NURS 296- LEVEL 6 Student Clinical Guidelines

Independently:	***Supervision:***	***Not Allowed:***
Students may perform *Independently*.	**Students must *have RN supervision* (preceptor or staff). The level of supervision depends upon the risk level of the procedure. Low risk procedures should be observed to "verify competency" and may be allowed to be done independently per the judgement of the preceptor. High risk procedures will be considered "consistent direct observation"**	**Students are *NOT allowed* to do at any time.**
• Hand hygiene, clean gloving, don/doff PPE, enter and exit isolation rooms • Vital Signs including oximetry and pain • Simple ambulation, use of assistive devices as needed • Transfers and positioning patients (with help as needed) • Basic ADLs—Hygiene, feeding, bathing/showering, mouth care, skin care, etc. • Assist with elimination needs—bedpan, urinal, condom catheter, stoma care • Simple Dressing Change • General survey, comprehensive physical assessment, geriatric assessment • Cardiac monitor lead placement • Application of TED/SCD • Oxygen administration • Assist with incentive spirometry • Pre-op teaching	**Consistent direct observation** • Sterile procedures (catheterization, suctioning, sterile wound care/wound vac, lab draws) • Medication verification, removal from Pyxis, and administration* • IV fluid and IV medication administration • Insert peripheral IV's • NGT insertion, placement verification, irrigation • Feeding tube: placement verification, feeding, med administration, flushes • Preceptor co-signs all documentation in EHR **Observation to verify competency:** • Specialty assessments: Antepartum, postpartum, neonatal, pediatric • Specimen collection: capillary blood glucose; urine (clean catch,	• Verify or administer blood or total parenteral nutrition (TPN) (per facility policy) • Verify or manage PCA's (per facility policy) • Administer chemotherapy by any route • Administer medication via epidural/spinal catheters • Take verbal or telephone orders or acknowledge orders

	sterile spec from catheter); wound; sputum; stool • NGT removal • Urinary catheter care/removal • Oral suctioning • Chest tube assessment • Peripheral line assessment, saline flush, removal • Central line assessment (no dressing change)	

*See “Safe Medication Administration by Nursing Students” policy