

**Madisonville**



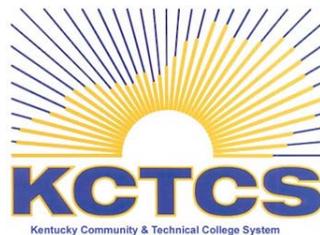
**Community College**

HIGHER EDUCATION BEGINS HERE

# **Respiratory Care**

# **Clinical Preceptor**

# **Handbook**



Kentucky Community & Technical College System

<b>CONTENTS</b>	<b>PAGE</b>
<b>Mission Statement</b>	<b>1</b>
<b>Vision</b>	<b>1</b>
<b>Purpose &amp; Goal</b>	<b>1</b>
<b>Philosophy</b>	<b>1</b>
<b>AARC Statement of Ethics &amp; Professional Conduct</b>	<b>2</b>
<b>Respiratory Therapist Shall</b>	<b>2</b>
<b>Description of the Respiratory Care Profession</b>	<b>3</b>
<b>Respiratory Care Scope of Practice</b>	<b>3</b>
<b>Technical Standards</b>	<b>4</b>
<b>The Role of the Clinical Preceptor</b>	<b>6</b>
<b>Criteria for Appointment as a Clinical Preceptor</b>	<b>6</b>
<b>FERPA</b>	<b>7</b>
<b>Various Roles and Methods in Teaching</b>	<b>8</b>
<b>Teaching Methods Used in Each Quarter</b>	<b>8</b>
<b>Clinical Guidelines</b>	<b>9</b>
<b>Delineation Between Clinical Time &amp; Clinical Site Employment</b>	<b>10</b>
<b>Emergency Calls</b>	<b>10</b>
<b>Lunch Breaks</b>	<b>11</b>
<b>Medical Records</b>	<b>11</b>
<b>Student Identification</b>	<b>11</b>
<b>Health and Safety</b>	<b>12</b>
<b>Dress Code</b>	<b>12</b>
<b>Student Conduct</b>	<b>12</b>
<b>Daily Evaluation and Record of Clinical Activities</b>	<b>13</b>
<b>Clinical Standards of Appearance and Attire</b>	<b>13</b>
<b>Clinical Attire</b>	<b>14</b>
<b>Clinical Task Performance Evaluation System</b>	<b>15</b>
<b>Affective Daily Evaluations</b>	<b>16</b>
<b>Task Performance Evaluations</b>	<b>16</b>
<b>Adult Daily Log</b>	<b>17</b>
<b>Adult Floor Therapies</b>	<b>17</b>
<b>Adult Critical Care Log</b>	<b>18</b>
<b>Adult Diagnostics Log</b>	<b>19</b>

<b>Clinical Affective Evaluation</b>	<b>20</b>
<b>Nasotracheal Suctioning – Data Arc</b>	<b>22</b>
<b>Performance Evaluation Summary Record</b>	<b>25</b>
<b>Useful Telephone Numbers</b>	<b>26</b>
<b>ABG Puncture</b>	<b>27</b>
<b>Aerosol/Humidity Therapy</b>	<b>28</b>
<b>Artificial Airway Care</b>	<b>28</b>
<b>ETT</b>	<b>29</b>
<b>Assessment of Vital Signs</b>	<b>30</b>
<b>Chest Physiotherapy</b>	<b>30</b>
<b>CPAP Therapy</b>	<b>31</b>
<b>CPR/Intubation</b>	<b>31</b>
<b>Evaluation of the Chest Film</b>	<b>31</b>
<b>Extubation</b>	<b>32</b>
<b>Incentive Spirometry Therapy</b>	<b>32</b>
<b>MDI Therapy</b>	<b>32</b>
<b>Nebulizer Therapy</b>	<b>33</b>
<b>Oxygen Therapy</b>	<b>33</b>
<b>Nasal Cannula/Simple Mask</b>	<b>34</b>
<b>Non-Breather Mask</b>	<b>34</b>
<b>Miscellaneous O<sub>2</sub></b>	<b>35</b>
<b>Venturi Mask</b>	<b>35</b>
<b>Sputum Collection</b>	<b>35</b>
<b>Suctioning</b>	<b>36</b>
<b>TENT Therapy</b>	<b>37</b>
<b>Manual Ventilators</b>	<b>37</b>
<b>Ventilator Therapy</b>	<b>38</b>
<b>Ventilator Problem Solving</b>	<b>39</b>

## **Mission Statement**

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

## **Vision**

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

## **Purpose & Goals**

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

## **Philosophy**

The Faculty of the Respiratory Care Program believes that:

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

## **AARC Statement of Ethics and Professional Conduct**

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

### **Respiratory Therapists shall:**

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

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

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

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

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

Promote disease prevention and wellness.

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

Follow sound scientific procedures and ethical principles in research.

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

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

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

Refrain from indiscriminate and unnecessary use of resources.

## **Description of the Respiratory Care Profession**

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

## **Respiratory Care Scope of Practice**

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

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

The focus of patient and family education activities is to promote knowledge of disease processes, medical therapy and self-help. Public education activities focus on the promotion of cardiopulmonary wellness. **Madisonville Consortium for Respiratory Care Education**

## Technical Standards

### Purpose

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

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

<b>Standard</b>	<b>Issues</b>	<b>Examples of Required Activities</b>
Gross and fine motor skills appropriate to perform patient care procedures to national standards which include safety and efficiency	Motor Skills	Safely care for patients by manipulating machine controls and equipment. Occasionally crouching, squatting or bending to obtain/evaluate equipment and patients; assist patients from lying to sitting and or standing positions; hand eye coordination sufficient to perform an arterial blood gas puncture and suctioning
Appropriate physical strength and endurance to be able to access patient as well as perform therapies on patients for extended periods of time	Strength and Endurance	Transporting patients and equipment within a facility; standing or being mobile in clinical settings for 6 hours or more; strength to perform intubation; and assist in moving of patients in beds, on stretchers and wheelchairs. Constant standing, walking and lifting of up to 20 pounds
Auditory ability sufficient to monitor and assess health care needs of patients	Hearing	Hear monitor alarms, equipment audible alarms, voices with background noise, and through protective equipment, calls for help
Tactile ability appropriate for assessment of physical health conditions	Tactile	Be able to palpate patient pulses. Perform didactic and therapeutic percussion, and physical assessment of the chest
Ability to deal effectively with stressful situations, and maintain a professional and positive interactions with others	Temperament	Perform procedures on patients who maybe in pain due to a variety of reasons. Maintain a sense of professional behavior when under stress

## THE ROLE OF THE CLINICAL PRECEPTOR

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

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

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

## CRITERIA FOR APPOINTMENT AS A CLINICAL PRECEPTOR

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

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

## **FERPA**

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

### **What are Educational Records?**

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

### **When Can Information Be Released Without Student Consent?**

- The law allows disclosure without consent to:
  - School employees who have a legitimate educational interest
  - Other schools, upon request, in which a student is intending to enroll
  - Appropriate parties in connection with financial aid to a student to determine eligibility, amount or conditions of financial aid, or to enforce the terms and conditions of aid
- Parents when a student over 18 is still a dependent
- Certain government officials of the U. S. Department of Education, the Comptroller General, and state and local educational authorities, in connection with an audit, authorized representatives of the U. S. Attorney General for law enforcement purposes or state or federally supported education programs

- Individuals who have obtained a judicial order or subpoena
- School officials who have a need to know concerning disciplinary action taken against a student
- Appropriate parties who need to know in cases of health and safety emergencies when necessary to protect the health and safety of the student and / or others
- State and local authorities, within the juvenile justice system, pursuant to specific state law
- Alleged victim of a crime of violence the results of a disciplinary proceeding with respect to that crime
- Parent or legal guardian of a student under the age of 21, information regarding any violation of university policy or state, federal or local law, governing the use or possession of alcohol or a controlled substance

### **VARIOUS ROLES AND METHODS IN TEACHING**

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

### **TEACHING METHODS USED IN EACH QUARTER**

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

## CLINICAL GUIDELINES

### **Attendance in Clinical Areas:**

- Students are expected to attend **all** scheduled clinical sessions.
- Data Arc is used for tracking attendance. Each student is responsible for clocking themselves in/out. No other student is to sign another student in or out. Falsifying DataArc information will be considered academic dishonesty and treated as such in the disciplinary process.
- If a student fails to clock in/out on a clinical day he/she will receive a written warning and a 10% grade reduction on the first offense. All occurrences thereafter will result in a "0" (zero) for their daily clinical grade.
- Students may not leave the clinical facility during clinical hours without first obtaining permission from the Director of Clinical Education. When permission is granted, the assigned instructor will be notified by the Director of Clinical Education.
- The Respiratory Care Program **requires** students who are assigned to a clinical site to inform the Director of Clinical Education if he/she is going to be tardy or absent. The student should call no less than one (1) hour before clinical assignments begin. If Director of Clinical Education cannot be reached, the student may call the Program Director.
- Since punctuality and reliability are essential for success in your career, and a characteristic sought by all employers, students who are late for clinical assignments will receive **a 10% grade reduction** on their daily evaluation for EACH tardy.
- Tardies are defined as  $\geq 10$  minutes late. (If the student arrived on time but was unable to clock in the clinical preceptor should document arrival time in the comment section on the evaluation form.)
- Students who are **absent** from a clinical assignment will receive a zero (**0**) for the daily grade once allowed absences have been taken. A grade of zero will also be applied for any daily work assigned that day.
- If a student leaves their assigned clinical facility greater than 15 minutes early without consent of the instructor of record, a written warning and 10% grade reduction will result. Repeated offenses will be deemed excessive absences from clinical time.
- Absences that are deemed **excessive** by the Director of Clinical Education will result in an incomplete for the course. The student will be required to make up the missed time or, at the discretion of the Director of Clinical Education, may be required to repeat the entire course if it is not feasible to make up the time.

## **Delineation Between Clinical Time and clinical Site Employment**

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

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

## **EMERGENCY CALLS**

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

**CODE BLUE:** Students will respond to the area of the emergency. Two (2) students will be assigned to remain and take part in the emergency operation. Those students NOT assigned will immediately return, to their previously assigned duties, unless otherwise instructed by their preceptor. An equal opportunity to gain experience in emergency patient care will be provided, whenever possible.

**NOTE:** Students assigned to ICU, NICU and other special rotations (Cardiac Rehab, Surgery, Cath Lab, etc.) will respond **ONLY** to emergencies in the unit to which they are assigned.

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

## **USING THE TELEPHONE SYSTEM**

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

## **LUNCHES AND BREAKS**

Students are allowed ½ hour for their lunch break when they are schedule for full day clinics and on all PM shifts. An assigned lunch break will not be made, but may be taken at a time when the assigned duties are completed or at the discretion of the assigned clinical preceptor. Breaks are to be taken at the discretion of the preceptor and are limited to 15 minutes in length.

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

## **MEDICAL RECORDS**

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

- Medical records may not be removed from a nursing station or from the Medical Records Department at any time.
- Medical records may not be reproduced at any time, in any form, for any purpose.
- Tape recorders or lap top computers are not allowed in the Medical Records Department.
- Prior to viewing a medical record located in the Medical Record Department, the student must have a request form with all the required information completed, the form must be signed by a full-time faculty member.

## **STUDENT IDENTIFICATION**

1. Students are required to wear their Madisonville Community College I.D. badges at all times, when on clinical assignment.
2. No other type of I.D. badge may be worn when on duty as a student (i.e. No hospital employee badges may be worn.)

## **HEALTH AND SAFETY**

### **School Related Accidents and Incident Reports.**

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

## **DRESS CODE**

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

## **STUDENT CONDUCT**

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

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

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

## **DAILY EVALUATION AND RECORD OF CLINICAL ACTIVITIES**

Each day the student is assigned to clinical duty, he/she will be responsible for submitting a clinical evaluation, to be completed by the assigned preceptor. Also, the student must submit a clinical log validated by the assigned preceptor.

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

## **CLINICAL STANDARDS OF APPEARANCE AND ATTIRE**

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

### **Basic Grooming - Meticulous personal hygiene is required!**

- Hair** Must be clean and **off** the face. Long hair must be managed so that it does not fall forward when attending to the patient. Conservative hair color and professional style required and must meet the approval of the faculty. Male students' hair should be no longer than collar length.
- Beards & Mustaches** Beards and mustaches are permitted; however they must be kept short, neatly trimmed and clean. If a male student wishes to grow a beard, he must notify clinical faculty. Otherwise the student is expected to be clean-shaven at all times
- Nails** Fingernails must be kept short, trimmed and clean. Nail polish must not be chipped and must be clear or neutral color. **Absolutely** no acrylic, artificial or nail overlays allowed.
- Make-up** Conservative application of make-up is allowed, with a light shade of lipstick.
- Deodorant** Deodorant should be applied daily, and reapplied throughout the day as needed.
- Fragrance** **COLOGNE, PERFUME, SCENTED BODY WASH, LOTIONS OR SCENTED AFTER SHAVE IS NOT ALLOWED!** Many of our patients have *severe allergic reactions* to these "triggers". Many other patients who are nauseated experience exacerbation of the nausea when exposed to these offenders.
- Tattoos** All tattoos must be completely covered.
- Jewelry** Jewelry should be kept to a minimum so as not to interfere with patient care, infection control, or your personal safety.

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

**Watches** - A watch with a second hand is required.

**Necklaces** – A single conservative chain may be worn inside the collar.

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

**Pins** -- Students must seek approval from program faculty for any pins attached to the name badge.

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

**Body Piercing** – Body piercing must not be visible to patients.

**The clinical facilities and MCC will not be responsible for jewelry worn in the clinical area. The best policy is to leave your jewelry at home. You may be asked to remove anything from your person during clinical assignments, if it is deemed unprofessional. Chewing gum is not allowed in any facility during clinical rotations!**

## **CLINICAL ATTIRE**

**Scrubs** Required uniform are to be worn.

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

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

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

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

## **Clinical Task Performance Evaluation System**

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

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

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

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

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

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

## **AFFECTIVE DAILY EVALUATIONS**

- Evaluation forms are available on-line through Data Arc.

### **THE STUDENT MUST:**

- Complete the applicable daily logs in Data Arc for every clinical day, with the exception of clinical simulation rotations.
- 
- Give the instructor the completed form **at least 30 minutes** before the end of the clinical day.

### **THE CLINICAL INSTRUCTOR WILL:**

- Score the student's performance on a 1 – 5 scale on the applicable evaluation on DataArc.
- Provide a written comment when any falls outside the expected norms.
- Validate the daily log completed by the student.

The Program Faculty believe if when the student is evaluated as anything other than “average” it is critical to the student's learning experience to have full documentation of the behaviors that placed their performance in a higher or lower category. The instructor will:

- Answer any questions the student has about the evaluation.
- Submit the completed evaluation.

### **THE STUDENT WILL:**

- Electronically sign the evaluation acknowledging they have seen and reviewed the evaluation.

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

## **TASK PERFORMANCE EVALUATIONS**

- All performance evaluations are to be handled following the steps listed above.
- Task Performance Evaluations are to be completed and submitted to the Director of Clinical, within two weeks of date performed to receive full credit online through Data Arc. All clinical forms are due within two weeks of the date performed to received full credit.
- Any hard copies of clinical forms are to be turned in to the Director of Clinical Education's office in the appropriate folder.

## Adult Daily Log

<b>Student:</b>		<b>Clinical Instructor:</b>	
<b>Date:</b>		<b>Clin. Inst. Signature:</b>	
<b>Clinical Site:</b>		<b>Area:</b>	
<b>Location:</b>			
<b>Physician Contact</b>	<b>Time</b>	<b>Brief Description of the activity including Physician name.</b>	
Patient Focused			
Tutorial			
Small Group			
Large Group			

**Describe today's most significant experience.**

**NOTE:** Please enter the number of observations, performances with assistances and performances unassisted for each procedure.

## Adult Floor Therapies

Procedures	Obs.	Perf. w/asst.	Perf. unasst.	Procedures	Obs.	Perf. w/asst.	Perf. unasst.
<b>General</b>				<b>Aerosol &amp; Humidity Therapy</b>			
Isolation Procedures				Face Tent			
Charges				Face Mask			
<b>Patient Data</b>				Trach Collar			
Vital Signs				T-Piece			
Chest Assessment				Ultrasonic Nebulizer			
Patient Assessment				<b>Aerosol Drug Administration</b>			
X-ray Interpretation				Metered Dose Inhaler			
<b>Oxygen Therapy</b>				Dry Powder Inhaler			
Nasal Cannula				Small Volume Nebulizer			
Simple Mask				<b>Hyperinflation Therapy</b>			
Partial Rebreather				Incentive Spirometry			
Non-Rebreather				Intermittent Positive Pressure Breathing			
Air Entrainment Mask				<b>Bronchial Hygiene Therapy</b>			
Pulse Oximetry				Chest Physiotherapy			
Transport with Oxygen				Coughing			
				Breathing Exercises			
				Mucous Clearance Adjuncts			
				Intrapulmonary Percussive Ventilation			
				<b>Generic</b>			
				Generic			

Adult Critical Care							
Procedures	Obs.	Perf. w/asst.	Perf. unasst.	Procedures	Obs.	Perf. w/asst.	Perf. unasst.
<b>Resuscitation</b>				<b>Ventilatory Care</b>			
Setup & Ventilation via Endotracheal Tube				Ventilator Setup			
Setup & Ventilation via Mask				Routine Ventilator Check			
Adult CPR Airway & Ventilation				Ventilator Parameter Change			
Adult CPR Compressions				Ventilator Circuit Change			
<b>Suction Procedures</b>				Ventilator Graphics Analysis			
Endotracheal Suctioning				Capnography			
Nasotracheal Suctioning				<b>Weaning from Mechanical Ventilation</b>			
Tracheal Suctioning				Weaning Parameters			
In-Line Suctioning				Weaning			
<b>Endotracheal Tube/Tracheostomy Care</b>				<b>Noninvasive Positive Pressure Ventilation</b>			
Securing Artificial Airway				Noninvasive Ventilator Setup			
Tracheostomy Care				Noninvasive Ventilator Check			
Cuff Management				<b>Patient Transports</b>			
Heat/Moisture Exchanger				Manual Ventilation during Transport			
Intubation				Transport Ventilatoon Setup			
Extubation				<b>ICU Performance Level</b>			
<b>Aerosol Drug Administration</b>				Surgical ICU			
In-Line Metered Dose Inhaler				Medical ICE			
In-Line Small Volume Nebulizer				<b>Generic</b>			
				Generic			

## Adult Diagnostics

Procedures	Obs.	Perf. w/asst.	Perf. unasst.	Procedures	Obs.	Perf. w/asst.	Perf. unasst.
<b>Pulmonary Function Testing</b>				<b>Pulmonary Testing</b>			
Peak Flow				Bronchoscopy Assisting			
Bedside Spirometry				Metabolic Assessment			
Spirometry				Stress Testing			
Methacholine Challenge				Adult Sleep Studies			
Nitrogen Washout Helium Dilution				<b>Radiology Testing</b>			
Diffusion Study				Lung Scan			
Plethysmography				Computed Tomography Scan			
Pulmonary Function Test Quality Assurance				Magnetic Resonance Imaging			

<b>Arterial Blood Gases</b>			
ABG Sampling			
ABG Analysis			
ABG Analyzer Quality Assurance			
<b>Hemodynamic Monitoring</b>			
Arterial Line Sampling			
Pulmonary Artery Line Sampling			
Pulmonary Artery Pressure Measurement			
Thermodilution Cardiac Output Measurement			

<b>Cardiology Testing</b>			
Electrocardiography			
Cardiac Catheterization			
Echocardiography			
Holter Monitoring			
<b>Generic</b>			
Generic			

## CLINICAL AFFECTIVE EVALUATION

Affective Evaluations are intended to be completed at the end of each clinical area or unit rotation and again at the end of the clinical course

<b>Student</b>	
<b>Clinical Instructor</b>	Name: _____ Signature: _____
<b>Date</b>	
<b>Clinical Site</b>	
<b>Area</b>	

**Likert scale: 5 - exceptional, 4 - above average, 3 - acceptable, 2 - below average and 1 - unacceptable.**

Appearance						
	5	4	3	2	1	NA
<b>1 Professional appearance (cleanliness, grooming and proper attire).</b>						
	Always exceptionally neat and well groomed. Always wears appropriate attire.	Appearance is consistently appropriate and wears appropriate attire.	Is usually neat and well groomed. Usually wears appropriate attire.	Appearance is occasionally less than appropriate	Appearance is rarely appropriate.	Not Observed
Dependability / Reliability						
	5	4	3	2	1	NA
<b>2 Attendance</b>						
	Never Absent		Rarely absent but informs appropriate personnel		Absent repeatedly and neglects to inform appropriate personnel	Not Observed
<b>3 Arrives to work prepared and on time.</b>						
	Always arrives on time and prepared	Regularly arrives on time and prepared	Is seldom late or unprepared, but notifies appropriate personnel	Is periodically late or unprepared	Is frequently late and unprepared	Not Observed
<b>4 Dependable / reliable (Completes assignments with minimal direction, trustworthy, credible, responsible)</b>						
	Is always dependable and skillfully completes tasks	Is very dependable and completes tasks	Is dependable and accomplishes tasks with minor assistance	Somewhat dependable and is inconsistent in completing tasks	Is rarely dependable and has difficulty completing tasks	Not Observed
Interpersonal Relations / Communications						
	5	4	3	2	1	NA
<b>5 Functions effectively as a member of the healthcare team</b>						
	Excellent team worker, effectively consults, integrates and shares information with team members	Very good team worker, relates well to team members and usually consults and shares information	Good team worker, consults and shares information with team members when encouraged	Poor team worker, rarely consults or shares information with team members	Not a team player, doesn't know when to consult or share information with team members	Not Observed
<b>6 Contributes to a positive environment within the department (likable, friendly, helpful, loyal)</b>						
	Exceptionally friendly, helpful, loyal and always speaks with good purpose	Consistently friendly, helpful, loyal and usually relates well with personnel	Usually friendly, relates well with other personnel the majority of the time	Sometimes moody or unfriendly, does not always speak with good purpose	Unable to get along with others or makes no attempt, sometimes creates friction	Not Observed
<b>7 Accepts supervision and works effectively with supervisory personnel (accepts constructive criticism and guidance)</b>						
	Always seeks constructive feedback, accepts guidance, and changes behavior for personal improvement	Consistently shows a willingness to accept suggestions, shows improvement in behavior the majority of the time	Usually accepts guidance or direction, frequently improves behavior	Sometimes willing to accept direction, rarely modifies behavior	Rarely accepts guidance or direction, is defensive or argumentative and unwilling to change behavior	Not Observed

8	<b>Appropriately interacts with patients (courteous, thoughtful, empathetic, displays patience, and non-judgmental).</b>					
	Always demonstrates respect, sensitivity and consideration for others, consistently anticipates and attends to patient's and family's needs for comfort and help	Consistently shows concern and support of others, usually anticipates and attends to the patient's and family's needs for comfort and help	Usually concerned for and supportive of others, reasonably aware of and attentive to patient's and family's needs for comfort and help	Seldom shows concern or interest in others, inconsistent in attending to patient's and family's needs for comfort and help	Selfish, sometimes inconsiderate or rude, unaware of patient's needs or insensitive to patient's or family's feelings	Not Observed
9	<b>Conducts himself/herself in an ethical and professional manner (displays integrity, sincere and applies discretion).</b>					
	Always exhibits concern for the dignity and welfare of patients and team members; prevents conflict of interest; always takes measures to deal with conflict effectively	Consistently displays concern for dignity and welfare of patients and team members; prevents conflict of interest; seeks assistance when conflict arises	Generally displays concern for dignity and welfare of patients and team members; avoids conflict of interest; and recognizes conflicts as they arise	Sometimes neglectful of patients or team members dignity or welfare; occasionally fails to recognize conflict of interest; needs direction in avoiding conflict	Is negligent or inconsiderate of patients or team members dignity or welfare; or demonstrates conflict of interest; or provokes conflict	Not Observed
10	<b>Communicates effectively within the healthcare setting (communicates appropriate information, applies confidentiality, uses appropriate medical terminology).</b>					
	Always communicates in a concise manner; relating appropriate and complete information; always maintains confidentiality	Consistently communicates important information; regularly ensures confidentiality	Usually communicates in a thorough manner; ensures confidentiality	Needs some prompting in gathering and accurately communicating information; at times is negligent in maintaining confidentiality	Has difficulty collecting and communicating appropriate information; fails to maintain confidentiality	Not Observed
<b>Quality of Work</b>						
	5	4	3	2	1	NA
11	<b>Efficient planning and management of time (prioritizes work, adapts to changing workload and completes assignments on time).</b>					
	Plans ahead, always works efficiently and manages time wisely	Completes assigned tasks in a timely fashion, and seldom needs direction	Completes assigned tasks, needs occasional direction	Inconsistent in completing tasks and needs help in prioritizing work	Rarely completes assigned tasks, wastes time and needs constant assist. and direction	Not Observed
12	<b>Is self-directed and responsible for his/her actions.</b>					
	Is self-directed and manages work responsibly	Needs minimal amount of supervision and accepts responsibility	Needs normal amount of supervision and usually accepts responsibility	Requires frequent direction and has difficulty assuming responsibility	Requires constant supervision and dodges responsibility	Not Observed
13	<b>Confident in abilities, exercises good judgment and maintains composure in stressful situations.</b>					
	5	4	3	2	1	NA
	Self confident, always seeks assistance when appropriate, respects professional boundaries and remains calm in stressful situations	Respects limitations, recognizes professional boundaries, usually seeks assistance when necessary, usually remains calm in stressful situations	Recognizes limitations the majority of the time, occasionally seeks assistance when necessary, acts appropriately in stressful situations	Not always aware of limitations or professional boundaries, occasionally fails to seek assistance which jeopardizes patient care	Doesn't know when to seek assistance, oversteps professional boundaries and makes inappropriate decisions that are harmful to patient care	Not Observed
14	<b>Participates in educational activities that enhance clinical performance.</b>					
	Readily initiates learning activities and participates willingly in learning activities	Sometimes initiates learning activities and participates willingly in learning activities	Participates willingly in learning activities	Participates willingly in learning activities when prompted	Participates only with encouragement from Instructor or Supervisor	Not Observed
Please write any additional summative comments for this student here:						

# NASOTRACHEAL SUCTIONING



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## EQUIPMENT AND PATIENT PREPARATION

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

## IMPLEMENTATION OF PROCEDURE

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

13. Monitors patient response (i.e. breath sounds, oxygen saturation, respiratory rate and pattern, heart rate and rhythm, sputum characteristics, presence of bleeding, level of pain, cough, and ICP) (ref. #1)
14. Responds to hazards or complications as appropriate (e.g. mechanical trauma, misdirection of catheter, desaturation, dysrhythmias, bronchospasm, changes in hemodynamic status, elevated ICP) (ref. #1)

### **FOLLOW-UP**

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

### **DEMONSTRATES KNOWLEDGE OF FUNDAMENTAL CONCEPTS** (ref. #1 & #3)

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

### **CLINICAL COMPETENCY PERFORMANCE CRITERIA**

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

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

### **Summary performance evaluation**

Please use the following criteria and select the appropriate pop-up menu.

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

**Unsatisfactory performance** – not ready for clinical application. Requires remediation under one of the following categories

**Minor** - Unsatisfactory: needs to review fundamental concepts or requires re-evaluation of minor deficiency(s) (ex. forgets to wash hands during the Follow-up stage. Must be re-evaluated on this step not the whole procedure).

**Major** - Unsatisfactory: requires additional supervised clinical practice and complete re-evaluation of the procedure.

**REQUIRED:** Summary Performance Evaluation

**References:**

- 1) AARC Clinical Practice Guideline: "Nasotracheal Suctioning" RC 1992;37: p898-901
- 2) CDC, Guideline for Hand Hygiene in Healthcare Settings. MMWR Oct. 25, 2002; vol. 51(No. RR-16)
- 3) Scanlan CL, Spearman CB, Sheldon RL: "Egan's Fundamentals of Respiratory Care" Mosby 7th, 1999, Ch. 29
- 4) Burton GG, Hodgkin JE, Ward JJ: "Respiratory Care A Guide to Clinical Practice" Lippincott 4<sup>th</sup>, 1997, Ch. 19

Summative Performance Evaluation:

Satisfactory \_\_\_\_\_  
Minor Unsatisfactory \_\_\_\_\_  
Major Unsatisfactory \_\_\_\_\_

\_\_\_\_\_  
Name of person being evaluated

\_\_\_\_\_  
Signature of Direct Supervisor

\_\_\_\_\_  
Date

**Madisonville Consortium for Respiratory Care Education**  
**Performance Evaluation Summary Record**

Procedure	Class
Vital signs X3 (pulse, respiratory rate, arterial blood pressure)	RCP 150
Chest Assessment	RCP 150
Emergency Department	RCP 150
Post Anesthesia Care Unit	RCP 150
Small Volume Nebulizer	RCP 175
Meter Dose Inhaler	RCP 175
Incentive Spirometry	RCP 175
Chest Physiotherapy	RCP 175
Intubation #1 & #2 – Muhlenberg	RCP 175
Intubation #3 & #4 - RMC	RCP 175
Adult Routine Ventilator Check	RCP 200
Endotracheal Suctioning	RCP 200
Arterial Line Sampling	RCP 200
ABG Sampling Puncture	RCP 200
ABG Analyzer / Quality Assurance	RCP 200
Adult Weaning Parameters	RCP 225
Adult Weaning	RCP 225
Adult Ventilator Setup	RCP 225
Adult Circuit Change	RCP 225
Oxygen Administration	RCP 225
Neonatal Routine Ventilator Check - St. Mary's	RCP 250
Setup and Ventilation Via Endotracheal Tube	•
Aerosol/Tent Therapy	•
Nasotracheal Suctioning	•
IPPB Therapy	•

- As procedure is available

**USEFUL TELEPHONE NUMBERS:**

<b>MADISONVILLE COMMUNITY COLLEGE</b>	<b>(270) 821-2250</b>
<b>REGIONAL MEDICAL CENTER</b>	<b>(270) 825-5100</b>
<b>RESPIRATORY CARE DEPARTMENT (RMC)</b>	<b>(270) 825-5155</b>
<b>METHODIST HOSPITAL</b>	<b>(270) 827-7700</b>
<b>MUHLENBERG COMMUNITY HOSPITAL</b>	<b>(270) 338-8000</b>
<b>DEACONESS HOSPITAL</b>	<b>(812) 450-3024</b>
<b>KENTUCKY BOARD FOR RESPIRATORY CARE</b>	<b>(859) 246-2747</b>
<b>NBRC</b>	<b>(913) 599-4200</b>
<b>TINA SIDDON</b>	<b>(270) 824-1748</b>
<b>OWENSBORO MEDICAL HEALTH SYSTEM – MIKE SISLEY, RRT</b>	<b>(270) 688-2000</b>
<b>CORNER HOME CARE</b>	<b>(270) 788-3346</b>
<b>ST. MARY’S MEDICAL HEALTH SYSTEM</b>	<b>(812) 485-4829</b>
<b>KELLY HAYES</b>	<b>(270) 824-1747</b>
<b>COAL MINERS CLINIC</b>	<b>(270) 338-8000 Ext. 8389</b>

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

Included here are some sample questions for your convenience.

## **ABG PUNCTURE**

Questions:

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

## **AEROSOL / HUMIDITY THERAPY**

### Questions:

1. What would you do if you entered a patient's room to set up an aerosol mask and the patient appears to be sleeping?
2. If a nebulizer is set at 70% and the oxygen flow meter is set at 10L/min, what is the total flow of gas to the patient?
3. What would you do if a patient refused to keep his aerosol mask on because it kept getting his face wet?
4. What are the results if the total flow to the patient does not exceed his/her inspiratory demands?
5. What will happen to the  $FIO_2$  if enough water accumulates in the large-bore tubing to impede flow to the patient? Why does this happen?
6. How would you set up a T-piece if the physician's order specified exactly 75%  $O_2$  to be delivered?

## **ARTIFICIAL AIRWAY CARE**

### Tracheotomy Questions:

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

## ETT

### Questions:

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

## **ASSESSMENT OF VITAL SIGNS**

Questions:

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

## **CHEST PHYSIOTHERAPY**

Questions:

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

## **CPAP THERAPY**

Questions:

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

## **CPR/INTUBATION**

Questions:

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

## **EVALUATION OF THE CHEST FILM**

Questions:

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

## **EXTUBATION**

Questions:

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

## **INCENTIVE SPIROMETRY THERAPY**

Questions:

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

## **MDI THERAPY**

Questions:

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

## NEBULIZER THERAPY

### Questions:

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

## OXYGEN THERAPY

### Questions:

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

## NASAL CANNULA/SIMPLE MASK

### Questions:

1. Explain what will happen to the  $FIO_2$  to the patient if the patient's ventilatory status changes.
2. If the patient has COPD with  $CO_2$  retention, will a change in the ventilatory status be hazardous to the patient and why or why not?
3. You are doing oxygen rounds and the patient is on two liters of oxygen and is smoking in the room. The patient has been informed of the hospital's rules about not smoking in the hospital and the "No Smoking" signs are posted. The patient refuses to put out the cigarette and request that you leave the room. What would be the appropriate steps in this situation?
4. You go into a patient's room and find the patient in the bathroom without the patient's nasal cannula. The patient is very dyspneic and cyanotic. The patient refuses to use the bedpan or the bedside commode. How would you rectify this problem?
5. What is the lowest liter flow at which this mask should be run and why?
6. While doing oxygen rounds, you enter the room of a comatose patient and notice that they have vomited into their simple mask. What would you do first?
7. A patient complains that the mask hurts their face. How could you remedy this problem?

## NON-BREATHING MASK

### Questions:

1. What is the appropriate flow rate for a non-rebreathing mask?
2. Why should the reservoir remain 1/3 full throughout the breathing cycle?
3. What follow-up assessment would be appropriate for a patient on a partial rebreathing  $O_2$  mask?
4. What would you recommend if the patient could not tolerate having the partial rebreathing mask on (the patient gets a "smothering" feeling with the mask properly in place).

## MISCELLANEOUS O<sub>2</sub>

Questions:

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

## VENTURI MASK

Questions:

1. What is the total flow to the patient if a venture bask is running at 81pm while set on 35%?
2. What is the effects of the FIO<sub>2</sub> of the venture mask if the patient tucks their covers up around their neck, covering the entrainment port?
3. How will a change in the patient's respiratory pattern affect the FIO<sub>2</sub> deliver of this device?
4. A patient ordered to wear a 28% venture mask is complaining of becoming SOB while eating. How could you remedy the problem?
5. The physician orders you to set up a 60% venture mask. What would you do?

## SPUTUM COLLECTION

Questions:

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

## SUCTIONING

### Questions:

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

## TENT THERAPY

Questions:

1. What is the appropriate flow rate for a croup tent?
2. What other disease states would benefit from croup tent therapy?
3. Where should the O<sub>2</sub> analyzer sensor be placed when analyzing a croup tent rounds?
4. What would you say to a mother who repeatedly keeps unzipping the canopy so that she can hold her baby and the child needs the therapy constantly.
5. What toys should the child not be allowed to play with inside a croup tent? Be specific.

## MANUAL VENTILATORS

Questions:

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

## VENTILATOR THERAPY

### Questions:

1. A patient has a minute ventilation of 20L/min with an IMV rate of 20/min and  $V_T = 1000\text{cl}$ . The flow rate is 40L/min. The patient appears to be “fighting” the ventilator, is using accessory muscles to breath and is in distress. What would you do?
2. You are caring for a 72 year old patient on mechanical ventilatory support who has a history of severe mental retardation and metastasis cancer. A family member comes into the room and ask you to disconnect the patient and let him die. What would you do?
3. You are about to perform a ventilatory check. A physician in the room says “What are you doing? Only a therapist is allowed to do that.” What would you do?
4. If the peak pressure is 28 cm H<sub>2</sub>O, what should the low and high pressure alarm settings be?
5. After placing the patient on the ventilator, you notice that the patient’s exhaled tidal volume is 325 ml less than the set tidal volume. What could cause this?
6. What would you do if you disagreed with the physician’s ordered ventilator settings for a patient?
7. While setting up the ventilator, the patient mouths to you that they do not want to be placed on any life support system. What would you do?
8. The machine you are checking will not pass a leak test. Your supervisor tells you “that’s ok; we need it on a patient.” What would you do?
9. The ventilator you are checking keeps giving you a “vent.in.op” alarm and “system failure” message. You are along on evening shift. You need another ventilator. What would you do?
10. Trace gas flow through the circuit and identify the exhalation valve.
11. What is the purpose of the leak check?
12. A patient on a ventilator appears dyspneic and is combative. The patient’s chest wall is moving but breath sounds are difficult to assess. What can you do?

## VENTILATOR PROBLEM SOLVING

### **Case One:**

During a 4 day period, a mechanically ventilated patient on +10 PEEP has gained 3 kg. Fluid intake measures about 3000 ml/day and output is 1550/day. The peak pressure reading has increased from 28 to 4L. Lung compliance has decreased from 35 to 26 ml/cm H<sub>2</sub>O. Breath sounds reveal bilateral rales (crackles). What is the cause of these changes and how would you correct the situation?

### **Case Two:**

A 60 kg patient is being mechanically ventilated following acute MI. Ventilator settings are Vt of 900 ml, frequency of 12 and FIO<sub>2</sub> of 0.40. ABG's were Pa CO<sub>2</sub> of 30 torr, pH of 7.50, and PaO<sub>2</sub> of 110. What changes might be appropriate?

### **Case Three:**

Following surgery, a patient is kept temporarily on mechanical ventilatory support. The patient's peak inspiratory pressure rises from 25 to 58 cm H<sub>2</sub>O in a 90 minute period of 100% oxygen. Chest wall movement is asymmetrical with movement greater on the right side. Breath sounds are distant on the right and absent on the left. The left side is dull to percussion and the right side is resonant. The trachea is deviated to the left. What is the problem and the best solution?

### **Case Four:**

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

### **Case Five:**

A patient on mechanical ventilation in the assist/control mode has the following ABG results: pH 7.61, PaCO<sub>2</sub> of 23 torr, PaO<sub>2</sub> on FIO<sub>2</sub> of 0.35. The Vt is 900 ml and the rate is 20/min. What is an appropriate immediate action?

### **Case Six:**

The minute ventilation on a ventilated patient is 64lpm. The PaCO<sub>2</sub> is 30 torr, the pH is 7.51, and the PaO<sub>2</sub> is 110 torr on an FIO<sub>2</sub> of 0.24. What would you recommend for this patient?

**Case Seven:**

A mechanically ventilated patient had the following arterial blood gases and ventilator parameters: PaO<sub>2</sub> of 74 torr, PaCO<sub>2</sub> of 39 torr, pH of 7.41, PEEP of +3, SIMV of 3 with a spontaneous rate of 12, pressure support +5 above PEEP. The patient's spontaneous Vt is 470 ml and the FIO<sub>2</sub> is 0.35. The patient's NIF is -38 cm H<sub>2</sub>O and their vital capacity is 18 ml/kg ideal body weight. What changes would you make at this time?

**Case Eight:**

Auscultation over the trachea during positive pressure ventilation reveals a slight audible leak in the area at peak inspiration. Cuff pressures are currently 18 cm H<sub>2</sub>O. What would be your next action?