PEDIATRIC CLINICAL ORIENTATION- Most Crucial Rules

MUST BE REVIEWED EVERY NIGHT BEFORE CLINICAL

GENERAL

a. Absences: 2 calls before 0530 *on the morning* of the scheduled clinical day: 1). SCVMC Pedi: (408) 885-5255 & 2). DAC Office S91M (408) 864-5529. SNs responsible for information/announcements missed on unit or post-conference
b. Dress code enforced (includes tools); must have SCVMC nametag visible at all time on uniform top. Entire uniform washed daily. Ø stuffed pockets. (Nothing in chest pocket please- falls out on patients).
c. Binder (c name on top/cover page) required.
d. Required in binder: organized sections for all paperwork, BBP packet and immunizations, Pedi calendar is useful, Skills Check off sheet is required. Bring binder to Clinical. Stack binders in charting room bookcase or back desk area when not being used; Ø binders in client rooms.
e. **NO**: backpacks, purses, cell phones visible, perfumes, perfumed lotions, obvious smoke odor.
f. Break 15-20 min. when convenient for client. Lunch is 30 min. (Lunches should start by 1000 in order to easily accommodate all patient care). No eating, drinking or chewing on floor; May use playroom refrig & mw. SNs cover each other's client during breaks- sign out on sheet in small charting room. All clients must be visualized every 15 minutes.
g. SNs may not use copy machine; Instructor can make copies for you.
h. SNs may sign off skills check list before post-conference starts (if time) or at home *on a daily basis*.

CLIENT DAILY CARE FOLLOW Clinical Daily Schedule

1. **Write a new Pedi Worksheet each day** for all sites x at SASH, CRC or Parkway; fill out w/s completely; carry this sheet in your pocket. Notify Instructor immed. if assigned a client you've had before. Share daily w/s c Instructor (and student PRN nurse if there is one) by 0830 & report client diet/feeding/med times. Do not write on your hands.
2. Read Care of Infant/Toddler Sheet if caring for child <3y.
3. Actively write AM report on client, back/ ® top of Pedi w/s. Clarify report & guidelines c RN. Ask to attend RN assessment. Check child immed. p AM report and do IV assessment: Check all 7 IV items on Pedi w/s. Do not wake child to check site.
4. **Always** talk to parent before touching their child. Always talk/play c child & wash hands before touching them. Provide privacy for all infants & children with bathing, changing diapers, using urinals.
5. When child awake, check ID band & IV site BEFORE doing VS.
6. V.S., pain scale, & basic (head to toe) assessment done @ 0800/1200, B/P only if ordered. Temps: Infants=Ax or R if ordered, TM (ear) > 1y (must be 20#), > 4y = Oral. Wts usually done on noc shift or ac in AM if not done on nights. Complete and chart focused assessment by 0900. May do again later c RN, PRN, Instructor, as possible
7. Notify RN & instructor ASAP of: any unusual V.S. or abnl. exam findings, d/c plans & teaching, status changes (ex: Ø Intake or Output, fever, concerns, abnls, pain), what MD says & does in room, immed before client d/c's; document d/c teaching. Reassigned p client gone.
8. I & O = 0600-1400: Weigh all diapers; STRICT I & O on all kids. Urinals MUST be within reach of males.
9. Yellow cover gown for isolation. NO gloves in the hall unless weighing diapers.
10. Accompany client to all procedures, tests, therapy, etc. Be c client when all technicians & professionals @ bedside; monitor visitors; be helpful to staff. Seek learning experiences; offer TLC, games, play, talk. Teach. CP Monitor may be on 'standby' when in direct contact c child. Absolutely you should try to be present for MD rounds.
11. All students (on & off ward) report to instructor on Pedi by 1245. For lunch feeding decision → to wake or not to wake to feed, consult c RN. Must report off to RN & discuss client's charting ~ 1230; Tear off client identifiers.

SAFETY = #*1 RESPONSIBILITY* *Clients may not be out of room or off units s RN permission*

1. Protection of IV sites is a very high priority. Use tape/board/cup/diaper to protect PRN. IV site **must** be visualized at least every 2 hours & before IV med given. Get help assessing IV site. Watch IV occlusion meter.
2. Liberal use of gloves; **Only wear @ bedside & to weight diaper in hallway**; Must remove gloves & wash hands before charting or touching anything; Hand washing between children a & p procedures, meds, changing linens, etc. You must gel hands in and out of patient rooms.
3. Sharps containers = needles & sharps. Trash cans used for soiled or wet diapers or trash; Red plastic bags=secretions, blood. Yellow/Blue plastic bags=linen. Please only change dirty linen.
4. Students may not draw **any** blood (finger sticks).
5. **Precaution cards posted** outside door; read/follow carefully, ask for clarification if needed. Read & follow all signs @ bedside & outside door.
6. Supervise all kids near water/baths. RN ok needed before giving showers.
7. SR↑ when adult not at immed bedside=remind parents. Bed in lowest position except during direct care. Strap/tie children into equipment. Bubble-top cribs are used if child can pull up to stand.
8. Alcohol your stethoscope from top to bottom at the start *and* end of each shift.

MEDS ***Give ALL meds with instructor* or Staff RN if they ask instructor**

1. Med times must be clearly indicated on daily Pedi w/s- verify c instructor/PRN. Make appointments at 0800 with Instructor for all meds, IV bag & tubing changes & all procedures & appts for child.
2. By 0600: you may be asked to help a peer with med sheets. Remember, they will be asking you also.
3. Meds MUST be given on time (1/2 hour before preferable). Instructor will help assign math checker. Before notifying instructor that you are 'ready' to give meds: Be prepared for instructor's questions/complete math sheets/gather all supplies in drawer/consult with parents & child r/t best way to give med/check, 2 checks of the 5 rights done, wash hands. Is everything you need at the bedside?
4. Never disconnect/open IV tubing. Never turn off IV pump unless RN instructs; Students responsible for all 1300 meds, procedures, etc. = do at 1230
5. Never give PRN med without consulting c RN.
6. IV + PO = ____ ml/h requires SN/RN consult r/t child's PO intake & UOP.
7. Change IV bags q 96 hours (no additives) & when bag almost empty, IV bag fluid must last until 5 pm. Main tubing change q 96 hours; secondary tubing for IVPB and Syringe Pump meds q 24 hours.
8. If PO meds < 20 cc = measure & give by syringe.

DOCUMENTATION Use only black ink (Ø gel or roller pens)

1. **Confidentiality**: **Write client first & last name** & **ID # top right corner of Pedi w/s only; CUT OFF DAILY & dispose appropriately before leaving Pedi Ward.**
2. Do written work in charting room or back desk area- whichever is closest to your client's room. Keep charting table/counters cleared.
3. Focused/ Comprehensive Assessment Documentation: On the 'focus' area (system(s) of concern) and includes **'documentation signature'** which includes first initial and full last name, title (SN) & (DAC) all on one line. ALL documentation must be legible and no blank spaces are allowed. Your focused assessment is to be completed, documented and submitted to the brown folder (in the small charting room) by 0900. Be prepared to rewrite it using the suggestions from the instructor.
4. Complete and submit the Nursing Diagnoses, three three-part statements, and the QSEN documentation by 1200. (Submit it to the brown folder in the small charting room).