Assess and reassesses skin integrity
   b. Clean and dry skin routinely per facility policy
   c. Apply pressure reduction methods as appropriate for patient

10. Urinary Catheter:

   a. Apply principles of sterile technique throughout the procedure
   b. Assess and reassesses proper placement
   c. Position catheter to promote drainage and prevent dependent loops of tubing
   d. Apply catheter securing device per facility policy
   e. Perform catheter care per facility policy

f. Discontinue catheter per orders or screening policies

11. Enema
    a. Use correct solution and type enema
    b. Adhere to all *Medication Administration Standards*
    c. Gather necessary equipment
    d. Place patient in correct position on left side unless contraindicated.
    e. Control flow to avoid patient discomfort
    f. Monitor for adverse effects
    g. Record intake and output

12. Vital Signs

    a. Measure, record, and report accurately
    b. Assess patient trends
    c. Report abnormal findings to RN and instructor
    d. Review medical order for vital sign variance

13. Pain Assessment/Intervention and Evaluation Standards

    a. Assess the patient's pain using a valid and appropriate scale
    b. Intervene promptly based on patient established pain goal
    c. Inform the patient of possible pharmaceutical and non-pharmaceutical methods of pain control
    d. Involve patient and family in pain goal setting
    e. Evaluate and document patient's response to intervention

14. Wound Care

    a. Follow hospital policy, protocol, or orders for type of would care
    b. Assess and reassess wound, drainage or dressing
    c. Assess and manage drains according to type and function
    d. Document wound intervention/assessment per facility policy
        e. Student do not stage wounds
    f. Dressing Changes
        g. Determine the need for sterile or clean technique
        h. Apply principles of sterile or clean technique throughout the procedure
    i. Irrigation:
        j. Use correct solution at appropriate temperature
        k. Instill into correct body area
        l. Control flow (rate and volume) of solution

15. Blood Glucose Monitoring

    a. Clean patient's finger, or site, per facility policy
    b. Collect blood sample and assures hemostasis
    c. Report results to RN and Clinical faculty
    d. Treat result per student scope
    e. Verify documentation

LEVEL II PERFORMANCE STANDARDS – SEMESTER 2

1. Subcutaneous Medication Administration

    a. Adhere to all *Medication Administration Standards*
    b. Identify landmarks, selects and prepares appropriate site
    c. Use correct needle and syringe
    d. Use aseptic technique
    e. Engage needle safety device appropriately

2. Intramuscular Medication Administration

    a. Adhere to all *Medication Administration Standards*
    b. Identify landmarks, selects, and prepares appropriate site
    c. Use correct needle and syringe
    d. Use aseptic technique
    e. Aspirate per facility policy or required to rule out any insertion into underlying blood vessels
    f. Engage needle safety device appropriately

3. Care of the Neonate

    a. Adhere to all *Medication Administration Standards*
    b. Adhere to neonatal policy per facility
    c. Perform and evaluates neonatal assessments and care in accordance with age-appropriate parameters
    d. Maintain support of the head and neck when moving or positioning neonate
    e. Transport and identifies neonate per facility policy

4. Care of the Pediatric Patient

    a. Adhere to all *Medication Administration Standards*
    b. Adhere to student role in pediatrics
    c. Perform and evaluates pediatric assessments and care in accordance with age-appropriate parameters
    d. Apply growth and development principles during the provision of care
    e. Calculate daily weight-based fluid I&O requirement

5. Care of the Obstetric Patient

    a. Adhere to all Medication Administration Standards
    b. Adhere to student role in obstetrics
    c. Understand and follows student scope, checking in with faculty prior to performing skills
    d. Perform and evaluate postpartum assessment

6. Injections: Intradermal Injection move to 2nd

    a. Adhere to all Medication Administration Standards
    b. Identify landmarks, selects, and prepares appropriate site
    c. Use correct supplies

d. Use aseptic technique
e. Perform patient teaching; verifying follow-up requirements
f. Ensure a bleb or wheal occurs during injection
g. Report abnormal results and verifies documentation

7. Peripheral Saline Lock Maintenance

    a. Perform IV site Assessment per facility policy and as needed
    b. Verify patency following facility policy
        i. Type, amount, technique, and frequency of flush
    c. Cleanse access port per facility policy
    d. Document site condition and patency

8. IVPB medication via peripheral saline lock or infusing IV

    a. Adhere to all Medication Administration Standards
    b. Assure correct solution, additives, and rate
    c. Ensure appropriate concentration and compatibility
    d. Perform IV site Assessment per facility policy and as needed
    e. Verify patency
    f. Cleanse access port per facility policy
        i. Prime tubing maintaining sterility of relevant tubing parts
        ii. Use equipment safely and appropriate
    g. Ensure all medication has been delivered

9. Patient Controlled Analgesia (PCA)

    a. Adhere to all *Medication Administration Standards*
    b. Adhere to all *Pain Assessment/Intervention and Evaluation Standards*
    c. Assess patient's understanding of and ability to self-administer medication
    d. Operate pump safely and primes per facility policy
    e. Document per facility policy

10. Patient Epidural Analgesia Assessment

    a. Adhere to all *Medication Administration Standards*
    b. Adhere to all *Pain Assessment/Intervention and Evaluation Standards*
    c. Assess and reassess for decreased sensory and motor function and ongoing pain level
    d. Assess integrity of tubing, catheter, and dressing
    e. Report complications to RN and Clinical Faculty

LEVEL III PERFORMANCE STANDARDS – SEMESTER 3

1. Venous Access Device Care

    a. Perform site assessment
    b. Determine and apply sterile or clean technique
    c. Identify type of catheter; recognizes unique characteristics
    d. Follow facility policy for size and type of syringe
    e. Verify and maintains patency

i. Perform site assessment prior to flush, and/or fluid delivery
ii. Clean access port
iii. Follow facility policy to maintain and preserve the device

f. Care and Dressing Change
i. Maintain and secures the line throughout procedure
ii. Apply principles of clean and sterile technique throughout the procedure
iii. Follow facility policy for frequency, injection cap changes and dressing technique

h. Blood Draws
i. Draw waste as specified by facility policy, disposing per OSHA guidelines
ii. Draw specimen, labels, and verifies proper documentation
iii. Flush and changes injection caps per facility policy following blood draw

i. Removal
i. Perform assessment prior to discontinuing
ii. Follow facility policy, utilizing precautionary measures to prevent complications
iii. Inspect catheter integrity and reports irregularities
iv. Ensure hemostasis and applies dressing

2. Intravenous Parenteral Nutrition Delivery

a. Adhere to all Medication Administration Standards
b. Deliver medication approved by *Cuesta College Student Nurse IV Drug Administration*
c. Assure correct solution, additives, and rate with 2 RNs
d. Ensure appropriate concentration and compatibility
e. Perform IV site/central line assessment per facility policy and as needed
f. Verify patency with delivery
g. Cleanse access port per facility policy
iii. Prime tubing maintaining sterility of relevant tubing parts
iv. Use equipment safely and appropriate
g. Ensure all medication has been delivered
h. Document delivery in EMR

2. Intravenous Push Medication Administration

a. Adhere to all *Medication Administration Standards*
b. Deliver medication approved by *Cuesta College Student Nurse IV Drug Administration*
c. Verify compatibility with infusions
d. Prepare, dilute, and label syringe appropriately
e. Demonstrate correct administration technique for type of venous access
f. Verbalize and demonstrate appropriate rate of administration
g. Incorporate ongoing assessment criteria during IVP administration

3. Ostomy Care
a. Assess and reassess stoma and peristomal skin integrity
b. Monitor stoma and cares for peristomal region
c. Determine appliance type
d. Apply or change device as directed
e. Empty appliance as required
f. Monitor output and reports abnormal findings

4. Chest Tubes

   a. Identify rationale for chest tube and goals of care
   b. Assess for air leak, crepitus, drainage, skin and dressing integrity
   c. Maintain integrity of collection device
   d. Maintain patency of tubing, ensures connections are secure, and appropriate suction per order
   e. Position drainage chamber below chest
   f. Report assessment and complications to RN and Clinical Faculty

5. Blood Administration

   a. Validate order
   b. Verbalize rationale for blood component
   c. Ensure informed consent and patient rights and education are completed prior to transfusion
   d. Assess IV access prior to obtaining blood
   e. Identify correct patient with blood component using a two-person verification process
   f. Perform assessments and reassessments prior, during and post transfusion
   g. Adhere to time for transfusion based on type of blood component and patient condition
   h. Monitor, initiate, and report interventions in the event of an adverse reaction

6. IV Starts

   a. Assess peripheral venous indications
   b. Prep IV site and supplies without contamination
   c. Insert IV catheter using aseptic technique
   d. Engage needle safety device properly
   e. Validate patency
   f. Secure catheter with dressing
   g. Label dressing with initials and date of insertion

7. Airway Management
   a. Hyper-oxygenate prior to intervention
   b. Verify appropriate suction and equipment function
   c. Insert catheter appropriately
      i. Oropharyngeal suction - insert catheter only to pharyngeal area
      ii. Tracheal Suction - insert catheter only to tracheal area
   d. Assess secretion character and quantity
   e. Maintain a patent airway
   f. Ensure O_2 sat and oxygen delivery returned to baseline
   h. Tracheostomy Care
      i. Monitor cuff status appropriately
      ii. Change inner cannula per facility protocol
      iii. Assess stoma and clean site
   i. Reassessment airway and lung fields

9. Procedural Sedation
   a. Understand and follows student scope in observational role
   b. Verbalize understanding and implication of:
      i. Preprocedural universal protocol assessment
      ii. Preprocedural evaluation criteria
      iii. Labs, test results, physician documentation

iv. NPO status
v. IV site, hydration, preprocedural medication
vi. Monitoring and safety equipment

c. Report abnormal assessments and findings
d. Recognize common medications used and reversal agents, inclusive of recovery expectations
e. Understand discharge criteria, inclusive of a patient Aldrete Score and medications utilized

10. Total Parenteral Nutrition Delivery

h. Adhere to all Medication Administration Standards
i. Assure correct solution, additives, and rate
j. Ensure appropriate concentration and compatibility
k. Perform IV site/central line assessment per facility policy and as needed
l. Verify patency
m. Cleanse access port per facility policy
    i. Prime tubing maintaining sterility of relevant tubing parts
    ii. Use equipment safely and appropriate
g. Ensure all medication has been delivered
h. Document delivery in EMR

LEVEL IV PERFORMANCE STANDARDS – SEMESTER 4

a. Students are not allowed to perform skills in emergency patient situations. Emergency care for patients in crisis is taught this semester, but students are not checked off or certified to perform these competencies in the clinical setting.
    1. <u>Advanced Adult Assessment</u>
        a. Acute Care –perform and document assessment criteria incorporating medications, interventions and supportive teaching elements required for acute patients' needs
        b. Adult Critical Care- recognize elements of an advanced physical assessment incorporating both hemodynamic and respiratory interventions, demonstrate proper calculations for critical care infusions.
        c. Emergency Care – Understand and follows student scope in observational role for triage and basic care
        d. Mental Health Status
    2. <u>Critical Care Response Team – understands and follows student scope in observational role for:</u>
        a. Rapid Response Team criteria, implementation and documentation
        b. Code Blue activation, implementation and nursing role
    3. <u>Electrocardiogram</u>
        a. Interpretation of atrial, ventricular, paced and irregular/blocked rhythms and recognize appropriate interventions and accurate documentation in EMR
        b. Documentation expectations
        c. Implications and outcomes related to rhythm variations and the common mediations to treat patients
    4. <u>Nursing Leadership</u>
        a. Integrate the RN role as a member within the profession of nursing
        b. Recognize the various roles and interact with the management team
        c. Integrate professional communication and supportive delegation as a team member
        d. Demonstrate job readiness through a professional application process
        e. Understand the patient and family needs towards end of life
        f. Analyze how nurse leaders can address discrimination and bias in nursing

ACCOMMODATIONS

Nursing Theory Courses Accommodations

As required by the Americans with Disabilities Act (ADA), accommodations are provided to ensure equal access for students with verified disabilities. To determine if you qualify for accommodations, please get in touch with DSPS. The nursing faculty encourages students with disabilities to explain their needs and appropriate accommodations to your faculty as soon as possible. To receive accommodations, bring verification from the DSPS for the accommodations to your instructor at the beginning of each semester and no later than one week before an exam. Accommodations are not applied retroactively for any exam.

Students needing accommodations should inform the course instructor and Director of Nursing as above, so arrangements may be made with the proctoring center to prepare your exam. It is the student's responsibility to make an appointment with the proctoring center for your testing. If you utilize the proctoring center, an exam may not be available in the classroom if you change your plans. Please consult with your instructor ahead of time.

Clinical and Skills Courses Accommodations

As required by the Americans with Disabilities Act (ADA), accommodations are provided to ensure equal access for students with verified disabilities. To determine if you qualify for accommodations, The nursing faculty encourages students with disabilities to explain their needs and appropriate accommodations to your faculty as soon as possible. To receive accommodations, bring verification from the DSPS for accommodations to the Director of Nursing at the beginning of each semester or upon receipt. Students must complete clinical skills within a specified time frame; extra time is not given for clinical skills testing in the lab.

If you have a change in health or are injured after your nursing program's required entry physical, let your instructor and Director of Nursing know immediately or as early as possible before clinical; failure to do so may be viewed as academic dishonesty. In the event of an illness or injury, a Physician or Primary Care Provider release may be required to attend a clinical course.

Students must meet essential eligibility requirements for participation in the clinical area and comply with hospital policy. Accommodations for the clinical area are evaluated on a case-by-case basis. Faculty may consult with the clinical site concerning hospital policy. See also Nursing Performance Standards in your Nursing Student Handbook.

PHYSICAL REQUIREMENTS

A physical examination must be completed and signed by a healthcare provider to ensure the student is physically and emotionally able to meet the functional abilities required to perform safe patient care. The physical must be completed no sooner than June before beginning the nursing program, must be on the physical examination forms, and must be at the student’s own cost. The physical examination will be maintained in the student file in the nursing office throughout the nursing program.

*If, at any time, before or after acceptance into the program, a student's physical or emotional health is such that it is a potential threat to the well-being of a patient or themselves, the student will be denied access to clinical agencies. The student may be required to obtain an updated physical exam and medical clearance to participate in clinical activities if altered health status or changes occur during the

program. Conditions that require a healthcare provider document confirming a student to return to class and clinical could be and are not limited to surgical procedures, pregnancy, or post-partum.

A student who is absent due to illness for more than three days needs to follow up with the program director and faculty. The student may be asked to present a healthcare provider note, releasing the student to return to the classroom and clinical setting (please refer to attendance policy).

HEALTH SCREENING

Significant health screening requirements must be met before entering the clinical area. Each student must meet vaccination, titer, physical exam, and drug testing requirements and provide documentation by the required deadlines. You may elect to have these requirements performed at your own medical provider's office or a clinic. In any case, all documentation regarding health screening MUST be provided to the current compliance tracking system. Students must be prepared to provide drug screening results to clinical sites at any time during the program.

INJURY & PHYSICAL STATUS CHANGES POST-ADMISSION PHYSICAL EXAM

If your physical status changes since the admission physical exam to enter the program, the student must inform the faculty immediately to investigate possible clinical accommodation(s). In the event of an injury that may impact or restrict the student's

ability to participate in the academic or clinical setting, a written release must be obtained from the student's care provider to allow the student to resume participation in required coursework. The Cabrillo College associate degree nursing program follows the guidelines established within each clinical facility regarding restricted activity.

Example: you fracture your ankle and must wear an ankle boot to ambulate. In this case, we will need to get clearance from the clinical agency and a release note from your primary care provider for clinical work (with or without limitations) to admit you back to clinical. Failure to notify the program may be considered academic dishonesty.

LIVESCAN FINGERPRINTING

Students may be required to complete Live Scan (inkless electronic fingerprinting) if the clinical site to which the student is assigned requires the procedure. LiveScan fingerprints are electronically transmitted to the Department of Justice (DOJ) and, in some cases, to the Federal Bureau of Investigation (FBI) to complete a criminal record check. LiveScan fingerprinting can be completed at the County Sheriff's office, Perry’s Parcel, and other locations in our area.

PROOF OF IMMUNITY REQUIREMENTS

Proof of immunity records for COVID, MMR, Varicella, T-dap, Hepatitis B, annual flu, and Tuberculosis screening are required by clinical agencies to be in the student file in the nursing office throughout the nursing program. Students may not attend clinical practicum without current immunity records and Tuberculosis screening in their student nurse file at Cuesta College. Missed clinical due to a missing or expired immunity or Tuberculosis screening records will count as a clinical absence. Tuberculosis screening is to be done in the summer so it does not expire during the academic year.

STUDENT INSURANCE

Students carry their own personal health insurance. The college carries professional liability and injury for the nursing student while in clinical. Additional professional liability insurance is a personal choice.

STUDENT INJURY OR EXPOSURE

Cuesta College nursing students experiencing an injury on campus or in a clinical setting must report the incident to their instructor and the nursing program director. If necessary, the student will be seen in the emergency room or medical care center, whichever is deemed appropriate for the situation. The student and instructor complete a Student Injury/Exposure Report. The form is obtained from your instructor. If medical treatment is required, the student is to complete the Workman Compensation Claim Forms with the Human Resource Department within 24 hours, or the next business day. If the incident involves verbal or physical threats, state law requires reporting to the Cuesta College Public Safety Department. Healthcare facility paperwork also needs to be completed per agency policy.

CPR CERTIFICATION FOR THE HEALTHCARE PROVIDER

CPR (Cardiopulmonary Resuscitation) certification for the healthcare provider is required for students to attend clinicals. Students may not participate in clinicals without a current copy of their CPR certification card or certificate in their student file in the nursing office at Cuesta College. A new CPR certification must be obtained the summer prior to beginning the RN program to ensure that it will not expire before graduation. If, for some reason, a CPR certification is expired, the student may not attend clinical. Missed clinical due to expired CPR certification will count as a clinical absence.

BACKGROUND AND DRUG SCREEN CLEARANCE FOR CLINICAL PLACEMENT REQUIREMENT

A background check and drug screen clearance are required by clinical facilities and will be completed by the student before clinical placement can occur. The Background Check and Drug Screen Policy, and a list of convictions and/or charges that would prevent clinical participation can be viewed on the division website.

In addition, students are required to report any arrest or pending charge that occurs while the student is enrolled in the nursing program to the nursing program director within two weeks of the occurrence. The consequences of such actions will be evaluated individually.

A DOJ (Department of Justice) fingerprint background check will be completed and submitted to the BRN after submitting your NCLEX application upon program completion for RN licensure eligibility.

The cost of all background checks is the responsibility of the student.

SIMULATION LAB

Simulation is incorporated into all four semesters of the program. Students participate in simulation during scheduled lab, open lab, and as part of their clinical rotations.

Simulation experiences provide the nursing student the opportunity to use clinical judgment and critical thinking while caring for a patient in a safe learning environment. Scenarios increase in complexity as the student progresses through the program.

The student nurse dress code is enforced during simulation. Preparation for simulation per the instructor is required. Respect for classmates and a confidential environment that promotes a safe

learning environment is a requirement to participate in simulation, and violations of either will prohibit participation. Missed simulation days reflect clinical or theory absences.

MENTORING PROGRAM FOR LVN to RN, RE-ENTRY, and TRANSFER STUDENTS

A mentoring program exists for re-entry and transfer students to facilitate a smooth transition into the RN program. Re-entry and transfer students will be scheduled to meet with the program director, success specialist, and clinical faculty prior to class and clinical to be introduced to the basics of entering the program. Re-entry and transfer students will also be paired with a classmate mentor. In addition, faculty are available during office hours and appointments.

CERTIFIED NURSING ASSISTANT (CNA) ELIGIBILITY TO TEST BY EQUIVALENCY

Students can take the Certified Nursing Assistant (CNA) exam after the first semester of the nursing program. Information on how to take this exam will be available upon request from the nursing program director. The application to test for CNA by equivalency is completed and submitted by the student to the California Department of Public Health (CDPH) for approval. The CDPH approval process may take 1 - 3 months before testing is granted.

STUDENT NURSE INTERNSHIP ELIGIBILITY

The student internship is an elective work-study course for students who have completed the first semester of the RN program and who enroll in NRAD 219A or NRAD 219B. The internship course's purpose is to give the student an opportunity to understand the RN role and practice selected skills more fully under the supervision of an RN mentor. Information and expectations will be provided to students and are explained in the internship course syllabi.

Internship positions are dependent on facility needs and vary from year to year. Information from the BRN regarding student workers (student interns) can be found at: http://www.rn.ca.gov/pdfs/regulations/npr-b-15.pdf

LETTER OF RECOMMENDATION FROM FACULTY REQUESTS

Students may request verbal or written recommendations from faculty. The student is to request permission from the faculty member to be a reference and provide the faculty member with a "Student Reference Request" form that the faculty will retain in their files. As a courtesy to the faculty, the request should be made at least two weeks in advance. This form may be found on the nursing website at: https://www.cuesta.edu/academics/scimath/nah/nah_resources.html

PROGRAM EVALUATION

Students are given the opportunity to participate in all areas of the program. Student input is valued and often requested. Opportunities for student evaluations of the Cuesta College AND program and faculty include but are not limited to:

1. Course surveys are completed at the end of each semester. These confidential surveys are sent to students by the nursing program director and request feedback regarding theory courses, clinical instruction and facilities, skills and lab, textbooks, and available student resources.

2. A program survey is completed at the end of the program to obtain feedback on all four semesters of the RN program. This confidential survey is sent to students by the program director at the completion of the 4th semester/program.
3. Students are requested to evaluate faculty through the college faculty evaluation process and timelines.
4. Opportunities are scheduled throughout the program for students to provide informal feedback to faculty and the program director:
   - Class Representatives from each class are invited to attend faculty meetings once a month. Class representatives collect feedback from all the students in their class to bring to the faculty at these meetings.
5. An Alumni Survey will be sent to graduates approximately one year after completing the program to obtain feedback on how the program prepared them to be an entry-level nurse.
6. Employer surveys are completed on each graduating class about one year after working as a nurse.

Nursing (RN & Accelerated RN) Absenteeism and Tardiness Policy

All theory classes and clinical days begin and end at the times listed on the course schedule unless otherwise communicated by the instructor. Any schedule changes will be posted on Canvas (Announcements), sent via email, or posted on classroom doors.

Excessive absences may result in course failure or dismissal from the program due to inability to meet course objectives.

General Expectations

- Students must notify their instructor before the start of class or clinical if they will be absent for any reason.
- Failure to notify the instructor may result in a grade reduction or inability to take an exam.
- Follow your instructor's preferred method of communication.
- Students may not attend lecture if they have missed a scheduled exam that day.

Theory (Classroom)

- Tardiness
  - A tardy is defined as:
    - Arriving more than 5 minutes late
    - Leaving class early
    - Returning late from a break
  - Three tardies = one absence
- Attendance Limits
  - Theory hours missed are cumulative.
  - Students may miss no more than 3 total hours of theory per course.
  - Exceeding 3 hours may result in a failing grade.
- Expectations
  - If you will be late, notify your instructor and enter the classroom quietly.
  - If you arrive late, it is your responsibility to check in with the instructor to receive attendance credit.

    - Students are responsible for obtaining missed notes and content.
- Make-Up Work
    - A make-up assignment will be assigned at the instructor's discretion.
    - Assignments are due within one week of the absence.
    - Failure to complete the assignment on time may result in a grade reduction or dismissal from the program.
- Extenuating Circumstances
    - Students with extenuating circumstances must meet with the instructor and Nursing Director.
    - If approved, a plan for completing missed work will be developed by the Director and faculty.

Clinical

- Tardiness
    - If you are tardy and notify your instructor:
        - The instructor/director will determine the required make-up time.
        - Tardiness greater than 30 minutes requires a full make-up day.
- Attendance Limits
    - Students may miss no more than 3 clinical days per semester.
    - Make-up is not guaranteed if absences exceed 3 days.
    - Students with 3 or more absences must meet with faculty and the director to determine next steps.
- Make-Up Requirements
    - Clinical absences must be made up on designated Clinical Make-Up Days.
    - Missing a required make-up day will result in:
        - Failure to meet clinical objectives
        - Course failure and dismissal from the program
- Breaks
    - Clinical schedules include:
        - One 15-minute break
        - One 30-minute meal break
    - Break timing is determined by patient care needs and faculty direction.
- Illness
    - If absent due to illness for 3 consecutive days, a physician's note is required.
    - Students must be able to safely provide full patient care upon return.

Pregnancy Concerns:

Antepartum

It is recommended that students notify their instructor(s) regarding their pregnancy as soon as it is confirmed. In addition, you must meet with the Associate Dean/Director of nursing. The student may

be required to obtain an updated physical exam and medical clearance to participate in clinical activities if altered health status or changes occur during the program. Conditions that require a healthcare provider document confirming a student to return to class and clinical could be and are not limited to, surgical procedures, pregnancy, or post-partum. Regardless of accommodation(s), the course outcomes must be met to pass the course(s).

Postpartum

All students who are hospitalized must provide a completed clearance letter signed by a healthcare provider, to ensure the student is physically able to meet the functional abilities required to perform safe patient care. If postpartum complications exist, the same requirements apply. The clearance letter from the physician must state that the student is able to return to the full and essential RN level of functioning as outlined in the ADA Registered Nursing Regardless of accommodation(s), the course outcomes must be met to pass the course(s).

Lactation

Lactating students have the right to pump or breastfeed an infant in a private, comfortable space. Students should inform their instructor(s) if a lactation space is required. A breastfed infant may not remain with the lactating mother in a classroom or clinical setting other than the lactation room. If a caregiver is bringing the infant to the lactating student on campus or at clinical for the purpose of breastfeeding, campus/clinical regulations for checking in and out must be followed.

Breastfeeding needs should be communicated to the instructor. Lactating students are encouraged to pump or breastfeed during class break time. If a lactating student must pump or breastfeed an infant at times other than during designated break times, it is the student's responsibility to follow up with the instructor regarding any content that may have been missed during their absence from class. Regardless of accommodation(s), the course outcomes must be met to pass the course(s).

Lactating students are responsible for providing and maintaining their own supplies.

Sick Leave-Post Surgery and/or Illness

The student must present a written clearance from a physician to the Associate Dean. A physical examination is to be completed and signed by a Physician, Nurse Practitioner or Physician Assistant, to ensure the student is physically able to meet the functional abilities required to perform safe patient care. The clearance letter from the physician must state that the student is able to return to the full and essential RN level of functioning as outlined in the ADA Registered Nursing Essential Job Functions. This may result in a Leave of Absence (See below).

1.

RESEARCH OF PATIENT MEDICAL RECORDS

1. Research of a patient medical record is for the RN program curriculum and course requirements only.
2. Students will follow agency protocol for review of medical records.

3. Medical records, including any document with patient identifying information, are NOT to be removed from the clinical units or photocopied. These actions are a violation of patient confidentiality(HIPAA).

4. Electronic Medical Records may only be accessed while present at the clinical site. Accessing an Electronic Medical Record while off site is considered a violation of patient confidentiality (HIPAA).

5. Violations of this policy and/or patient confidentiality are cause for discipline and may result in dismissal from the program.

RN PROGRAM TEST QUESTION CONSTRUCTION Reference: NCSBN.org

Faculty have been actively preparing and transitioning curriculum and testing formats to prepare students for the Next Gen NCLEX Test Plan.

To meet the standards of the NCLEX-RN Test Plan and prepare students for this testing format, nursing faculty in all levels of the program will develop exams with alternate item questions in addition to the standard multiple-choice type of question. Alternate item exam questions may include:

1. Select-all-that-apply, which requires a candidate to select multiple responses.
2. Fill-in-the-blank items, which require a candidate to type in number(s) in a calculation item.
3. Hot spot items, which ask a candidate to identify one or more area(s) on a picture or graphic.
4. Chart/exhibit format where candidates will be presented with a problem and will need to read the information in the chart/exhibit to answer the problem.
5. Ordered response items, which require a candidate to rank order or move options to provide the correct answer.
6. Graphic options, which present the candidate with graphics instead of text for the answer options and they will be required to select the appropriate graphic answer.
7. Matching response items, which requires the candidate to match/pair items in the first list to an item on the second list for the correct responses.
8. Essay questions require the candidate to write in their response to the question.
9. True and false requires the candidate to select the correct answer.

NCLEX-RN (LICENSURE EXAM) PREPARATION & REVIEW CLASS

An NCLEX success program is provided at no cost to enrolled students to prepare students for passing NCLEX. The integrated program is incorporated during the four semesters of the nursing program and includes computerized practice exams using NCLEX-style questions. In addition, a Live Review course is provided late in the 4th semester or immediately following graduation. This resource is offered through grant funding from the California Community College Chancellor's Office. Students are expected to participate fully.

RN LICENSURE (NCLEX) APPLICATION PROCESS AND TIMELINE

Information on the process and timeline to submit your NCLEX application to the BRN will be provided to you by the program director and in the NRAD 004E: NCLEX Prep course offered in the 4th semester. Currently the timeline to submit your application for NCLEX to the BRN is no sooner than 2 weeks prior to your graduation date and no later than your graduation date. Resources on the NCLEX exam and application are also available on the California BRN website at rn.ca.gov and the National Council of State Boards of Nursing website at ncsbn.org.

SKILLS LAB COMPETENCIES

- Competency guidelines will be in the course syllabus.
- Competency schedules will be developed by the lab instructor. Students must adhere to this schedule.
- If a student does not pass the competency, repeat of the competency will be scheduled on a different day, allowing time for the student to review and practice the skill.
- Students who need to repeat a competency must make an appointment ahead of time with the course instructor.
- If a student fails a competency twice, they will not be able to return to clinical until they have passed that skill competency. This may result in missed clinical day(s) and missed opportunities for performing the skill in clinical. This jeopardizes the student's ability to meet clinical objectives.
- If a student fails a competency a third time, the student will be evaluated for eligibility to continue in the program.

PHARMACOLOGY MATH GUIDELINES

Mathematical computations must be labeled using an appropriate unit of measurement (i.e., mg, mL, mcg, units, drops).

1. Calculations for weight-based dose ranges must be demonstrated clinically.
2. Rounding rules: '4' or less, round down; '5' or greater, round up
3. A calculation with an answer resulting in a number less than '1' must have a leading zero. Failure to use a leading zero can result in a medication overdose. Example: 0.35 mg
4. A calculation with an answer resulting in a number greater than '1' must not have a trailing zero. Adding a zero can result in a medication overdose. Example: 3 mg not 3.0 mg
5. When calculating deliverable doses for both adult and pediatric patients, results will be rounded to the hundredth place.
   Example: Order: methylprednisolone 60mg
   Available: methylprednisolone 125mg/2mL. Dose: 0.96mLs
6. Calculations need to be rounded to doses that are deliverable using the appropriate delivery device. Multiple syringe sizes may be needed to deliver the correct dose. The following are examples of different deliverable doses using different size syringes:
   0.38 mL should be drawn using a 1mL syringe
   2.45 mL should be drawn using a 1mL syringe and a 3mL syringe
7. For converting pounds to kilograms in the adult patient, round to the nearest tenth; for a pediatric patient, round to the nearest hundredth. See the calculations below for examples:
   Adult: Example - 52 pounds = 23.636363 (calculator answer) → 23.6 kg final answer
   Pediatric: Example – 52 pounds = 23.636363 (calculator answer) --> 23.64 kg final answer
   The final answer is used to calculate weight-based dose ranges.
8. For medications such as Lipids and Critical Care drips requiring the use of a Smart Pump, infusion rates may require rounding to the tenth place to administer a deliverable dose.
   Example: Lipids 13.3 mL/hr

QUIZ AND TEST REVIEWS

Quizzes and tests may be reviewed in the instructor's office during office hours or by appointment.

- Tests may be reviewed one course test at a time.
- Students notes taken while reviewing tests can only include broad concepts and ideas only. Quizzes and test questions are never to be written, copied, photographed, or reproduced by the student.
- No cell phones or electronic devices are to be used while reviewing tests.
- Violations of this policy are cause for discipline and may result in dismissal from the program.

MISSED QUIZ & TEST MAKE-UP

- The student must call or notify the faculty before the examination for absences.
- Failure to show up for a test at the assigned time without previously notifying the instructor may result in a zero for that exam. The decision regarding make-up will be made by the faculty and RN program director.
- Tests and quizzes must be made up within one week and prior to the next class meeting.
- It is the student's responsibility to arrange make-up tests with the class instructor.
- Discussion of the quiz or test with any classmate while waiting to take the test will be cause for dismissal from the program.

DISABLED STUDENT PROGRAMS AND SERVICES (DSPS) TESTING ACCOMMODATIONS

Disabled Student Programs and Services (DSPS) are available for accommodations for testing. Students make their own appointment to determine available options. The following guidelines have been agreed upon by the nursing faculty and the DSPS department.

1. The DSPS student is responsible to be familiar with their accommodations and to request them each semester using the process outlined on Cuesta's DSPS webpage.
2. Student must first send their instructors a faculty notification letter via AIM.
3. The AIM form must be sent one week prior to the test date and two weeks before finals.
4. Student and faculty agree on the test date and start time when completing the AIM request, changes cannot be made without prior approval from faculty.
5. Students will schedule to take the test as close as possible to when the rest of the class is testing.
6. No extension of time will be granted if the student is late to the agreed test time slot.
7. Absences will follow the Missed Quiz and Test Make-up Policy.
8. Students testing in DSPS are not to discuss the test with students who have, or have not, tested yet. Discussion of the quiz or test with any classmate while waiting to take the test will be cause for dismissal from the program.

FINAL EXAM POLICY & EXCEPTION GRID

Students must score a minimum of 70% on the final exam. Exception: Student scoring between 65 – 69% or meets or exceed the following:

Pre-Final Average Score (tests/quizzes only)	Final Exam Score %
76	69
77	68
78	67
79	66
80 or above	65

Please note:

- Students need to have a passing accumulative average of 70% in their overall course test scores prior to taking the final to qualify for the exception grid. This does not include percentage on the total course. This refers to examinations only and not accumulative assignments.
- There will be no rounding up on the pre-final average score or the final exam score.
- Performance up until the final exam accounts for the percentage of the final grade as indicated in the course syllabus. Student scoring between 65 – 69% average of all pre-final test scores meets the exception grid.
- **Meeting the requirements of scoring 70% or higher on the final does not automatically qualify a student to pass the course.**

STUDENT SUCCESS AND RETENTION POLICY

The student must maintain a 70% or better in all nursing course work to pass each semester and remain in the nursing program.

The program has an aggressive retention policy. Students are required to meet with the instructor of record and Success Specialist for all Test/Quiz score <75%, or if the student receives a Clinical Practice Plan or Probation.

CREDIT BY EXAMINATION (CHALLENGE OF COURSE)

Occasionally, a student believes they have mastered the nursing content of a course and may choose to seek credit by examination (challenge the course). To receive credit by examination (challenge a course), the student must perform the following by the second week of the first-class session.

- Research and follow the current Cuesta College Credit by Exam Policy as stated in the Cuesta College catalog.
- Submit evidence for consideration to the nursing program director including:
    - Name of the course to be challenged
    - Rationale
    - Supporting evidence, including course descriptions, previous education, or work experience, that justifies the ability to challenge the course

LEAVE OF ABSENCE

If a student experiences a situation that interferes with successful progression through the program, it may be necessary to petition for a leave of absence. Valid reasons for requesting a leave of absence include medical emergencies and personal and/or family problems.

For a Medical LOA, a letter from a healthcare provider supporting the medical basis and length of the request for the leave must be given to the Director of the Nursing program with the written request for an LOA. Approval of the leave of absence will be based on the documentation received.

Students who have been on Medical Leave will be required to submit a release signed by their healthcare provider, prior to returning.

The maximum absence policy will apply. The length of medical leave will be determined according to individual circumstances and generally will not exceed one year.

Personal or family issues may be discussed with a success specialist. A letter stating the need and timeframe for the leave should be given to the Director of Nursing.

Following the leave of absence, the student will return to the nursing program under provisions specified in the terms of the LOA request.

ONE YEAR LEAVE OF ABSENCE (LOA) REQUEST

Students currently enrolled in the nursing program may request a one-year leave of absence (LOA) using the following guidelines. A student may only take one LOA while in the program.

1. A formal written request for a LOA is to be submitted to the program director within two weeks of the last class attendance.
2. A plan for success must accompany the student's written request for the one-year LOA. The plan should include how the student will stay current in nursing theory and skills during the LOA and what they will do during the time off to be successful if re-entry occurs. When possible, employment or volunteering in healthcare during the LOA is recommended to increase success upon re-entry.
3. LOAs are approved by the director and faculty.
4. LOAs are good for one year only and students return date is defined by the Associate Dean/Director. May not exceed one year.
5. A student may receive only one LOA.
6. Re-entry following a one-year LOA is not guaranteed but considered on a space-available basis and according to the re-entry policy.
7. Upon completion of the plan, the student will make an appointment with the director and provide documentation of the actions taken during their leave to optimize their success upon their return to the program. The director will review the student's completed plan with nursing faculty to determine if the student is eligible to return.

Students who drop the program within the first two weeks of the first semester are ineligible for a LOA and will need to reapply to the program in a subsequent year. All admission criteria specific to the year they are applying, and the Cuesta College catalog must be met.

RE-ENTRY and ENROLLMENT

The re-entry and enrollment policy applies to returning Cuesta students, Advanced Placement LVN to RN, 30-unit non-degree LVN to RN option, transfer students, and international nursing graduates. All students entering the program must know theory content and be able to perform all skills taught in previous semesters to meet current course objectives and provide safe patient care in clinical practicum.

1. Re-entry and enrollment are space-available and approved by the nursing program director and faculty.
2. Re-entry and enrollment will be granted only once.
3. A written request to re-enter/re-enrolls will place your name on the priority wait list of students requesting re-entry/enrollment.
4. Re-entry and re-enrollment require a current and clear physical examination, background check and drug screen, and meeting all program and college requirements in place at the time of re-entry.
5. The program director and faculty will consider academic standing upon departure and potential success upon re-entry to determine eligibility for re-entry.
6. Theory and clinical courses must be taken concurrently. Students re-admitted into a semester must re-take all required courses in that semester.
7. Re-entry and enrollment students must meet with the Success Specialist before returning to develop a success plan.
8. A student may be re-admitted to the nursing program only once. No exceptions.
9. A student on a leave of absence must return to the program from which they took the leave (ex: RN Accelerate to RN Accelerated or RN traditional to RN traditional.)

Available spaces will be filled utilizing the enrollment and re-entry policy and considering the following statuses in the order written:

1. *Returning Cuesta ADN (RN traditional & RN Accelerated) nursing students*: Cuesta nursing students who exited from the program with a LOA, due to an unforeseeable emergency and justifiable reason.
2. *Cuesta nursing students who have received a failing grade in a nursing theory course, less than 70%:* Cuesta nursing students may request in writing to be readmitted into the semester from which they failed i.e., if a student fails 202A, they may request in writing to re-enter the second semester on a space available basis the next time the course is offered.
3. *Advanced Placement LVN to RN students*: Advanced Placement LVN to RN students not admitted through the formal application process for this pathway. Advanced Placement LVN to RN students who have completed all prerequisite coursework and requirements as defined by the generic RN application, including assessment testing. A formal application process exists to allow up to three reserved Advanced Placement LVN to RN students into the second semester.
4. *Transfer Students*: Students from other schools of nursing who have not been out of nursing school for more than one year must meet the academic criteria of the class to which they are seeking admission.
5. *30-Unit Non-degree Option LVN to RN student: LVN are approved to enter the third semester and take 30 credits to complete the RN program.*
6. *International Nurses*: Licensed nurses from other countries seeking endorsement in the USA must have academic transcripts interpreted by an official agency (i.e.: ACEI Application for Academic

Evaluation). Previous education will be assessed to determine equivalency of academic criteria into the semester to which they are seeking admission. Additional documentation may be requested.

CLINICAL PRACTICE PLAN

The intent of the *Clinical Practice Plan* is to support student success. A nursing faculty member initiates the *Clinical Practice Plan* when a student is not meeting Performance Standards, clinical objectives, and/or an area of the clinical evaluation tool. The student receives a copy of the *Clinical Practice Plan*.

- It is the student's responsibility to meet with the clinical instructor and complete the terms of the *Clinical Practice Plan*.
- Completed clinical practice plans need to be returned to the clinical instructor.
- A clinical practice plan may or may not include skills lab practice. If skills practice is a requirement of the clinical practice plan, the student is required to make an appointment with the skills lab faculty for completion.
- Repeated difficulty meeting Performance Standards, clinical objectives, or a concept from the evaluation tool may result in probation.

See Clinical Practice Plan Form on the next page.

Cuesta College RN Program Clinical Practice Plan

Level: 1 2 3 4
To:
From:
Date of event(s):
Referred to Success Specialist: YES NO *Student is responsible for contacting the Success Specialist*

At this time, you are practicing below the safe standard as outlined in the performance standards, clinical objectives and the clinical evaluation tool in the following area(s):

Caring	Lifespan/Cultural Care	Collaboration	Communication
Informatics	Nursing Process	Evidence-based Practice/ Quality	Safety
Confidentiality	Patient Teaching/Nurse Learning		

Description of performance deficiency and student response:

I want you to be successful! We have agreed on the following action plan for strengthening your practice:

- Meet with your clinical instructor.
- Review the Performance Standards, Clinical Objectives in the "B" syllabus and Clinical Evaluation tool.
- Demonstrate accountability and responsibility for your practice.
- Return completed plan to your clinical instructor.
- Other specific instructor recommendations:

You must complete your plan in order to return to clinical by_____.

I have read the above and discussed the contents in a meeting with the instructor.

Student Signature Date Signed Clinical Instructor Signature Date Signed

Skills lab practice documentation. To be completed by skills lab instructor.

Date	Time	Topic/Skills Comments	Instructor signature

A copy is provided to: Level Faculty, Skills Lab Instructors, Director, Assistant Director, Success Specialist, and Student File

CLINICAL PROBATION

1. Probation is a warning that the student has demonstrated a pattern of unsafe practice. This indicates that the student's performance is below 70% per clinical evaluation tool.

2. If a student has received Clinical Practice Plans and continues to practice unsafely as evaluated by the clinical instructor, the situation is evaluated by all nursing faculty to decide to place the student on probation. The type of practice plan, pattern of practice plans, and inability to self-correct are considered in the decision to place a student on probation.

3. Practice that would result in automatic probation:
    4. Practicing outside your scope as a student nurse
    5. Confidentiality/HIPPA violation
    6. Violation of the Intravenous Push Policy

7. When placed on probation, the instructor will discuss the situation and the clinical probation form will be completed. The student will sign this form as an indication that the contents have been discussed in a meeting with the student and instructor.

8. During the probation period, the student will receive a weekly Probation Progress Report from the clinical instructor.

9. If at any time during this probationary period the student continues to practice in an unsafe manner or below 70%, the student will be administratively dropped.

10. Faculty may extend the probation period if there has been insufficient opportunity to show progress.

11. To complete and end probation, the student must successfully complete all actions and expectations as outlined on the Clinical Probation Form.

12. Clinical performance will be monitored throughout the program to evaluate for repetition of prior unsafe practice patterns.

13. Students on probation may not be eligible for out-rotations per instructor's discretion.

14. If at any time during the probationary period the student performs below the level of 70%, the result will be a clinical failure. The student's clinical performance must be at the level of 70% prior to the end of the semester to pass the course. Students may not continue in theory classes if a clinical failure has occurred. At this point, a student will be administratively dropped from the program.

See Clinical Probation Form on next page.

Cuesta College RN Program Clinical Probation Form

Level: 1 2 3 4
To:
From:
Date of event(s):

Please check the appropriate box

◯ Functioning outside the scope of practice for a student nurse.
◯ Violation of Cuesta College nursing program policy related to: Confidentiality, HIPAA, Intravenous Push medication administration.
◯ Demonstrated pattern of unsafe practice.

Caring	Lifespan/Cultural Care	Collaboration	Communication	Communication
Informatics	Nursing Process	Evidence-based Practice/ Quality	Safety	Nursing Process
Confidentiality	Patient Teaching/Nurse Learning			

See Clinical Practice Plan(s) dated: _____

Description of performance deficiency or repetition of prior unsafe practice pattern.

Student action(s) necessary to address deficiencies and end probation:

Student expectations during probation:

- *Student will have ongoing weekly meetings with their clinical instructor.*
- *Student must make an appointment to meet with the Director of Nursing prior to returning to clinical.*
- *While on probation the student is required to meet with the Success Specialist weekly.*
- *While the student is on probation, the instructor must supervise all skills.*
- *Students who are on probation may not be eligible for out-rotations per instructor discretion.*

Date Probation period begins: _____

Date Probation will be evaluated to determine your ability to continue in the RN program:

_____

- *During the probation period, the student will receive a weekly Probation Progress Report from the clinical instructor.*
- *If at any time during this period the student continues to practice in an unsafe manner or below 70%, the student will be administratively dropped.*
- *Faculty may extend the probation period if there have been insufficient opportunities to show progress.*
- *In order to end probation, the student must successfully complete all actions and expectations.*

I have read the above and discussed the contents in a meeting with the instructor.

Student Signature:_____ Date:_____

Faculty Signature:_____ Date:_____

A copy is provided to: Level Faculty, Skills Lab Instructors, Director, Assistant Director, Success Specialist, and Student File

GROUNDS FOR DISCIPLINE or INVOLUNTARY DROP

The Cuesta ADN program will take disciplinary action, which may result in dismissal from the program for unprofessional conduct and for actions that include, but is not limited to the following:

1. Violations of the Student Code of Conduct policies established for all Cuesta College students, as outlined in Cuesta College catalog.
2. Violation of any policy, as outlined in the Consortium Background policy.
3. Failure to follow Nursing Student Handbook policies.
4. A student action that threatens the patient's physical or emotional well-being.
5. Conduct inconsistent with professional and ethical responsibilities of a student nurse as stated in the Student Nurse Code of Ethics.
6. Practicing outside the scope of a student nurse or performing skills not level specific.
7. Violations of patient confidentiality, including photocopying of the medical record or engaging in any activity that fails to protect the privacy of personal identifiable information.
8. Violations of Technology Agreement and inappropriate use of electronic handheld devices in class or clinical.
9. Impersonating any student, nurse, or health care worker in pursuit of employment, admission to the ADN program or other situation in connection with the program.
10. Falsifying or intentionally omitting information in any hospital, patient, or other record.
11. Dishonesty, forgery, alteration, or misuse of college documents, records, or identification; or knowingly furnishing false information to the district.

INVOLUNTARY DROP PROCESS

1. The situation will be reviewed by the nursing faculty and program director.
2. The nursing faculty and program director will decide to drop the student from the nursing program or to have them continue in the program on probation.
3. Students wanting to appeal an involuntary drop should refer to the Cuesta College Student Grievance Procedure in the College Catalog.

COLLEGE STUDENT COMPLAINT RESOLUTION PROCESS - ACADEMIC:

The student should begin by first talking to the instructor to attempt a resolution about any academic matters such as grades or coursework. If you still have concerns, you should talk to the specific Department Chair – in the nursing program, this would also include the Program Director. If this is not possible or unsuccessful, the student may then complete the Student Complaint and Resolution Form found on the student services website. This will take the concern to the next level of resolution.

SECTION IV
CLASS INFORMATION & TRADITIONS

CLASS INFORMATION & TRADITIONS

ELECTRONIC COMMUNICATION/GROUP EMAIL

Each class will be provided with the means to communicate through a learning management system (Canvas) that is restricted for the use of that class, faculty, and staff of the RN program. This is the preferred way to communicate with everyone in the program throughout the two-year program. Please note that the email option in each course is meant to communicate with the students and faculty in that course only.

Canvas e-mail is the official platform for program communication. Social media is not for communication of program and/or class information. Not all students participate in social media.

PROGRAM DIRECTOR MEETINGS

Meetings with the Director of Nursing will be scheduled throughout each semester. This is your opportunity to share feedback regarding your nursing education and receive essential information and updates from the Director. The information presented in these meetings is integral for on-going success in the program. Attendance is required.

CLASS GOVERNANCE

Each class will elect class representatives during the first semester of the program. The Nursing Program Director will facilitate. Class representatives are to update the Director regarding class projects, votes, and activities. Class representatives may stay the same throughout the entire two years, or upon discussion with the Director and class consensus, new representatives may be elected in the second year.

Officer roles are (roles may be shared):

- Class Representatives (minimum two per class)
- Historian

Class Representative: Provide leadership for class activities and decision making. Hold meetings or conduct class surveys. Provide class feedback at faculty meetings as scheduled by the program director to provide class feedback. The Nursing Program Director will provide a list of faculty meeting dates and times to the class representatives at the beginning of each semester. The typical time spent attending each meeting is about 10–15 minutes. In addition, Class Representatives will attend the advisory committee meeting each semester. This committee is chaired by the nursing program director and comprised of nurse leaders from the community and Cuesta College faculty members.

Historian: Collects pictures throughout the program to provide class memories. The Historian maintains the class bulletin board and creates a slideshow at the end of the program. See guidelines for slideshow later in this section.

CLASS TRADITIONS

The following long-standing class traditions have been found to demonstrate consideration and support to students entering, throughout, and graduating from the nursing program. Support of your peers should not be limited to these events.

1. Incoming RN Student Orientation: This event is held two to three months prior to program start date, to prepare the incoming class to enter the RN program. Class Representatives attend the event or collaborate with classmates to attend the orientation to present helpful information to the incoming cohort. The student portion of the orientation includes:
   - Advice on how to be successful in the program

- How to prepare for the program
- Organizational strategies – binders, calendar management, supplies to stock
- Dress code information
- Help with lunch, set-up, and clean-up. Work with the Division Assistant & Program Specialist on table and chair arrangements.
- Provide a simple welcome/survival kit or swag

2. Student Participation/Community Enrichment events: Students must participate in campus and community events throughout the program. Examples of such events include workshops/ seminars or guest speakers, blood pressure at career fairs, flu shots for the community, and non-profit charity events (ie Special Olympics, Alzheimer's Walk).

3. End of Fall Semester Party: This is an enrichment event held annually for faculty, staff, and all RN students to celebrate the successes of the fall semester when finals are over. The director, faculty, and staff plan the party. Students may be asked to pay a suggested donation to help cover food and facility costs.

4. Pinning Ceremony: This is a time-honored traditional ceremony where graduating students receive their nursing pin amongst community, faculty, classmates, families, and friends. Class officers will meet with the director and division assistant to plan this event.

   a. Student volunteers roles -
      - Ushers to hand out programs, seat guests, and return unused programs to nursing office
      - Direction signs guiding guests
      - Remove direction signs after the ceremony
      - Set-up and decorations
      - Refreshments - help pick up, set-up, serve and clean up

   b. Ceremony Program with agenda, class and individual student photos, sentiments, and acknowledgments - Representatives/students work with the director and Program Division Assistant to prepare the pinning ceremony program with group and individual class photos, sentiments, and acknowledgments. Creating and reproducing this program takes time, and the student portion is to be submitted to the program director for review. Examples of programs from previous years are available for your reference by request from the program director.
      - The agenda and acknowledgments are created by the director. Students should provide the names of organizations or persons who provided significant support or help to their class for consideration to be included in the program.
      - Class and individual photos are taken on the same day as the class photo with students in their clinical uniform.
      - Sentiments are individually written by students and should not exceed 200 words. The class should assign 1 or 2 students in charge of collecting the sentiments.

c. Ceremony roles –
   - Master of ceremony–Director/Associate Dean
   - Welcome and acknowledge dignitaries present – Dean or College VP or President
   - Faculty Speaker(s) will rotate and be selected by the class with director approval -speeches are 3 minutes each
   - Student Speaker(s) - 1 or 2 classmates are selected to speak for 2 – 3 minutes each
   - Calling of student names
   - Pinning and stole placement of each student as they walk across the stage
   - Other roles as determined by the director

   Notes for the guidance of a professional and smooth program
   – The total faculty and student speaker time should take no longer than 10 minutes, so consider this when choosing the number of people for each role.
   – Speeches are professional and are to represent the nursing program accordingly to healthcare community that is present
   – The class through the class representatives in collaboration with the director determine the full-time faculty roles

d. Pinning ceremony invitations - The nursing office will email pinning ceremony invitations to healthcare agency administrators and educators, college board of trustees and administration, and major donors to our program.

e. Entrance and exit music – The students select the entrance and exit music with the program director. The music will be communicated to the nursing program director three weeks prior to ceremony date.

f. Student Slide Show Presentation - The slideshow is created by the class to represent your experiences during the two years of nursing school and will be approved by the Associate Dean/Director. The content is professional and is to reflect the academic excellence of the nursing program. The slideshow is to be submitted to the program director for review three weeks before the ceremony. The slideshow format is 10 - 14 minutes in length and includes a photo of each student in alphabetical order followed by photo(s) of their choosing (i.e., family/pet/mentor), and concludes with photos that represent highlights and milestones throughout the four semesters. To the extent possible, represent all students equally, and all faculty equally.

g. Nursing Pin - In accordance with the long-standing nursing tradition, graduating students will receive pins and stoles by nursing faculty during a formal pinning ceremony. The Cuesta College RN program has a traditional pin for this purpose.

h. Pinning Ceremony Reception - First year students work with the program director and division assistant to host this event for the graduating class. The nursing department will provide light refreshments at the reception, such as cookies, cupcakes, coffee, punch, water, paper plates, silverware, and napkins.

5. CUESTA COLLEGE COMMENCEMENT: The college commencement is the college ceremony in which your associate degree is awarded. Nursing students are strongly encouraged to attend

commencement to represent the nursing department in this important college and community event.

SECTION V
COPIES OF STUDENT SIGNATURE FORMS
(TO BE RETAINED IN HANDBOOK)

CUESTA COLLEGE RN PROGRAM STUDENT

NO CHEATING HONOR PLEDGE

I understand that to demonstrate my preparation for completion of the Nursing Program, and subsequent state testing for licensure, I must pass multiple quizzes and exams, write papers, and research and present on certain topics throughout the program.

I also understand that to hold a license as a Nurse in California means I can safely perform care and interventions in response to client/patient changes. This will require me to have a certain base of knowledge and skills that I must be able to draw upon.

I am aware that posting instructor materials including exam information online without the permission of the instructor is in violation of San Luis Obispo County Community College District Standards of Conduct.

Finally, I understand that cheating on exams, utilizing artificial intelligence (AI) to complete papers, sharing quiz or test questions or graded assignments with any student will be cause for dismissal from the program. Presenting the work of others instead of my own, and/or not being able to receive a passing grade in a Nursing Program course indicates that I am not prepared to meet the requirements of safe client/patient care.

Therefore, I accept and understand that such cheating is not acceptable and will result in a failing grade on any assignment/exam for which I cheated. It could also result in my dismissal from the program.

_____

PRINT FULL LEGAL NAME

_____

Student Signature Date

Please Note: This form will be retained in your student file.

Professionalism Pledge

As a nurse, you're part of a professional clinical team. Nurse professionalism is about putting patients first, upholding ethics and bringing the right attitude to the class and in clinical every day.

To preserve the nursing profession's reputation, every nurse should be vigilant in the behaviors of attitude, education, certification, mentoring, and advocacy. The most important role of any nurse is to promote their patients' health and protect their safety. That responsibility is enormous, but it's obtainable when we maintain the professionalism nurses are known for.

- Classroom Values
  - Participate in class
  - Timeliness (punctual to class)
  - Communicate effectively
  - Care about your appearance
  - Be a critical thinker
  - Pay attention to detail
  - Be adaptable
  - Be respectful to faculty, fellow students and staff
  - Appropriate technology use (cell/device)

- Clinical Values
  - Place clients/patients first
  - Collaborate with and mentor others
  - Maintain a positive attitude
  - Uphold the standard of care
  - Be accountable and honest
  - Follow strong ethical practices
  - Be active with conflict resolution
  - Be a Leader

_____

PRINT FULL LEGAL NAME

_____

Student Signature Date

Please Note: This form will be retained in your student file.

Nursing and Allied Health Division
SLO Campus Office: 2722 Phone: (805) 592-9798
NC Campus Office: N2421 Phone: (805) 592-9426
BACKGROUND POLICY: AGREEMENT TO SELF REPORT

In accordance with the contracts held by the college and its affiliate partners, all students enrolled in the Cuesta College Nursing and Allied Health programs/courses are required to clear a background check in order to participate in clinical rotations, internships and externships.

As part of the background policy, students are required to self-report arrests, citations, and violations (including traffic violations over $1,000.00) incurred while enrolled, within one week of the occurrence. Reports are to be made to the Director of Nursing.

In addition, students with a misdemeanor or felony conviction since age 18 must report and make an appointment with the Director of Nursing within two weeks following orientation. Students who fail to follow Background Policy guidelines will become ineligible to attend clinical/field training and may be dismissed from the program/course.

Reporting of arrests/citations/violations will not necessarily exclude students from continued program participation. Each circumstance will be evaluated on an individual basis in order to determine an appropriate action.

By signing below, I confirm that I have read, understand and will comply with the Background Policy, as stated above.

_____	_____
Student's signature	Date
_____	_____
Student's printed name	Program/Course name

Nursing and Allied Health Division
SLO Campus Office: 2722 Phone: (805) 592-9798
STUDENT CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a student in the Cuesta College Nursing and Allied Health Division, I must hold client and student information in confidence.

All medical information acquired during patient research and patient care is confidential and I will not disclose that information to any person or persons not involved in the care or treatment of the patients, in the instruction of students, or in the performance of administrative responsibilities regarding the patients.

I will protect the confidentiality of patient information as required by law at all times. Photocopying and/ or removing medical records is not permissible.

Conversations between physicians, nurses and other healthcare professionals in the setting of a patient receiving care are protected and may not be discussed.

Other sources of medical information that are protected and confidential are medical records, emergency room department and ambulance records, base station reports, 5150 applications, child abuse reporting forms, elderly abuse reporting forms, laboratory requests and results, and x-ray results.

I understand that any violation of confidentiality with client or student information is cause for dismissal from the program.

_____ _____

Student's printed name Student's Signature

_____

Date

Nursing and Allied Health Division
SLO Campus Office: 2722 Phone: (805) 592-9798
STUDENT ACCEPTANCE STATEMENT

Having read all of the Cuesta College policies with care, I understand and accept my responsibilities as a student at Cuesta College in the Nursing & Allied Health Division and I agree to abide and be bound by these policies as a condition of enrollment in and graduation from my course/program. I further understand that policies may require revisions during my time in the course/program. If revision is necessary, I will be informed both verbally and in writing before the policy is in effect.

_____ _____

Student's Printed Name Student's Signature

_____

Date

CUESTA COLLEGE

Nursing and Allied Health Division
POLICY FOR AUDIO AND VIDEO RECORDING AND PHOTOGRAPHY IN LECTURE, LAB AND CLINICAL SETTINGS

As a student in the Nursing & Allied Health Division at Cuesta College, I understand and agree to the following technology policy for using audio or video recording, and photography in lecture, lab and clinical settings.

1. I understand that I must receive permission in advance from each faculty member or person that I intend to audio or video record and/or photograph.
2. I understand that confidential medical information is presented in lecture, lab, and clinical settings and that none of this information can be disclosed without the written consent of the individual it pertains to.
3. I understand and agree that if given permission to audio or video record in lecture, lab and/or clinical settings, all recordings are solely for my personal educational use while enrolled in Nursing and Allied Health programs/courses. The recordings may not be duplicated, exchanged, reproduced, altered, or posted publicly in any manner.
4. I understand and agree that I will not take pictures in lecture, lab and/or clinical settings without written permission of the subject being photographed.
5. I understand that I must comply with all healthcare agency policies on audio and video recording, and photography.
6. I understand and agree that if I violate any part of this policy:
    a. I will lose the privilege to record and/or photograph in lecture, lab and clinical settings.
    b. I may be dropped from the Nursing and Allied Health program/course for violation of program, division and college policies.
    c. I may be personally liable for damages to the person(s) whose right of privacy is violated by the unauthorized disclosure of confidential information.
7. I understand and agree that I will not use any technology device in the classroom for purposes other than instruction and violation of this will put me at risk of forfeiting the device. Examples of this include: texting, Facebook, viewing podcasts and/or movies.
8. I understand that any technology I use in association with Cuesta's Nursing and Allied Health programs/courses will be completely legal and in compliance with the student code of ethics found in the college catalogue and/or student handbooks or I may be dismissed from the program/course.
9. I further agree to defend, indemnify and hold harmless from liability Cuesta College, its officers, agents and employees while acting as such from all suits, damages, costs or expenses arising out of my intentional or negligent disclosure of any confidential information contained in the audio recordings, transcripts and/or pictures without written consent of the person(s) to whom the confidential information pertains.

I will abide by the conditions listed above:

_____

Student's Printed Name

_____ _____

Student's Signature Date

Talent Release Form

I do hereby give Cuesta College and their assigns, licenses and legal representatives the irrevocable right to use my name, picture, portrait, photograph, or live video and audio in all forms and media and in all manners, including composite or distorted representations. I am fully aware that my name, picture, portrait, photograph, or video footage will be used for the production of Cuesta College promotional works and commercials that I recognize may be broadcast or distributed nationwide. I waive any right to inspect or approve the finished version(s), including written copy that may be created in connection therewith. I have read this release fully and am completely familiar with its contents.

Participant Signature_____

Print Name_____

Date _____

Date of Birth_____

Phone _____

Rev 02/14 - STUDENT COPY (SIGNED FORM KEPT IN STUDENT FILE)

CONFIDENTIAL INFORMATION RELEASE FORM

FULL LEGAL NAME: (Print your name EXACTLY as it appears on your Social Security Card)

_____

First Middle Last

By signing this form, I authorize the Cuesta College Director of Nursing to release my social security number, date of birth, immunization records and background/ drug screen report to my clinical sites, as required, in order for me to obtain access to their Electronic Medical Records:

_____ _____

Student Signature **Date**

REMOTE ONLINE NURSING THEORY

AND CLINICAL COURSES

Students need to have adequate computer technology, a learning environment conducive to remote learning, and be available to attend classes at the designated day and time. If you, as an incoming nursing student, will not be able to adapt to the remote, online learning format, and allow yourself to be in remote learning classes at the designated day and time (synchronous learning), you may need to enter the program another time.

Please sign below indicating that you have read the statement above and are still able to begin the program.

_____

Student's Printed Name

_____

Student's Signature

_____

Date

Rev 5/23- STUDENT COPY (SIGNED FORM KEPT IN STUDENT FILE)

Cuesta College Skills Nursing Program Injection Supplies Agreement

You are participating in an injection Skills Lab experience as a component of your Nursing Program at Cuesta College. You may practice at home skills you learned to be better prepared for clinical.

You may be provided with injection supplies and equipment to use with your "Cube" as part of your professional training to allow you to practice at home.

These supplies are your responsibility. These supplies are only for you to practice with. Practice only on the "Cubes" that you are provided. These supplies are **not** to be used on humans or animals for practice. Do not practice on anything/anyone else. It is also your responsibility to keep the supplies out of reach of children or any incompetent adults. These items should be stored in your home in a plastic container to prevent accidental needle sticks to yourself or any family members.

You are also responsible for disposing of any supplies that you have borrowed from the skills lab properly. The correct disposal is to bring all needles and syringes back to the skills lab at the end of the semester to be disposed of into appropriate sharps containers.

You have now been instructed on the use, care, storage and disposal of injection supplies used in your nursing class. Here are possible supplies to be taken home for practice of SQ & IM injections and IV push practice medications;

1- 0.9% NS injectable USP, 20cc vial (water)

10 Alcohol Pads

1-3 mL Syringes (Luer -Lok)

1-1ml Syringe (Slip Tip-Luer-Lok)

2-5 blunt needles

1-Insulin Syringes

- 1-50 Units

1-Safety Needles

- 1-22g 1-1/2"
- 1-23g 1" (Safety Glide)
- 1-25g 5/8"

Multiple Practice medications

I understand that by signing this document I agree to take possession of the injection supplies listed above. I have received instruction on the safety and security of these items and how these items are to be used in practicing at home. If any item is damaged or found to be unusable, I will return it/them to the Skills Lab for appropriate disposal.

Print Name: _____ Signature: _____ Date: _____