

# JC Respiratory Care Program

## RES 115 Clinical Practice I

### Pre-Clinic Orientation Session

INSTRUCTOR:	Ann Flint, EdD, RRT
OFFICE:	JW 245
OFFICE PHONE:	(517) 796-8684
CELL PHONE:	(616) 446-3856
EMAIL:	flintanm@jccmi.edu

The pre-clinical orientation days for RES 115 are two 4 hour sessions held at JC. They are scheduled to run April 25 from 11am-3pm in HLC 204 and April 27 from 1pm-4pm in WA 216.

For these orientation sessions you need to bring pretty much all your clinical related documents:

A. Internet documentation:

1. Calendar
2. Time in and time out
3. Journal
4. Activities/procedures
5. Patient diagnosis
6. PEF's (proficiencies)

B. Large notebook with:

1. note paper
2. THIS SYLLABUS
3. Clinical Information and Policies Handbook
4. Equipment list

# Outline of Instruction

<b>Division:</b>	Health Sciences	<b>Area:</b>	Respiratory Care
<b>Course Number:</b>	RES 115	<b>Course Name:</b>	Clinical Practice I
<b>Prerequisite:</b>	RES 100 - Respiratory Care Techniques I and RES 104 Cardiopulmonary Assessment I		
<b>Corequisite:</b>	RES 110 - Respiratory Care Techniques II and RES 114 Cardiopulmonary Pathophysiology.		
<b>Credits:</b>	5		

## Course Description/Purpose

This course provides a hospital experience in which previously acquired classroom theory and laboratory skills can be exercised. Skills practiced include those associated with patient respiratory assessment, oxygen therapy, a wide range of bronchopulmonary hygiene therapies, and equipment processing.

## Major Units

- Basic Adult and Pediatric Care

## Educational/Course Outcomes

The course goals and objectives incorporate specific Associate Degree Outcomes (ADOs) established by the JC Board of Trustees, administration, and faculty. These goals are in concert with four-year colleges, universities, and reflect input from the professional communities we serve. ADOs guarantee students achieve goals necessary for graduation credit, transferability, and professional skills needed in many certification programs. The ADOs and course objectives addressed in this class include the following:

- Display acceptable fluency in professional attitudes, professional medical ethics, and concern for patient's rights as prescribed in the Respiratory Care program's Clinical Policies manual. **ADO 8**

**Academic Honesty Policy:** If I suspect you of academic dishonesty, I will follow JC's Academic Honesty Policy and take appropriate action up to and including assigning a **failing grade** for the paper, project, report, exam, or the course itself (whichever I deem necessary). To see the policy, visit: <https://www.jccmi.edu/wp-content/uploads/2015/11/1004.pdf> and <https://www.jccmi.edu/wp-content/uploads/2015/12/StudentCodeOfConduct.pdf>.

**Incompletes Policy:** (Excerpt from JC Policy) "A student may request an incomplete from the instructor. The incomplete will be granted only if the student can provide documentation that his or her work up to that point is sufficient in quality, but lacking in quantity, due to circumstances beyond the student's control. Furthermore, a written plan for making up the missing work within one semester must be completed by the student. Final determination of whether an incomplete will be given is the instructor's decision."

**Getting Extra Help:** (Besides visiting me during office hours)

It can be very frustrating when you do not understand concepts and are unable to complete homework assignments. However, there are many resources available to help you with your study of respiratory care.

- **CENTER FOR STUDENT SUCCESS:** Tutors (plus additional services for academic success) can be accessed by calling **796-8415** or by stopping by the **Center for Student Success, George Potter (Federer Room C)**. Arrange to get regular assistance from a tutor. Students requiring special assistance (including those affected by the Americans with Disabilities Act) should contact the Center for Student Success. This is the first step in acquiring the appropriate accommodations to facilitate your learning.
- **STUDY GROUP:** Find a study partner or a study group. Sometimes it helps to work through problems with another person.
- **JETNET:** I'll post a discussion board there where you can ask questions of me and/or the group. That way, you can get help at a time when you need it as the posts remain up there.
- **EMAIL:** The best and quickest way to get a hold of me, besides attending class, of course.
- **Redo problems** from tests and homework assignments, particularly ones that you got wrong or have trouble understanding. Remember that you must crawl before you can walk. Similarly, you must have a good handle on the basics of respiratory care before you can master the advanced concepts.

## **RES 115 ADULT BASIC CARE CLINIC SPRING 2016**

This clinical semester consists of two basic care rotations, each approximately five weeks long.

The first rotation is an introduction to basic respiratory care with the bulk of activities performed in various patient areas of the hospital. During this introduction there will be instruction, review, and assessment of the student's basic respiratory therapy skills such as: cylinder usage, equipment processing, isolation procedures, medical chart evaluation, oxygen concentration analyzing, basic cardiopulmonary physical assessment, oxygen rounds, pulse oximetry, incentive spirometry, SVN and MDI medication aerosol therapy, LVN aerosol therapies, chest physiotherapy, and cardiopulmonary resuscitation (if activity is available).

The second rotation's tasks will continue to build on the knowledge and skills students have acquired in the first 5 weeks and may further include: intermittent positive pressure breathing, drawing radial artery blood samples, oro/nasotracheal or endotracheal tube suctioning, and cuff management.

The overall goal of this semester is to produce and sharpen the student's basic care skills and knowledge to a level where hiring agencies would feel comfortable in assigning these individuals, within appropriate orientation guidelines, to adult basic care areas.

**EVALUATION**

Points for evaluation are assigned in the following fashion:

- a. Pass/Fail Components (**ALL** must be satisfactory)
  - 1) completion of patient assessments (**2 in first rotation, 2 in second rotation**)
  - 2) satisfactory physician contact time
  - 3) completion of mandatory proficiencies
  - 4) satisfactory affective evaluations
  - 5) satisfactory attendance and completion of logs and student journals
  - 6) completion of equipment list assessments
  - 7) satisfactory completion of special project (total of 100 points)
- b. patient assessments = 20 points (**4 patient assessments**)
- c. clinical exams = 20 points (**2 exams**)
- d. physician contact = 20 points
- e. activities/procedures = 10 points (**3 for completeness, 3 for accuracy, 4 for content/neatness**)
- f. proficiency evaluations = 20 points
- g. special project = 10 points  
100 total points possible
- h. attendance = +1 if no absences/tardies during the semester, or  
0 if only 1 absence/tardy during the semester, or  
-1 for **each** unexcused absence beyond the first during the semester.

Also regarding attendance:

1. Please refer to the JC Clinical Information and Policies Handbook, which states that “Any absence is considered unexcused if not accompanied by an appropriate notification of absence to the Clinical Instructor”.
2. In addition, students have been informed that they need to contact the Clinical Coordinator in case of absence.
3. Please be sure you have the correct phone numbers available in advance of your needing to use them.
4. Failure to call in properly will result in the consequences spelled out in the Handbook, and will also result in a **5 point deduction** from the final clinical grade for **each occurrence**.
- 5. Failure to maintain current health records will result in a 5 point deduction from the final clinical grade**

**GRADING**

To pass RES 115 the final course average score must be  $\geq 76\%$ .

Final Course Average Score = (total pts earned/total pts possible) x 100

**Grading Scale for All Respiratory Care Courses:**

4.0 = 93 - 100	2.5 = 80 - 83	1.0 = 68 - 72
3.5 = 89 - 92	2.0 = 76 - 79	0.5 = 64 - 67
3.0 = 84 - 88	1.5 = 73 - 75	0.0 = Below 64

## RES 115 PROFICIENCY EVALUATION LIST

MANDATORY - All skills/tasks listed as MANDATORY must be evaluated, in writing (PEF), by the end of the clinical semester. The **bolded** activities are used to determine the PEF component of the clinical grade

- Foundation #1. Isolation
- Foundation #2. Cleaning, Disinfection, Sterilization (Liquid)
- Foundation #3. Cylinder Safety & Transport
- Foundation #4. Handwashing
- Foundation #5. Medical Records/Chart Evaluation
- Foundation #6. **Measurement of O<sub>2</sub> Concentration**
- Foundation #7. Apical Pulse
- Foundation #8. Peripheral Pulse
- Foundation #9. Blood Pressure
- Foundation #10. **Patient Assessment**
  - #A.01.. **Oxygen Therapy**
  - #A.03.. Continuous Aerosol Therapy
  - #A.05.. **Medication Nebulizer Therapy**
  - #A.06.. **Metered Dose Inhalers (MDI)**
  - #A.07.. Dry Powder Inhalers (DPI)
  - #A.08.. **Incentive Spirometry**
  - #B.01.. **Pulse Oximetry**

OPTIONAL - These tasks/skills are presented in lecture/lab this semester but due to either low availability of clinical activity or because the topic is covered very late in the semester the related PEF does not have to be done this semester. If you do have the chance to have your performance assessed on an optional task then take the opportunity; those tasks which are optional this semester are mandatory next semester and if assessed now will not have to be re-assessed during the next clinic.

- #A.10.. Chest Physical Therapy
- #A.11.. Vibratory PEP (Acapella<sup>®</sup>, Flutter<sup>®</sup>, Vest, etc.)
- #A.13.. Airway Suctioning (Exposed Catheter)
- #B.02.. Radial Artery Puncture
- #B.07.. 12-Lead Electrocardiography

JACKSON COLLEGE - RESPIRATORY CARE PROGRAM  
**RESPIRATORY CARE CONSULT SYSTEM<sup>©</sup> ADULT BASIC CARE**

STUDENT \_\_\_\_\_  
 SEMESTER... SPRING /FALL ASSESSMENT: #1 #2 #3 #4 #5 EXTRA \_\_\_ DATE \_\_\_\_\_

**A. GENERAL PATIENT INFORMATION:**

1. PRIMARY DISEASE: EMPHYSEMA  CHRONIC BRONCHITIS  ASTHMA  CHF  CHEST TRAUMA   
 (limit selection to these) POST ABD/THORAX SURG  PNEUMONIA  LUNG CA  OTHER \_\_\_\_\_

2. AGE 57 y/o 3. SEX M/F 4. BODY TYPE: Thin Moderate Obese

5. PRESENT PULMONARY DIAGNOSES: Pulmonary dx or cardiac/renal/neuro dx that directly affect pulmonary function ONLY! If the pulmonary dx is not in the chart, you must determine the most likely dx (get help from instructor).

6. PERTINENT HISTORY: Hx related to present condition &/or general pulmonary health. May include job (coal miner), smoking hx, (40 pack-years, has not smoked for 7 years), previous respiratory conditions ( L pneumonectomy in 1983), etc.

7. RELEVANT SUBJECTIVE INFORMATION (from patient interview): Information from a bedside recent history; i.e., the IMMEDIATE history of the patient's present condition. Seek information specifically about  
1) dyspnea (and variations including DOE, orthopnea, and PND),  
2) presence of wheezing or other abnormal sounds associated with the respiratory cycle,  
3) chest pain, and  
4) cough (how often, how strong, is it productive).

EXAMPLE: Pt c/o DOE but denies orthopnea or PND. States he has a productive cough q AM and several times during the day of thick, yellow sputum. States he "breathes easier" after his bronchodilator therapy.

8. RESPIRATORY THERAPIES ORDERED (ONLY therapies done by RTs. Include ALL relevant order information.):  
List ALL active orders which are actually implemented by RTs, as written in the chart. Do not forget to include O2 tx.

Example: Hospital Medications

- 1) O2 @ 2 L/min by NC,
- 2) Albuterol 2.5 mg in UD 2.5 mL NS by IPPB q4<sup>o</sup>,
- 3) Atrovent MDI 4 puffs QID.
- 4) Vanceril MDI 2 puffs BID

Home medications

- 1) Combivent QID
- 2) Advair 500/50 BID

**B. RESPIRATORY PHYSICAL ASSESSMENT (FILL IN BLANK OR CIRCLE APPROPRIATE DESCRIPTORS):**

1. RESP. RATE 11 Br/min 4. SVC 2.87 L 7. ORAL TEMP 37.5 °C  
 2. TIDAL VOLUME 460 mL/Br 5. MIP -48 -cmH<sub>2</sub>O 8. CENTRAL CYANOSIS.....Y/N  
 3.  $\dot{V}_E$  5.06 L/min 6. WOB.....OK ↑ ↑ 9. PERIPHERAL CYANOSIS.....Y/N  
 10. BREATH SOUNDS ALL abnormal/adventitious breath sounds. Note locations of all abnormalities.

11. SECRETIONS Note: 1) quantity 2) viscosity 3) color 4) cough effort.

Example: Patient expectorated approximately 5-10 mL of thick, yellow sputum with a strong cough effort.

12. PHYSICAL SIGNS OF COPD:

- a. ↑ A-P DIAMETER..... Y/N
- b. DIGITAL CLUBBING..... Y/N
- c. ORTHOPNEA..... Y/N
- d. ACCESSORY MUSCLE USE..... Y/N
- e. ↑ T<sub>E</sub>..... Y/N

**C. CARDIOVASCULAR ASSESSMENT** (FILL IN BLANK OR CIRCLE APPROPRIATE DESCRIPTORS):

- 1. HEART RATE 96 B/min
- 2. RHYTHM.....REGULAR/IRREGULAR
- 3. BLOOD PRESSURE...SYS 125 mmHg/DIAS 88 mmHg
- 4. SKIN COLOR nl
- 5. SKIN TEMP sl. warm
- 6. Periph. Edema Y/N
- 7. NECK VEIN ENGORGE Y/N

**D. NEUROLOGICAL ASSESSMENT** (CIRCLE APPROPRIATE DESCRIPTORS):

- 1. LEVEL OF CONSCIOUSNESS..... Comatose Obtunded Somnolent Lethargic Awake/Alert
- 2. DISORIENTED TO..... Person Place Time No apparent disorientation
- 3. SIGNIFICANT CNS DRUGS: anti-convulsants, analeptics (resp. stimulants), respiratory depressants, pain medications

**E. LABORATORY TESTS:**

- 1. SPUTUM CULTURE Results pending

---



---



---



---

- 2. CHEST X-RAY RML atelectasis, hyperlucency of other lobes and flattening of diaphragms consistent with air-trapping.

---



---



---



---

3. LABS (start with MOST RECENT lab data and record others in REVERSE chronological order)

	Date	Time	Electrolytes:	K <sup>+</sup>	Na <sup>+</sup>	CO <sub>2</sub>	Cl <sup>-</sup>		Glucose	BUN	Creat.
a.	2/7/15	1445		5.0	102	28	89	156	8	1.2	5.0
b.											
			CBC:	WBC	RBC	Hgb	Hct	Plt.		Other:	
c.	2/7/15	1445		14K	5.6	18.9	48%	346K			
d.											

4. BLOOD GAS DATA (start with MOST RECENT ABG data and record others in REVERSE chronological order)

	Date	Time	pH	PaCO <sub>2</sub>	HCO <sub>3</sub> <sup>-</sup>	PaO <sub>2</sub>	SaO <sub>2</sub> /SpO <sub>2</sub>	Hgb	OXYGEN DEVICE	L/min	F <sub>I</sub> O <sub>2</sub>
a.	2/7/99	1445					93%		NC	1.5	0.26
b.	2/6/99	0630					88%		none		0.21
c.	2/5/99	0645	7.39	53	29	94	96%	14.8	NC	2	0.28
d.	2/4/99	0700	7.41	47	27	48	84%	14.6	NC	2	0.28

**F. MOST RECENT ABG**

	DATA	INTERPRETATION / COMMENTS
Acid-base status	PaCO <sub>2</sub> 53 mmHg HCO <sub>3</sub> <sup>-</sup> 29 mEq/L pH 7.39	complete JC interpretation (compensated respiratory acidosis)
Ventilation status	PaCO <sub>2</sub> 53 mmHg V <sub>E</sub> 5.06 L/min	acceptable, hyper- or hypoventilation. note resp. effort (hypoventilation c̄ ↑ WOB but ok V <sub>E</sub> )
Oxygenation status	PaO <sub>2</sub> 94 mmHg SaO <sub>2</sub> 96%; Hb 14.8 g/dL	JC interpretation. Note O <sub>2</sub> %, [Hgb], etc. (corrected hypoxemia on 2 L/min NC; good [Hgb])

G. **PULMONARY MATH:** Calculate the following equations using information gleaned from the patient chart. (Please use a barometric pressure (PB) of **760 mmHg** for appropriate calculations if the correct PB is not known for the day of the assessment). Note the large spaces made available here, and please **SHOW YOUR WORK**—and the appropriate **UNITS**. If you do not have an appropriate set of data to complete a calculation (i.e, no ABGs), please **note this** and list a set of **“made-up” values** so that you can perform the calculations. However, ideally you will **seek out patients** who will have **all of the required data** available, so that you can see how these values are applied in the real world.

1. **PAO<sub>2</sub>**

$$PAO_2 = FiO_2 (PB - PH_2O) - CO_2/RQ$$

(using values from 2/5/14 ABG, and normal values for P<sub>B</sub>, P<sub>H<sub>2</sub>O</sub>, and RQ):

$$PAO_2 = 0.28 (760 - 47) - 53/0.8 = 0.28 (713) - 66.25$$

$$PAO_2 = 199.64 - 66.25 \qquad PAO_2 = \mathbf{133.39 \text{ torr}}$$

2. **P(A-a)O<sub>2</sub>**

$$P(A-a)O_2 = PAO_2 - PaO_2$$

(using values from 2/5/14 ABG, and calculated PAO<sub>2</sub> above):

$$P(A-a)O_2 = 133.39 - 94 = \mathbf{39.39 \text{ torr}}$$

3. **CaO<sub>2</sub>**

$$CaO_2 = (Hgb \times SaO_2 \times 1.34) + (PaO_2 \times 0.003)$$

(using values from 2/5/14 ABG):

$$CaO_2 = (14.8 \times 0.96 \times 1.34) + (94 \times 0.003) = (19.04) + (0.28)$$

$$CaO_2 = \mathbf{19.3 \text{ vol\%}}$$

H. **ORDERED DRUGS WITH PULMONARY CONSEQUENCES:**

COMMON NAME	PHYSICAL ACTION	THERAPEUTIC GOALS
albuterol	sympathomimetic bronchodilator	↓ WOB & ↑ distri. of $\dot{V}_E$ 2° to ↓ RAW
Atrovent	anticholinergic “	“ “ “ “
Vanceril	steroidal anti-inflammatory & bronchodilator	“ “ “ “ and
		↓ chances of future inflammatory response
Lasix	↓lung fluid (2° to ↑U.O.) → ↑DLCO & ↑CLT	↑ PaO <sub>2</sub> & ↓ WOB
digoxin	↓lung fluid (2° to ↑C.O. & ↓pulm. pooling) → ↑DLCO & ↑CLT	↑ PaO <sub>2</sub> & ↓ WOB
O <sub>2</sub>	↑P(A-a)O <sub>2</sub> → ↑O <sub>2</sub> diffusion → ↑PaO <sub>2</sub> & ↑SaO <sub>2</sub> → ↑CaO <sub>2</sub>	↑ C <sub>T</sub> O <sub>2</sub> & ↓ dyspnea

NOTE: Group drugs which are the most functionally similar together.

I. **DIAGNOSIS:** Pulmonary Dx and Functional Pathology (Get from pathology book, RRT, or Dr.)

RESPIRATORY DISORDER	Chronic Bronchitis
	IF APPLICABLE, INDICATE WITH √
ATELECTASIS	
ALVEOLAR CONSOLIDATION	
INCREASED ALVEOLAR CAPILLARY MEMBRANE THICKNESS	√
BRONCHOSPASM	√
EXCESSIVE BRONCHIAL SECRETIONS	
DISTAL AIRWAY WEAKENING	



**J. RESPIRATORY THERAPY ORDERS AND CONFIRMING INDICATIONS** (Confirm with physical assessment and lab data YOU have gathered. Do NOT reiterate indications stated by others in the chart, conclude from your OWN assessment information that you've recorded on the opposite side of this form.):

ORDERED THERAPY	ACTUAL PATIENT SYMPTOMS/SIGNS INDICATING NEED FOR THERAPY
1) O <sub>2</sub> tx (2 L/min by NC)	Hypoxemia on RA (see note below on protocol NC O <sub>2</sub> titration to 1.5 L/min)
2) bronchodilator tx:	
a) sympathomimetic (albuterol, 2.5 mg q4° aerosolized by IPPB)	No wheezing heard; may be some bronchospasm 2° to c. bronchitis inflamm. AND...
b) anticholinergic (Atrovent, 4 MDI puffs QID)	Pt. still has mild ↑WOB, ↑TE, ↑A-P diameter, & ↑accessory vent. muscle use indicating continuing problems c̄ AW obstruction
c) anti-inflammatory, steroidal (Vanceril, 2 MDI puffs BID)	Dx of chronic bronchitis which includes chronic airway inflammation
3) lung expansion tx (IPPB q4°)	Pt. is ambulatory, has a strong cough, and can achieve VC > 15 mL/kg tx ∴ this therapy appears to be <b>NOT INDICATED</b>
<b>NOTE: Where is the Evidence?</b>	

**K. RESPIRATORY CARE CONSULT NOTES** (NOT to be a restatement of charted plans. Develop your OWN plans according to OPTIMAL therapy as stated in the pathology & therapy sections of your texts.):

Write in the form of a consult note. Address to "Dear Dr. Young (or whoever)." Confirm/refute therapies as ordered. State additional helpful therapies. If you recommend a change in therapies, explain why.

EXAMPLE

Dear Dr. Young: (DON'T use "Dr. Flint"; I'm neither a doctor nor this note's intended audience.)

Therapy & Suggestion	Justification
----------------------	---------------

- |   |  |
|---|--|
| 1) This patient's NC O <sub>2</sub> tx appears indicated by the presence of room air hypoxemia, although at lower than the presently ordered 2 L/min level. Following O <sub>2</sub> management protocol procedures, the patient's O <sub>2</sub> has been titrated to 1.5 L/min and is maintaining a SpO <sub>2</sub> of > 92%.  |  |
| 2) Bronchodilator therapies appear indicated by continuing signs of ↑RAW (↑WOB, ↑TE, use of accessory ventilation muscles, and evidence of air-trapping) and pt's. subjective improvement $\bar{P}$ treatment. Consider substituting Flovent for Vanceril. Flovent is equivalent to Vanceril in cost and effectiveness, but at half the dosage and with a lower risk of systemic steroidal effects. Consider changing the albuterol tx to q4° wa and prn @ noc; it is presently q4° throughout the night; but the patient is sleeping well @ night $\bar{S}$ c/o SOB when woke for PM tx.   |  |
| 3) I suggest IPPB be DC'ed and albuterol be delivered via MDI and be monitored by nursing. Patient achieves acceptable spontaneous SVC and MIP, is ambulatory, & cooperates performing DB & C for nursing. IPPB may worsen his hyperinflation.  |  |
| 4) Consider adding CPT to RML, QID, to attempt to hasten resolution of atelectasis. Consider ordering breathing/coughing instruction (FET, ACB, AD) to improve cough effectiveness and ↓airtrapping.  |  |
| 5) For long term management, you may wish to have a pre-/post-bronchodilator PFT performed. If the pt's high RAW proves to be significantly reversible, then you may wish to explore other maintenance bronchodilators (the BID $\beta_2$ agonist Serevent and the QD anticholinergic tiotropium) or other, non-steroidal anti-inflammatories (one of the leukotriene modifiers such as Accolate or Singulair). To assist with home management of secretions, use of PEP or Flutter™ devices may be explored. To best determine post-hospitalization respiratory treatment alternatives, a pulmonary rehab. consult would be helpful. |  |

Sookie Flint, SRT

**Worksheet For: Respiratory Care Consult Note**

Recommendation	Therapy & Technique	Justification
Suggested Present Therapy(ies) to Continue As Prescribed		
Suggested Present Therapy(ies) to Alter		
Suggested Present Therapy(ies) to Discontinue		
Suggested New Therapy(ies)		
Suggested Additional Consults		

## Asthma Management Drug Consult Worksheet

A resident just starting a pulmonary rotation has been assigned an asthmatic patient. The patient has moderate baseline bronchospasm and experiences severe exacerbations 2 to 3 times per year requiring hospitalization. The patient has been placed on mechanical ventilation twice during extreme conditions of status asthmaticus.

The resident asks you for a thumbnail sketch of the kinds of drugs that might be useful in the management of this patient's asthma.

- A. Name 2 modern **rescue/reliever bronchodilators** which operate through different modes of action (1a. & 1b. are different only in their isomeric make-up); and a combination drug.

	<b>Mode of Action</b>	<b>Generic Name</b>	<b>Brand Name</b>
1a.	_____	_____	_____
1b.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

- B. Name 3 **non-steroidal maintenance/controller bronchodilators** and their modes of action.

	<b>Mode of Action</b>	<b>Generic Name</b>	<b>Brand Name</b>
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

- C. Name 3 categories of **maintenance/controller anti-allergic/anti-inflammatory** drugs, which work through different modes of action, a combination agent, and cite examples of drugs available in each category.

	<b>Mode of Action</b>	<b>Generic Name</b>	<b>Brand Name</b>
9.	_____	a. _____	_____
		b. _____	_____
		c. _____	_____
10.	_____	a. _____	_____
		b. _____	_____
		c. _____	_____
		d. _____	_____
11.	_____	a. _____	_____
		b. <u>formoterol+ budesonide</u>	<u>Symbicort</u>

## CLINICAL CALENDAR

Month	Date	Day	Event
May	24,26	Tues./Thurs	<b>Orientation at hospitals</b>
May	31	Tues.	First day of <b>Rotation 1</b>
June	13	Monday	<b>Case study #1 due.</b> <b>Contract for special project due.</b>
June	16	Thurs.	<b>Formative Evaluation</b> filled out by <b>CI due</b>
June	20	Monday	<b>MANDATORY</b> Clinical mtg. on JC campus <b>9:30-11:30am.</b> All documentation <b>validated</b> in <b>ClinicalTrac.</b>
June	30	Thurs.	Clinical first half of clinical shift only; Last day of Rotation 1. <b>Instructor CIC mtg. 12n-3pm.</b> <b>Summative Evaluation</b> filled out by <b>CI due.</b> <b>Students evaluate clinical site by July 1.</b>
July	11	Monday	<b>MANDATORY</b> Clinical mtg. on JC campus <b>9:30-11:30am.</b> <b>Clinical Exam 1.</b> <b>Case study #2 due.</b> All documentation <b>validated</b> in <b>ClinicalTrac.</b>
July	5	Tuesday	First day of clinical for <b>Rotation 2</b>
July	21	Thursday	<b>Formative Evaluation</b> filled out by <b>CI due</b>
July	25	Monday	<b>MANDATORY</b> clinical mtg. on JC campus <b>9:30-11:30am.</b> <b>Case study #3 due.</b> All documentation <b>validated</b> in <b>ClinicalTrac.</b>
August	2	Tuesday	Last day of Rotation 2. <b>Summative Evaluation</b> filled out by <b>CI due.</b> <b>Students evaluate clinical site by August 5.</b>
August	4	Thursday	<b>Lab Practical 9am-1pm.</b> <b>CIC meeting 1-3pm.</b>
August	5	Friday	<b>MANDATORY</b> Clinical mtg. on JC campus <b>10am-1pm.</b> <b>Clinical Exam 2.</b> <b>Case study #4 due.</b> <b>Equipment list and special project</b> documentation due. All documentation validated in <b>ClinicalTrac.</b>

-----

## CLINICAL DOCUMENTATION: A SURVEY

TOPIC	REQUISITE ACTIVITY
1. Information & Policies book ....	Review pertinent elements for the start of a new semester.
2. RES 100 lecture calendar .....	Review what you have already learned.
3. RES 100 lab calendar .....	Review what you have already learned.
4. Clinic Syllabus .....	Review to familiarize with the broad goals of the ensuing semester.
5. RES 115 clinic calendar .....	Familiarize and place where it can be easily checked during the course of the semester.
6. RES 110 lecture calendar .....	Become familiar with this. Use during course of semester to coordinate clinical activity with classroom lecture content.
7. RES 110 laboratory calendar....	Become familiar with this. Use during course of semester to coordinate clinical activity and relate clinical expectations with laboratory content.
8. PEF list .....	Become familiar with this. Use during course of semester to request clinical assignments and establish an appropriate pace of progression through the clinic.
9. PEFs and Task Analyses .....	Become thoroughly familiar with so that tasks may be instructed on and your skills may be developed according to JCC Respiratory Care program standards. <b>PEFs are completed by CIs</b> with grade point values determined by the Clinical Coordinator.
10. Teaching modules.....	Some modules may be available for assisting you to advanced standing status (i.e., for students progressing at a faster rate than normal JCC lecture/lab calendars indicate is occurring); check with the JCC Clinical Coordinator as to what modules are available.
11. Equipment list .....	Use as a guide your performance and knowledge on a wide range of specific equipment related to the rotation's clinical tasks and skills. This form is <b>completed by the CI and validated</b> ,
12. Punch in and punch out .....	To be completed each and every day clinic is assigned. Note arrival/departure times on employee time-stamp clock and record to the closest minute.
13. Activity /Procedure.....	A document which records 1) your daily activity (tasks performed), and 2) totals for these categories for a defined cumulative period. This form is <b>validated DAILY by the CI</b>

<u>TOPIC</u>	<u>REQUISITE ACTIVITY</u>
14. Student journals.....	Journal entries based on daily clinical activities and events are completed by students and can be read by CIs and JCC program personnel to facilitate student/program communications. Entries are to be made daily. CIs or the clinical coordinator may enter dialogic comments in the students' journals. Journal entries are <b>validated by a CI</b> .
15. Physician contact forms.....	Notes taken on physician contacts and validated by CIs. The generated entries are evaluated with grade point values determined by the Clinical Coordinator.
16. Patient Assessment forms.....	You are to complete this form; it will be evaluated by CIs for accuracy and completeness and is used by CIs to guide group discussions of interesting patient cases. Patient assessments are to be done as scheduled on calendar and are graded by the clinical coordinator.
17. Clinical Quiz Items.....	<b>CIs are responsible for generating a minimum of 20 test points</b> , preferably NBRC format multiple choice items, for the rotation's scheduled exam(s). There will be an additional 30 items from the JCC Respiratory Care program. The clinical coordinator will administer and score all 50 items.
18. Formative evaluation forms.....	A short, evaluation of student progress on several key attributes. Because the program requests an anecdotal recording of critical student behaviors, the proper completion of this document is more time consuming than may first appear to be the case. This form is <b>completed by the CI, validated, conferenced over with the student</b> , and submitted to the clinical coordinator.
20. Summative evaluation forms.....	A comprehensive, evaluation of student progress performed by the CI near the completion of a clinical rotation. Because the program requests an anecdotal recording of critical student behaviors supporting the instructor's evaluation of the student, the proper completion of this document can be time consuming. This form is <b>completed by the CI, validated, conferenced over with the student</b> , and submitted to the clinical coordinator.

# DISCIPLINARY ACTION

Violation of clinical policies can result in administrative action ranging from counseling to permanent discharge from the program. All policy deviations are considered cumulative throughout the program, discipline will be based upon the total of policy infraction occurrences, not each occurrence of each type of deviation.

If any form of disciplinary action is taken, the student is encouraged to first discuss the alleged offense and implied disciplinary action with the Clinical Instructor, Clinical Coordinator, and/or Program Director. In every case an attempt will be made to remedy the situation at this level. In the event that the student feels he/she has justification for challenging the offense or decision for disciplinary action, see the JCC appeals process.

## Routes of Disciplinary Action for Clinical Policy Deviations:

### A. PRIMARY VIOLATIONS

Disciplinary Action: ANY DEVIATION IN THIS GROUP RESULTS IN **PERMANENT** DISCHARGE FROM THE PROGRAM AND A **FAILING GRADE**.

#### Offenses:

1. Committing **THE SAME secondary** violation for a second documented time, or a **third secondary violation of any kind**, whether simultaneous or consecutive.
2. Disclosing confidential information about any patient, student, hospital employee or the hospital without proper authorization.
3. Leaving hospital premises during assigned clinical hours without proper authorization.
4. Removing from the hospital any patient records or official hospital records without proper authorization.
5. Falsifying any student or official hospital records.
6. Using abusive, obscene, or threatening language to any patient, visitor, student, or hospital employee.
7. Engaging in disorderly conduct that threatens the physical well-being of any patient, visitor, student or hospital employee.
8. Obtaining, possessing, selling, or using drugs or other illegal or controlled substances on hospital premises.
9. Stealing, abusing, misusing or destroying the property or equipment of any patient, visitor, student, hospital employee, or the hospital.
10. Possessing weapons, wielding or threatening to use firearms, illegal knives, etc. on the hospital premises.
11. Assaulting any patient, visitor, student or hospital employee.

**B. SECONDARY VIOLATIONS**

Disciplinary Action: A student will receive a first written warning notice as the first step of the probation process for unsatisfactory performance. A second written warning notice is the second step of the probation process. A third written warning notice of any kind, whether simultaneous or consecutive, would count as a **primary violation** and result in the student's **immediate dismissal** (see Primary Violations, offense #1). These notices will be issued as soon as possible after the problem is identified. Serious violations may warrant immediate removal from the program.

\*\*\* NOTE \*\*\* The commission of **THE SAME secondary** violation for a **second** documented time is considered a PRIMARY violation and treated as such (see Primary Violations, offense #1).

## Offenses:

1. Acting in an unprofessional manner, as determined by JCC RC Program personnel, while in the role of an JCC RC clinical student.
2. **Accepting** authority or responsibility beyond the level of training or demonstrated competencies in the program.
3. Failing to exercise reasonable care in the performance of duties.
4. Dressing inappropriately or otherwise presenting an inappropriate appearance based on Hospital and/or College policies (see JCC Program Policy Handbook for Dress Code).
5. Smoking in restricted areas.
6. Leaving an assigned clinical area without proper authorization.
7. Being excessively (chronically) tardy (to be determined by the Clinical Instructor and Clinical Coordinator, but generally greater than 2 times in an 8 week period) or significantly tardy (greater than 10 minutes without proper notification).
8. Being excessively (chronically) absent (to be determined by the Clinical Instructor and Clinical Coordinator, but generally greater than 2 times in a 15 week semester) or being absent without proper notification.
9. Using machines or equipment without proper authorization.
10. Violating safety rules and regulations or failing to use safety equipment provided.
11. Creating or contributing to unsafe or unsanitary conditions.