

University of New England
School of Nurse Anesthesia
716 Stevens Avenue
Portland, Maine



Class of 2013

CLINICAL PRACTICUM HANDBOOK

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MISSION STATEMENTS

University Mission Statement:

The University of New England provides a highly integrated learning experience that promotes excellence through interdisciplinary collaboration and innovation in education, research, and service. (University Catalog 2010-2011).

Westbrook College of Health Professions Mission Statement:

The Westbrook College of Health Professions provides students with dynamic educational experiences that emphasize an integrated and interdisciplinary perspective on health and healing, based on a comprehensive definition of health and well-being that incorporates biological, psychological, social and spiritual dimensions aimed at enhancing the quality of life for all members of society. (University Catalog 2010-2011).

School Mission Statement:

The mission of the School of Nurse Anesthesia is to provide an academic environment, which allows students to master the intellectual and technical skills necessary to become competent in the safe conduct of anesthesia. It does this by providing a select group of experienced, graduate level nurses with the highest level of didactic, simulation lab and clinical site experiences. Our graduates develop life-long scholarship, critical thinking skills and professionalism needed to become compassionate, patient-centered anesthesia providers in solo practice or within anesthesia care teams.

OVERVIEW OF CURRENT AFFILIATION SITES

The University has contractual agreements with numerous healthcare institutions and facilities throughout the New England area and beyond, which provide the necessary clinical experiences in anesthesia. Clinical training sites may be added to sites already in use, and may serve as complete training sites or may offer specialty training as part of the overall clinical program. These sites represent primary and enrichment clinical sites. Students will be afforded appropriate input in assignment of sites; however, sites are assigned by the program clinical director and are not optional, as they may provide the student with required experiences to qualify for certification.

Aroostock Medical Center, Presque Isle, Maine
Bridgton Hospital, Bridgton, Maine
Cary Medical Center, Caribou Maine
Central Maine Medical Center, Lewiston, Maine
Concord Hospital, Concord, New Hampshire
Cottage Hospital, Woodsville, New Hampshire
Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire
Eastern Maine Medical Center, Bangor, Maine
Elliot Hospital, Manchester, New Hampshire
Emerson Hospital, Concord, Massachusetts
Goodall Hospital, Sanford, Maine
Health Alliance Hospital (UMass), Leominster, Massachusetts
Houlton Regional Hospital, Houlton, Maine
Johns Hopkins Hospital, Baltimore, Maryland
Maine Coast Memorial Hospital, Ellsworth, Maine
Maine General Hospital, Augusta, Maine
Maine General Medical Center, Waterville, Maine
Maine Medical Center, Portland, Maine
Mayo Regional Hospital, Dover-Foxcroft, Maine
Mercy Hospital, Portland, Maine
Millinocket Regional Hospital, Millinocket, Maine
Morton Plant, Clearwater Beach, Florida
Northeastern Vermont Regional Hospital, St. Johnsbury, Vermont
Plastic Surgery Associates, Portland, Maine
Riverview Dental Clinic, Portland, Maine
Southern Maine Medical Center, Biddeford, Maine
St. Joseph Hospital, Nashua, New Hampshire
St. Vincent Hospital, Worcester, Massachusetts
University of Massachusetts Worcester, Worcester, Massachusetts
Veterans Administration Hospital, (Togus), Augusta, Maine
Wentworth Douglass Hospital, Dover, New Hampshire

A complete updated list of clinical affiliation sites is maintained on the Typhon web site along with web addresses and contact information. Students are required to access this information at least a month prior to clinical rotation and contact the clinical coordinator for information regarding the rotation to the site.

GRADUATION CRITERIA

1. Satisfactory completion of all didactic material.
2. Satisfactory completion of clinical experience as required by UNE School of Nurse Anesthesia and Council on Accreditation of Nurse Anesthesia Educational Programs.
3. Satisfactory completion of stated UNE School of Nurse Anesthesia objectives.
4. Completion of twenty-seven actual months in program, inclusive of time off approved by the program.
5. All time commitments in the didactic and clinical areas must be satisfied
6. All clinical records must be completed and available to the Anesthesia School Administrative staff.
7. Clinical evaluations must be completed and signed.
8. Completion of the capstone project with an assigned passing grade.
9. All fees must be paid in full.
10. All library books must be returned.
11. All relevant University and programmatic evaluations must be submitted.
12. Completion of See exam as required by MSNA student handbook.

BEHAVIORAL OUTCOME CRITERIA

Upon completion of this educational program, the student shall demonstrate, to the satisfaction of the faculty, specific competencies expected of graduates. These competencies identify knowledge and skills necessary for competent entry-level practice of nurse anesthesia. Upon completion of the program, the graduate will:

1. Perform a thorough preanesthetic assessment and formulate a comprehensive anesthetic care plan for each assigned patient based on the preanesthetic assessment of that patient.
2. Use a variety of current anesthetic agents, techniques, adjunctive drugs and equipment as appropriate while providing anesthesia.
3. Ensure the use of appropriate agents/techniques to protect the patient from iatrogenic complications.
4. Apply appropriate safety principles and precautions in caring for patients to prevent or minimize any potential risk.
5. Utilize universal safety precautions and appropriate infection control measures to ensure the safety of the patient, staff and CRNA.
6. Conduct a comprehensive and appropriate check of all equipment before and during use.
7. Provide first echelon care and maintenance of all anesthesia equipment. Identify malfunctioning anesthesia equipment and take appropriate action when confronted with anesthetic equipment-related malfunctions.
8. Position and/or supervise the positioning of patients to assure physiological functioning, safety and the prevention of injury.

9. Administer general anesthesia in a safe and conscientious manner to patients of all ages and physical conditions for a variety of surgical and medically related procedures.
10. Perform and manage a variety of regional anesthesia techniques in a safe and conscientious manner to patients of all ages and physical conditions for a variety of surgical, medical, and pain related procedures.
11. Interpret and utilize appropriate invasive and noninvasive monitoring modalities, accurately interpreting the data obtained and adjusting the anesthetic management accordingly.
12. Calculate, initiate and manage fluid therapy and blood component therapy.
13. Recognize and appropriately respond to anesthetic complications that occur during the perioperative period.
14. Evaluate the postoperative course of a patient.
15. Recognize own limitations and seek consultation when indicated.
16. Provide anesthesia services for patients in trauma and emergency cases.
17. Function as a resource person for airway and ventilatory management of patients.
18. Serve as a leader or member of a cardiopulmonary resuscitation team and possess advanced cardiac life support (ACLS) recognition and pediatric cardiac life support (PALS) skills and certification.
19. Participate in quality improvement activities.
20. Critically analyze published data in the field of anesthesia and apply new evidence in technology, pharmacology, and techniques to patient care.
21. Function within the appropriate legal requirements as a registered professional nurse, accepting the responsibility and accountability for his/her practice.
22. Demonstrate competency as an integral member of the surgical team to include skilled communication, data processing and theory transference as it pertains to the overall anesthetic care of the surgical patient.
23. Develop interpersonal behaviors consistent with that of a health care professional.
24. Demonstrate personal and professional integrity and the ability to interact on a professional level.

CLINICAL EDUCATION PERSONNEL

School of Nurse Anesthesia Director of Clinical Education

The Director of Clinical Education is a member of the University Of New England School Of Nurse Anesthesia Faculty whose chief responsibility is to coordinate the clinical assignments of students and oversee the clinical phase of the program. This individual will also serve as the course coordinator for the Clinical Practicum's I-V, providing students with the practicum syllabi and learning objectives to be used during the clinical phase. The Director of Clinical Education is the principle contact and liaison between the School of Nurse Anesthesia and the Clinical Affiliate Sites. The **Director of Clinical Education** will approve all personal time off (PTO), evaluate the student's clinical progress utilizing

formative and summative evaluations in addition to clinical faculty feedback to determine the grade for each clinical practicum.

Affiliate Site Clinical Coordinator: The Clinical Coordinator provides in addition to instruction, primarily, orientation, assignments, evaluation and record keeping while students from the University of New England are assigned to anesthesia clinical rotations.. This individual is responsible for monitoring student scheduling, and clinical progress. They may be invited to participate in selection and evaluation of students for admission when feasible, as well as participate in campus based instructional activities. The principle responsibilities of the Clinical Coordinator are to:

1. Serve as liaison/contact person between the institution and the School of Nurse Anesthesia. Facilitate the acquisition of necessary contractual agreements and credentialing documentation.
2. Orient students to the clinical anesthesia area.
3. Coordinate clinical assignments and rotations in conjunction with the program Clinical Director. Provide coordination to clinical affiliate faculty for evaluation and scheduling.
4. Evaluate and document ongoing student performance in conjunction with student clinical objectives to include daily evaluations and summation evaluation as needed.
5. Participate in the admission process of students when possible.

Clinical Affiliate Faculty

All clinical faculty will be credentialed physician or CRNA providers at the individual affiliate sites and are able to provide the necessary expertise and knowledge for a comprehensive and relevant clinical experience.

Responsibilities of Clinical Affiliate Faculty

1. Remain current in the field of anesthesia as exemplified by maintaining current Certification (i.e., attending meetings, lectures, workshops and reading pertinent literature).
2. Participate in the clinical evaluation of students as required by the program.
3. Discuss anesthesia care plans with students.
4. Remain immediately available to students in the clinical area.
5. Mentor and supervise students in the practice of anesthesia in the clinical arena.
6. Communicate student issues and concerns to the Clinical Director.

Certified Registered Nurse Clinical Faculty

All nurse anesthetists involved in the clinical teaching of nurse anesthesia students shall:

1. Be currently certified/recertified by the National Board of Certification and Recertification.
2. Maintain current, valid licensure as required by the state to practice as a certified registered nurse anesthetist.
3. Be knowledgeable in the teaching/learning process including student evaluation.

Physician Faculty

All physicians involved in the clinical teaching of nurse anesthesia students shall:

1. Be currently credentialed comparable to their position and responsibility.
2. Be knowledgeable in the teaching/learning process including student evaluation.

Clinical Affiliate Faculty Evaluation

Evaluation of clinical faculty will be based on self-evaluations and evaluations completed by students. (See Appendix for evaluation tools)

CLINICAL PHASE POLICIES/EXPECTATIONS

RESPECT FOR PATIENT RIGHTS

Students are required to respect patients and their rights while on affiliation in the clinical arena. In reference to patient rights, the student is expected to:

1. Behave professionally as defined by the program and provide an appropriate level of care.
2. Clearly identify oneself to patients as a Registered Nurse training in nurse anesthesia or a Student Nurse Anesthetist (SRNA). One should never present themselves as a graduate nurse anesthetist. Students must also wear a clearly marked nametag (per the site) that identifies proper role identification as deemed appropriate by individual clinical sites.
3. Hold all patient information in strictest confidence and adhere to Health Insurance Portability and Accountability Act (HIPAA) guidelines. Pictures or other documents related to patient care shall not be copied or removed from the clinical environment without the proper patient consent.
4. Insure informed consent.

CLINICAL WEEK EXPECTATIONS

As each clinical site has its unique scheduling needs, we offer each site the flexibility to schedule students as deemed appropriate with guidelines established by the program. Students need time to prepare care plans for the next day and study as well, so student clinical time will be limited to a maximum of 45 hours/week (this does not include room set-up and working up patients for the next day or postoperative visits).

CLINICAL ROTATION POLICIES

A comprehensive clinical experience is designed on an individual basis to meet the clinical experience requirements for certification as well as prepare the student for practice in a variety of settings. Students should be aware of their obligations at each clinical affiliate site.

1. Students will ensure at least four (4) weeks before their clinical rotation (or as identified as required by the individual site) that credentialing procedures and required pre-clinical inservices with the clinical site are complete. Contact information will be provided by the program. Caution: Some clinical sites will require additional RN licensure which may take months to obtain. Students must determine if they meet the licensure requirements when the assignment is made to allow time to negotiate the licensure process.
2. At least 4-6 weeks prior to the first day of each rotation, the student should contact the Clinical Coordinator to discuss "first day" expectations and other details.
3. The first day at each rotation site is usually spent in orientation, observation, and becoming familiar with the physical plant and expectations unique to the clinical site.
4. Students are expected to be in the Operating Room (OR)/Anesthesia Area at least one hour prior to the beginning of assigned cases. This allows ample time to prepare and assemble the necessary equipment, prepare the patient, and discuss the planned care with their Clinical Instructor. At times, clinical instructors require a phone call the evening prior to discuss the plan of

- care. Students are expected to comply with this requirement in addition to any individual requirements deemed appropriate by the site.
5. The student is expected to complete each day's clinical assignment/caseload. This means that some cases may not be completed until late in the afternoon on some days. If cases do run late, the student may be given some compensatory time off so student clinical time will be limited to a maximum of 45 hours/week (this does not include room set-up and working up patients for the next day or postoperative visits). Again, this must be discussed with the Clinical Coordinator/Clinical Instructor.
 6. The student should make every effort to obtain an assignment the day prior to the procedure so that a preoperative visit/assessment can be made and an anesthesia care plan formulated. An anesthesia care plan is required for each patient. All care plans should include the 10 P's (**See Appendix for details**)
 7. If the Clinical Instructor determines the student is unprepared for the day's assignment, the student may be asked to leave the OR, and return when they are properly prepared to do the assigned procedure(s).
 8. The student is expected to make postoperative visits on their patients, when feasible, and document the visit on the patient's record. Although students are expected to visit all of their inpatients the day after surgery, each student will be expected to complete five (5) *Postoperative Surveys* (**See Appendix for tool**) and submit them to the program by the first of each month along with clinical evaluation forms. Postoperative surveys are to be completed on patients staying overnight in the hospital (i.e. inpatients or 23-hour admits). If students are working in an outpatient facility for a month, they should complete these forms based on the follow-up procedures for the facility (i.e. refer to postoperative telephone interviews conducted by outpatient nurses).
 9. All students will participate in an on call rotation as designated by the Clinical Coordinator. The students will have a minimum of fifteen (15) on-call experiences. These call experiences are defined as an 8,16,or 24 hour overnight shift on an evening, weekend, or holiday. An overnight shift taken from home with a beeper is considered a call shift, however, to count this shift toward the required 15, at least one case must have been done. This call experience is required to complete the clinical phase of the program. Exact length of call and days involved will vary and compensatory time off will vary from one clinical rotation to another. The student will participate according to the guidelines set up at each of the clinical rotations to which they are assigned.
 10. Students will be evaluated according to the *Clinical Objectives and the Clinical Practicum Evaluation* tool provided by the program.
 11. All personal time off (PTO) except sick time must receive prior approval from their Clinical Director at the University of New England (See PTO description below). If a student is unable to attend clinical due to illness, notify the clinical coordinator at the clinical site according to the affiliations department policies. In addition, email the Clinical Director and the staff assistant for recording purposes. This time must also be recorded in Typhon. Extended absence due to illness will be handled on a case by case basis with the clinical director and the program director. Extended illness or multiple absences may require make up shifts or extension of the clinical phase.
 12. In regard to extreme weather conditions, "on campus" cancellations do NOT apply to the clinical area. In other words, "snow days" do not exist in the clinical setting. Students can choose to call the clinical site and use PTO hours if they are unable to attend because of extreme weather conditions. These hours may require "makeup" as determined by the clinical coordinator which may include extension of the practicum. If students are scheduled for class on a day a campus closure occurs, the student is excused from clinical as well.
 13. Students are expected to fully participate in departmental professional initiatives. These initiatives include but are not limited to presenting journal articles or case studies, attending quality assurance and/or risk management meetings, and departmental meetings and conferences.

14. All students will hold all patient information in strictest confidence and adhere to Health Insurance Portability and Accountability Act (HIPAA) guidelines. Students must meet the University and clinical site requirements regarding HIPAA compliance.
15. Students are required to complete a rotation once an arrangement has been formally made with a clinical site, unless the program deems otherwise. Changes to the clinical rotation schedule are problematic and will only be considered for dire circumstances or to meet the COA clinical requirements.

ADMINISTRATIVE POLICIES

Clinical Communication Policy

Students are required to notify the program when there is a change in their address or phone number. The program will not be responsible for lost mail or late notification when a student does not provide notification of a change. The University provides email service as a primary contact method; however, the school must also be able to contact students by phone at all times while they are on clinical rotation, even during non-clinical hours. Students are required to provide access phone numbers, including their cell phone numbers, to the program prior to beginning the clinical phase. Students are required to check their University of New England email on a daily basis for important updates. All email communications to the program must be via the UNE email system for recognition purposes.

Equal Opportunity Statement

It is the policy of the University that no discrimination on the grounds of race, color, religion, age, sex, marital status, handicap, sexual orientation or national origin will be tolerated in any area.

Licensure and Re-certification

Students are required to maintain current a RN license in any state where they maintain a clinical site rotation. Compact licensure is recognized if applicable. A current copy of the student's RN license **MUST** be provided to the School prior to the expiration date and will be maintained in their individual file. Current ACLS/BLS/PALS certification and immunization status **MUST** be maintained throughout the clinical phase of the program.

If the School does not receive the required information prior to expiration, the student will be **immediately removed** from clinical rotation and may be placed on probation.

Clinical Documentation Policy

During the clinical phase of the program, students are required to complete a monthly Record of Clinical Experience via the *Typhon Group Nurse Anesthesia Student Tracking System* and submit ten (10) completed and signed copies of the *Clinical Practicum Evaluation* tool. Ensuring records are maintained is the responsibility of the student. The time-line for submitting the required information is as follows:

- ◆ Students are responsible for forwarding their *Clinical Practicum Evaluations* to the School no later than the first of each month. They can be faxed directly to the anesthesia office at (207) 523-1900, or may be emailed to the dept. staff assistant. Failure to communicate a reason for noncompliance with this policy may result in probation.
- ◆ The Record of Clinical Experience via Typhon must be completed within the same time-line. The School will go on-line and verify if records are complete, so the student will not need to forward a copy to the School. Data entry for each month may be locked out no later than the 5th of following month.
- ◆ If the required information has not been received/verified, the student may be placed on immediate probation.

Time Off

During the 19 month clinical phase of the program, students will be entitled to time off based on the University Calendar, to include Thanksgiving Break, Christmas Break (one week), Spring Break, Fourth of July (one week) . This will afford the student a break each semester. Additional personal time off will be considered on a case by case basis with prior approval from the clinical coordinator or the program director. It is requested that this time be coordinated so as not to interfere with clinical enrichment rotations. Any time taken in excess will have to be made up sometime during or at the end of the program. Graduation may be delayed as a result. Students must notify the anesthesia department when not reporting for clinical for any reason. Any time, other than sick, needs to be communicated to the school in advance. Sick time must be communicated that day. Failure to do so will result in the student immediately being placed on a focused attention status.

Students will be allowed time to attend conferences. A total of 6 days of conference time will be allotted. Students who serve in a special capacity on committees or in student organizations may be allotted more time as needed by the program director. Weekends spent at conference will be credited to the student for conference time off during the week.

Holidays Those holidays observed at the clinical affiliation site will also be observed by students at that site. These days **may vary** from one site to another, but may include:

- | | |
|---------------------|---------------------|
| 1. New Year's Day | 5. Labor Day |
| 2. Presidents Day | 6. Veterans Day |
| 3. Memorial Day | 7. Thanksgiving Day |
| 4. Independence Day | 8. Christmas Day |

Family Leave

If a student requires family leave, the Director should be notified. A leave of absence application may be required. Allowed leave time shall be decided on a case by case basis by the Program Director. The student will be required to make up time lost while on family leave in order to fulfill graduation requirements.

Non-Clinical Days

Periodically students will be granted non-clinical days off during the 19 month clinical phase. These days are designed to allow students time to work on special assignments; research/teaching projects and attend class. Students are not allowed to take time off to attend outside meetings, review courses, interviews, vacation, etc if they are on a specialty enrichment rotation unless discussed with the Director of Clinical Education and the site Clinical Coordinator ahead of time.

Interview Days

There will be two (2) days allowed for the student to interview for future employment. These days will usually be granted sometime during late spring or summer of the student's senior year just prior to graduation and require approval by the Director of Clinical Education as well as the clinical coordinator

Mission Experiences

On occasion students may be presented with an opportunity to attend an out of country medical mission. Approval from the School must be obtained prior to planning such a mission. A maximum of 5 days to attend the mission may be used. Time in excess of 5 days must be made up. These experiences are not sanctioned or recognized by the Council on Accreditation and therefore are a personal experience without recognition or authority from the Program. Experiences and time commitments may not be counted toward school or certification requirements. The student must procure a letter to the program from an individual mentor that will supervise and monitor the student during the experience.

Clinical Correlation Conferences

The program is required to ensure that each student partakes in at least 45 hours of clinical correlation conferences. Clinical correlation conferences include departmental meeting at clinical affiliate sites, journal club/reviews, case reports, QA reviews, M & M discussions, conferences, and/or in-services related to anesthesia. Students will document these experiences and the number of clinical correlation hours they have engaged in on their daily Typhon log.

Attendance

Participation in the professional activities of the anesthesia department at clinical sites and attendance at all formal classes at the University of New England held during the clinical portion of the program are considered **mandatory**. Illness, adverse weather and family crisis may be taken into consideration. Failure to comply with this policy will be reflected in final grades for the practicum course and could also lead to academic or clinical probation.

Dress

Proper operating room attire will be worn in the appropriate areas according to local clinical affiliation policies. Each student should have a laboratory coat available to wear when outside the operating suite. Acceptable shoes, scrub suits, head cover, masks and jewelry will be determined by the individual clinical sites.

The program dress code described in the student handbook shall apply to all other times the student is at clinical or representing the program at conferences or meetings.

Employment

No student shall represent themselves as a licensed provider or receive compensation for anesthesia services. No student shall be permitted to render anesthesia service outside of the University of New England Nurse Anesthesia program. Violations of this rule will be cause for immediate dismissal from the Program.

During clinical, students are strongly discouraged from full or part-time employment. If a student elects to engage in part-time employment, at least 8 hours must lapse between working part-time and reporting to the clinical site.

Environmental Hazards

All students must recognize the hazards associated with continued exposure to trace anesthetic gases. There is also evidence that indicates that these gases have a deleterious effect on the fetus, as does exposure in the MRI suite. In addition students should be aware of the affects of exposure to x-rays and methylmethacrylate, both commonly used in the operating rooms.

Professional Liability

The University provides professional liability coverage for each student on a rotation assigned or approved by the program faculty. The clinical coordinator provides proof of this coverage to each of the rotation sites. Only institutional affiliates identified by the Clinical Director will be considered "covered" sites. In the event that you become involved in **any situation** which may result in a professional liability action, whether groundless or not, you must **IMMEDIATELY** report the incident to your Clinical Coordinator. The Director of Clinical Education should receive communication, both verbally and in writing, either from the student, and or the Clinical Coordinator.

Exit Interviews

All students are required to attend an exit interview with administrative faculty prior to graduation. This opportunity is also extended to students who undergo voluntary or involuntary termination.

RULES OF CONDUCT WHILE ON AFFILIATION AT CLINICAL SITES

Success in the Nurse Anesthesia profession requires certain behavioral attributes including but not limited to personal commitment and hardiness, empathy, discipline, honesty, integrity, personal regard for others, the ability to work effectively with others in a team environment, and the ability to address a crisis or emergency situation in a composed manner. Adherence to these attributes requires a high level of maturity and self-control, even in highly stressful situations. During the clinical phase, students must conduct themselves in a highly professional manner consistent with the patient care responsibilities with which they will be entrusted. Failure to adhere to these standards (noted below) or comply with the *Clinical Rotation Policies* will result in a disciplinary action ranging from a written warning to immediate dismissal from the program (depending upon the violation and the circumstances surrounding the offense) as determined by the Program Director.

Offenses Include:

1. Creating or contributing to situations that jeopardize safety.
2. Failure to follow all policies in the *Student Code of Conduct* section of the University of New England Handbook. Unethical behavior such as academic dishonesty, falsifying logs or medical records is considered a violation of the Program's standards of conduct.
3. Failure to respect the confidentiality of patients and fellow students. One is not permitted to discuss any patients by name outside the clinical encounter situation. Students should not discuss other students with any other individual (i.e. clinical coordinators or student peers). For academic presentations, all identifying data, including name, initials, date of birth and facility where seen will be omitted.
4. Unauthorized possession, use, copying, or distribution of hospital records or disclosure of information contained in such records to unauthorized persons.
5. Use, distribution, or unauthorized possession of intoxicating beverages or drugs on hospital premises or reporting to work under the influence of intoxicants.
6. Unauthorized absence from the Anesthesia Department during regularly scheduled clinical hours.
7. Failure or refusal to follow instructions of a duly assigned clinical instructor, including refusal to accept clinical assignment.
8. Use of vile, intemperate or abusive language, or acting in a disrespectful manner to any employee, supervisor, patient, or visitor.
9. Any disorderly conduct on hospital premises.
10. Creating or contributing to unsanitary conditions.
11. Theft, fraud, or unauthorized use of property belonging to the hospital, patient, or visitor.
12. Disregard of one's appearance, dress, or personal hygiene.
13. Participation in or conduction of anesthesia or anesthesia procedures outside of the program framework.
14. Unprofessional behaviors, postings, or discussions on electronic social media.
15. Failure to comply to drug testing or a positive finding in conducted drug testing.

Failure to adhere to the ***RULES OF CONDUCT WHILE ON AFFILIATION AT CLINICAL SITES*** may result in a disciplinary sanction. Under these circumstances, the student would go before the Student Development Committee (see *Appendix for Purpose and Structure*). The Committee will make a recommendation to the Program Director.

The Program Director may then:

1. Issue a letter of concern or reprimand
2. Impose a Clinical Probation Status

3. Dismiss a student from the program
4. Institute an alternative sanction.

The SDC may consider any other behaviors in reaching a decision to make a recommendation to the Program Director for adverse actions. This includes actions outside the classroom or in the clinical rotation, which do not reflect well on the program, profession or individuals.

Should disciplinary action be taken the student has a right to fair and just treatment through the Academic and Disciplinary Appeals Process. Please refer to UNE Student Handbook to review the policies of the University on: Conduct Code; Judicial System; Academic and Disciplinary Appeals; Alcohol and Drug; Sexual Assault/Harassment Policy; Academic Dishonesty and Involuntary Administrative Withdrawal. ***All of these policies remain in effect while the student is enrolled at the University and/or on a clinical affiliation rotation.***

SUBSTANCE ABUSE POLICY

Purpose

The University of New England, School of Nurse Anesthesia seeks to create an environment that promotes healthy, responsible living. The School of Nurse Anesthesia recognizes that anesthesia providers, because of their exposure and the nature of their work, may be at high risk for substance misuse. Aside from impacting upon the personal and psychological integrity of the abusers, substance abuse may significantly impact the ability of anesthesia care provider to administer safe, competent patient care.

The School of Nurse Anesthesia is committed to assisting the student who exhibits behaviors reflecting misuse or abuse of alcohol and other drugs through the availability of assessment and referral mechanisms. The purpose of this policy is to provide the student with policies, guidelines, judicial responses as they relate to substance abuse and chemical dependency.

Policy

This policy applies to all students currently enrolled in the School of Nurse Anesthesia.

Failure to comply or refusal to cooperate with any aspect of this policy, or any clinical site hospital policy on substance abuse, will be subject to immediate disciplinary action, up to and including dismissal from the program, report to the state licensing board and complaint to local law enforcement authorities. Because of the paramount concern for patient safety, these disciplinary actions may be imposed without the customary mechanisms of academic warning, and probation period.

Students are personally responsible for conforming to the University's Alcohol and Drug Policy, local, state and federal laws and regulations controlling the possession, manufacture, use or distribution of controlled or illegal substances and alcohol.

The School of Nurse Anesthesia prohibits the illicit or unauthorized possession, use manufacturing, consumption, sale or distribution of illicit drugs and alcohol on University property or clinical affiliate sites.

A student who is arrested or charged with a drug offense which involves the off-duty sale, distribution, or possession of legal or illegal drugs must immediately inform the School of Nurse Anesthesia, Program Director of the arrest, the nature of the charges, and the ultimate disposition of the charges.

Students are expected to comply with the hospital policies at each clinical site. Clinical training sites may also require students to undergo drug/alcohol testing prior to placement or during clinical rotations at the site. Therefore, students may also be tested in accordance with the clinical training site's policy. Students, like employees, are required to comply with all hospital policies regarding pre-employment drug and health screening.

Students who take over-the-counter or prescribed medication are responsible for being aware of the effects the medication may have on their performance and personal behavior and ensure patient safety is not compromised.

Students are prohibited from reporting to the classroom or the clinical area under the influence of illicit drugs or alcohol.

With reasonable suspicion of substance abuse or chemical dependency, the School of Nurse Anesthesia will act to intervene and refer a student for assessment and treatment.

CLINICAL PRACTICUM PERFORMANCE EXPECTATIONS:

Students are evaluated by clinical instructors to assess progress toward meeting all of the clinical objectives. Students must meet the terminal objectives of each clinical practicum before advancement to the next level. The developmental levels for each clinical practicum are identified below and are associated with clinical objectives appropriate for that level. If program faculty have determined students have successfully met the clinical objectives, they will pass the clinical practicum.

<u>Summer Semester 2012</u>	<u>Clinical Practicum I:</u>	Novice
<u>Fall Semester 2012</u>	<u>Clinical Practicum II:</u>	Advanced Beginner
<u>Spring Semester 2013</u>	<u>Clinical Practicum III:</u>	Competent
<u>Summer Semester 2013</u>	<u>Clinical Practicum IV:</u>	Proficient
<u>Fall Semester 2013</u>	<u>Clinical Practicum V</u>	Novice Practitioner

Criteria for Clinical Practicum Promotion:

1. Acceptable clinical performance determined by clinical faculty evaluations, clinical instructor verbal and written feedback and attainment of clinical practicum objectives.
2. Completion of required clinical hours.
3. Submission of all clinical documentation by stated deadlines.

Program faculty are responsible for reviewing the student's clinical performance each month. If there are areas of concern noted, they must inform the student in writing of these concerns.

Clinical Probation:

A student can be placed on clinical probation or dismissed for:

1. Unacceptable conduct which is incongruent with the *Rules of Conduct while on Affiliation at Clinical Sites*.
2. Receiving an unfavorable evaluation documenting poor performance, failure to progress, and/or inability to meet the clinical practicum objectives as assessed by the program faculty.
3. Behavior, performance or judgment that jeopardizes patient safety.
4. Inability to display continual mastery of previously mastered clinical skills.
5. Failure to comply with submission of all required documents in accordance with the required deadlines for submission. (i.e. clinical evaluations, postoperative survey forms, professional licensure documentation).

As noted earlier, to be successful, students are expected to meet clinical practicum objectives. If student performance indicates, "needs improvement" in the first two months of a practicum course, this

will be monitored by the program faculty and communicated with the student and clinical faculty. It will be expected that the student obtain “acceptable” performance throughout the last month of the course. If the student fails to do so, program faculty may place them on probation. In addition, a clinical probation may be instituted at any time during a clinical course if a student exhibits unsafe or “unacceptable” clinical practice, or fails to submit the required evaluations or program required documentation of professional licensure.

Clinical probation entails a 30-day period. During this time program faculty will re-evaluate the student’s status. Students will communicate with program faculty and clinical faculty to develop a remediation plan based on their clinical evaluations, clinical faculty feedback and/or program faculty findings. The plan will include strategies for improvement of clinical performance. After the 30-day probation period, the student will be re-evaluated by the program faculty to determine if clinical objectives have been met. If they are successful, they will resume their clinical practicum at the same level of their peers. Failure to meet clinical objectives at that level will result in dismissal.

Students who have successfully met objectives of a clinical probation period and encounter subsequent performance issues may either be placed on a second 30-day probation period or dismissed from the program, as determined by the SDC and program faculty. If placed on probation, the process described would apply. The limit for all students is (2) probationary periods. If performance issues continue to occur after a student has successfully completed (2) probationary periods, the student would be immediately dismissed.

The clinical site for the probation period will be delineated by program faculty. Students will not be allowed to take PTO (except for sick time) during this period. All sick time off will be made up by adding it to the end of the probationary period.

STUDENT DEVELOPMENT COMMITTEE

Purpose:

The Student Development Committee is responsible for reviewing all student issues identified by the program director, faculty or students. This includes academic, behavioral and clinical issues.

Student Progression:

In addition to course grades and clinical or field evaluations, student progression is monitored through three processes: regular instructor evaluation of assignments and performance; a programmatic level review through regularly scheduled Comprehensive Student Reviews; and through Student Development Committee (SDC) Reviews as needed. Comprehensive reviews are the responsibility of the full faculty of each program. Each program also has a Student Development Committee (SDC), comprised of a minimum of three faculty members. Program Directors cannot serve on the SDC, but membership can include faculty from other college programs. The primary function of the SDC is to conduct reviews of student performance in order to assess whether a student can progress in a program, make a determination of student status, and to make recommendations for action when a student has failed to maintain academic and professional standards, whether in class, clinical setting, or community.

A. EVALUATION OF ASSIGNMENTS AND PERFORMANCE

The most sensitive and detailed assessment of student progress is that conducted on an everyday basis through the evaluation of assignments and student performance of classroom and clinical performance. To enhance success, performance concerns should be addressed with the student by the instructor as soon as they arise and not held for mid-term reviews, or end-of term grades. This may also lead to involvement of the student’s advisor and/or the Student Development Committee as determined by the faculty member. (See II. D. for grade standards, and III. B.3.a.& b. for process)

B. COMPREHENSIVE STUDENT REVIEW:

At a pre-determined time or times in each semester, (but no later than mid-semester,) the faculty of each program will conduct a comprehensive review of student performance. Students' standing will be noted as follows:

1. Good Academic Standing: Students who meet the minimum standards and requirements set by the program and UNE. Students in good standing may continue to progress without restriction toward graduation.
2. Probationary Standing: Students who remain on probation as a result of a prior SDC Review. Progress or concerns should be noted and discussed as needed at this time.
3. New Concern(s) Identified: Any concerns newly identified by the Comprehensive Student Review may be referred for Advising or to the SDC for resolution.
 - a. Referral for Advising: When initial or minor concerns are first noted by a faculty member *at or prior* to the Comprehensive Student Review, the relevant faculty member(s) will notify the student and the student's academic and/or field/clinical advisors as appropriate to review the circumstances in person with the student. The content and action steps determined at any such meeting will be documented and shared with the student in writing within two business days.
 - b. Referral to Student Development Committee: If a resolution cannot be reached at the level of the Advisor or the concerns are substantial in nature, the matter is referred to the SDC for a formal Review. Significant concerns may include academic performance (e.g. falling below a 3.0 GPA for semester or cumulative, C- or below in course, or "Fail" in a pass/fail course) or professional conduct. (See below.)

C. STUDENT DEVELOPMENT COMMITTEE REVIEW

SDC reviews are intended to support students' academic progression, and are required in cases where a student is failing to maintain academic standards in the classroom or field, is accused of engaging in professionally inappropriate behavior, or is accused of violating academic integrity. An SDC review can be recommended by an advisor or other faculty member, Program Director, or the faculty as a whole as an outcome of the Comprehensive Student Review. In the event of an alleged breach of ethical conduct, any aggrieved or responsible party may request that an SDC Review be conducted. Through the review process, the Student Development Committee is responsible for examining the concerns cited, evaluating their merits, determining student status, and recommending a course of action.

1. Responsibilities of the Committee Chair:

The SDC Chair is responsible for notifying all involved parties including the student when a formal SDC Review is required and the rationale for it. When the rationale includes clinical or fieldwork concerns, every effort will be made to include the relevant parties from the clinical or fieldwork site in the meeting either in person, conference call or videoconference.

2. Responsibilities of the Committee:

The SDC is responsible for:

- a) gathering all pertinent information relevant to the stated concerns from all relevant parties, including the identified student, faculty, advisors, preceptors or field instructors. The process is outlined in the standard SDC Review Form (INSERT link here.)
- b) Determination of Student Status:
 - i) Probation: Probationary status allows a student to continue under certain specific criteria as determined by the SDC at a formal review. Students placed on probation will receive a letter from the

PD outlining the conditions of probation and the steps required to return to good standing. Barring any exceptional circumstances, students who do not return to good standing within the specified time frame will be dismissed from the program.

- ii) Return to good standing: Once a student has successfully completed the criteria specified in the SDC Review to the satisfaction of the SDC, the Committee will inform the PD who will send a letter to the student indicating return to good standing.
- iii) Dismissal: Students may be dismissed for a variety of reasons, including but not limited to (1) unacceptable academic performance; (2) failure to remove probation status; or (3) a conduct violation.
- c) Recommending Actions steps:
The SDC will develop and recommend a plan of action to be taken to achieve stated outcomes, including the identification of responsible parties and expected dates of actions. This may include helping a student achieve educational objectives (e.g., remediation, use of the learning assistance center); employing alternate pathways to achieve educational objectives (e.g. extending field work hours beyond normal expectations, retaking a course); or specifying other terms for a student to remain in the program. The plan of action also describes the consequences for success (e.g. removal of probationary status) or failure to comply with or achieve the stated goals (e.g., probation, dismissal, or other.)
- d) Timetable: The SDC decision re student status and recommended action steps are made within two (2) business days following the meeting(s) and communicated to the program director in writing. The PD reviews the report and seeks clarification if needed. The PD then communicates the action steps to the student in writing within five (5) business days.
- e) Scheduling: To insure the greatest chance for a successful outcome, educational and conduct concerns should be identified as early as possible, and the SDC Review process initiated promptly. Except in rare exceptions, this means a minimum of 2 weeks prior to the end of the current semester or term.

3. Responsibilities of the Student:

The student is responsible for participating in the SDC Review process. This includes providing information as requested and playing an active role in the development of the action steps.

4. Responsibilities of the Program Director:

The PD has a unique role as a member of the faculty while also providing administrative oversight for all program functions. In the case of SDC Reviews, the PD will review the determination of status by the SDC to ensure that policies have been followed and procedures implemented. In the case that the PD believes that there are any potential concerns about the process, such as procedural irregularities or additional information that should be considered, the PD will communicate these concerns to the SDC for reconsideration. The SDCs recommended action steps will be reviewed by the PD for logistical viability (faculty workload, support services, etc.). The PD will then either approve the plan as is or recommend modifications to the SDC. Following this step, the SDCs determination of status and recommended action steps will again be forwarded to the PD, who then communicates the outcome to the student.

5. Responsibilities of the Associate Dean(s):

The Associate Dean(s) serves as a consultant to the SDC and PD re policies and procedures on an as needed basis.

6. Student Appeals:

A student has the right to appeal to the Dean decisions affecting progression following the process outlined in the [UNE Student Handbook](#).

C. ADDITIONAL PROCEDURES:

1. Leave of Absence (LOA). An LOA can be recommended by the Student Development Committee or be initiated as a student request. Students who desire to request a leave of absence are encouraged to begin the process with a discussion with their Academic Advisor. If a decision is made to proceed, a petition is completed by the student, signed by the Advisor, and submitted to the PD, who has final approval. Leaves of absence can be requested for academic, medical or other personal reasons, and are ordinarily granted for a period not to exceed one year. The petition form is available at: <http://www.une.edu/registrar/upload/leaveabsence.pdf>.

5. Withdrawal: Students wishing to withdraw for any circumstance must complete the required [University Withdrawal Form](#). Official withdrawal also requires approval by the PD.

IV. Appeals, Grievances, and Complaints Other Than Academic Progression

Occasionally, a student may have a grievance regarding another issue. A student grievance with a faculty member should be addressed first directly with the faculty member. If a student is not satisfied following this step, the student may request a review by contacting the PD. The director has the discretion to address the concern directly, or to form a grievance committee. Questions about procedural options should be directed to the PD.

Grievances or complaints about other aspects of the program may be brought to a faculty member or the PD by an individual student or through student class representatives. If this does not successfully resolve the concern, a single student or a group of students may bring their complaint or grievance to the College Dean or other relevant administrative unit as per the guidelines in the UNE Student Handbook.

Structure:

The Committee will consist of at least three faculty members, one of whom will either be from outside the MSNA Program faculty, or be clinical faculty in the case of clinical issues. The MSNA Program Director will appoint the chair. A quorum of at least three (3) members must be present (includes speaker phone presence) at a meeting before the Committee can make any recommendations.

The Committee will meet as necessary to investigate academic, clinical, or behavioral issues. The Student Development Committee may be convened at the request of any MSNA Program faculty member, clinical faculty or student. It will review student records and may interview students, staff, faculty members and clinical instructors.

A majority vote of the Committee members present is necessary to recommend disciplinary sanctions for a student. In this case, the Committee will prepare a detailed recommendation, including a course of action and/or a plan of improvement, and send it to the Program Director, who will make a final decision. Decisions of the Program Director will be sent to the student in writing.

Since decisions are not based entirely on academic or clinical grades, the Committee will consider relevant information from faculty, staff and clinical instructors, as well as prior academic performance, attendance, professional conduct and extenuating circumstances.

Committee Outcomes:

Failure in maintaining passing grades in didactic courses, clinical practicum, meeting clinical objectives, or adhering to the accepted Standards of Conduct may result in a disciplinary sanction.

Under these circumstances, the Committee will make a recommendation to the Program Director. The Program Director may:

1. Issue a letter of concern or reprimand
2. Impose a Probation Status
3. Dismiss a student from the Program

Appeals:

Decisions made by the Nurse Anesthesia Program, which a student believes to be unfair, may be appealed to the Dean of the College of Health Professions. To do so, the student should follow the review process set forth in the *University of New England Student Handbook*.

Clinical Evaluation Tools

Evaluation tools have been created and are utilized by both clinical faculty and students. The following evaluation tools will be employed (**see Appendix for tools**):

1. Clinical Practicum Daily Evaluation

Students are expected to have both the evaluation rubric for the current practicum course and a subsequent evaluation sheet with them **EVERY** day of clinical, so that they are available for clinical faculty to complete if they would like to offer feedback for the day. Failure to have these tools available could result in an “unacceptable” for the day. Students should provide their clinical instructor with an evaluation form at the beginning of the day so that clinical instructors can provide comments throughout the day. Failure to submit copies of (10) clinical evaluations to the school each month can result in clinical probation.

2. Clinical Practicum Summation Evaluation:

Students will periodically be evaluated by a summative format completed by the clinical coordinator, the clinical director or clinical faculty. This will be utilized as each student completes either a clinical practicum or an enrichment rotation.

3. Student Evaluation of Clinical Instructors:

Students are asked to complete evaluations on clinical instructors at each clinical rotation site. These forms will be collected, comments compiled and shared formally with the site.

4. Student Evaluation of Clinical Site:

Students have the opportunity to evaluate all of their clinical rotations sites. Forms are collected, comments compiled and shared formally with the site.

5. Clinical Faculty Self-Evaluations:

Clinical faculty will evaluate themselves annually. They will do so via standardized forms provided by the School. These forms will be collected, comments compiled and shared formally with the site.

6. Student Self-Evaluation:

Students will evaluate themselves ten (10) times per month per the *Clinical Practicum Evaluation* tool.

Clinical Objectives

Clinical objectives are designed to begin with basic knowledge and technical skills in the clinical arena. They are divided into practicum courses with each courses set of objectives building on the previous set. There is a gradual progression in skill and competency expectations throughout progressive practicum courses.

Developmental Level - Novice

Practicum I: May through August

At the completion of Practicum I in the clinical arena, the student will be able to perform the following skills related to the associated key area:

- A. Room Preparation:
 - 1. Check all equipment prior to use, including anesthesia machine, all monitors, airway equipment, and suction device.
 - 2. Have routine equipment readily available, including routine and emergency medications, IV set-up, back-up Ambu, warming devices, and any equipment pertinent to specific case.
- B. Pre Anesthesia Assessment:
 - 1. Identify patient, surgical procedure and confirm surgical and anesthesia consent forms validated.
 - 2. Establish rapport with the patient, including identifying oneself as a registered nurse training in anesthesia.
 - 3. Review the chart and identify pertinent information, including height, weight, NPO status, allergies, current medications (along with those taken the morning of surgery), co-morbidities, previous surgical history, airway assessment, pertinent lab values/diagnostic tests/availability of blood, and any complications related to anesthesia in the past
 - 4. Perform interview and assess airway, lungs, heart, assign ASA classification with guidance, and document findings.
- C. Anesthesia Plan:
 - 1. Research information that is pertinent to the case.
 - 2. Formulate a written care plan on each patient which takes into consideration the following: patient, pathophysiology, pharmacology, physical exam, procedure, positioning, pain and postoperative considerations.
 - 3. Discuss care plan with clinical faculty.
 - 4. Adapt to changes in the care plan.
- D. Intraoperative Case Management:
 - 1. Prepare the patient for general, regional or MAC anesthesia with assistance (please refer to E, F, and G for specific competencies).
 - 2. Ensure appropriate positioning and safety of the patient with guidance.
 - 3. Chart accurately and legibly with guidance.
 - 4. Interpret monitor values with guidance.
 - 5. Manage fluids appropriately with guidance.
 - 6. Provide adequate levels of anesthesia with guidance.
 - 7. Recognize problems/changes and seek help.
- E. General Anesthesia:
 - 1. Recognize status of airway and be able to manage it with guidance.
 - 2. Follow steps for induction of general anesthesia with guidance.
 - 3. Determine appropriate sequence of emergence from general anesthesia and timing with guidance.
- F. Regional Anesthesia:
 - 1. Recognize the indications for regional anesthesia.
 - 2. Demonstrate a basic knowledge of anatomy and physiology.
 - 3. Assess adequacy and level of regional blockade and manage side-effects with guidance.

- G. MAC:
1. Assure appropriate level of sedation.
 2. Recognize signs of airway obstruction, and intervene appropriately.
- H. Postoperative Management:
1. Transport patient to PACU with appropriate monitors and oxygen source (as needed) with assistance.
 2. Provide an accurate/complete report to PACU with minimal assistance.
 3. Assess patient level of pain and assure stability prior to transfer of care with guidance.
 4. Perform post-anesthesia assessment with guidance.
- I. Technical Skills:
1. Start IV's.
 2. Insert A-lines with assistance.
 3. Demonstrate proper operation of OR table.
 4. Intubate with guidance.
 5. Apply mask/airway and insert LMA with guidance and
 6. Demonstrate hand-bag-mask ventilation with guidance.
 7. Demonstrate proper use of support equipment such as infusion pumps, warming devices, and peripheral nerve stimulators with guidance.
- J. Cognitive Skills:
1. Demonstrate and/or articulate a basic knowledge base in relation to: anatomy and physiology, pharmacology, anesthesia techniques, surgical procedures.
 2. Integrate theory into clinical practice.
 3. Establish priorities and respond appropriately.
- K. Professional Attributes:
1. Demonstrate initiative by utilizing the learning environment (for example: researching information, seeking out additional learning opportunities).
 2. Interact well with all members of the anesthesia, surgical and nursing team.
 3. Render care in a caring and unbiased manner.
 4. Adhere to clinical responsibilities such as reporting to clinical prepared and in a timely manner and completes assignments as deemed appropriate.
 5. Accept constructive criticism when offered.
 6. Perform routine self-evaluation, identifying strengths and areas for improvement.

Prior to advancement the student must meet established basic clinical competencies based on evaluation by the clinical coordinator at the students' clinical site.

Developmental Level – Advanced Beginner

Clinical Practicum II- September through December

At the completion of two practicum course levels, the student will be able to perform the following skills related to the associated key area:

- A. Room Preparation:
1. Check all equipment prior to use, including anesthesia machine, all monitors, airway equipment, and suction device.
 2. Have routine, emergency, and case specific equipment and

medications set-up/readily available as well as IV set-up, back-up Ambu, and warming devices.

B. Pre Anesthesia Assessment:

1. Identify patient, surgical procedure and confirm surgical and anesthesia consent forms validated.
2. Establish rapport with the patient, including identifying oneself as a registered nurse training in anesthesia.
3. Respond to patient's questions appropriately.
4. Review the chart and identify pertinent information, including height, weight, NPO status, allergies, current medications (along with those taken the morning of surgery), co-morbidities, previous surgical history, airway assessment, pertinent lab values/diagnostic tests/availability of blood, and any complications related to anesthesia in the past
5. Perform interview, assess physical status to include airway, lungs, and heart, assign ASA classification and document findings.

C. Anesthesia Plan:

1. Research information that is pertinent to the case.
2. Formulate a written care plan on each patient which takes into consideration the following: patient, pathophysiology, pharmacology, physical exam, procedure, positioning, pain and postoperative considerations.
3. Discuss care plan with clinical faculty.
4. Discuss care plan with clinical faculty.
5. Adapt readily to changes in the care plan.

D. Intraoperative Case Management:

1. Prepare the patient for general, regional or MAC anesthesia. (please refer to E, F, and G for specific competencies).
2. Ensure appropriate positioning and safety of the patient with minimal guidance.
3. Chart accurately and legibly.
4. Interpret monitor values with guidance.
5. Manage fluids appropriately with guidance.
6. Provide adequate levels of anesthesia with guidance.
7. Recognize and manage problems/changes with guidance.

E. General Anesthesia:

1. Recognize status of airway and be able to manage it with minimal guidance.
2. Follow steps for induction of general anesthesia with minimal guidance.
3. Determine appropriate sequence of emergence from general anesthesia and timing with guidance.

F. Regional Anesthesia:

1. Recognize the indications for regional anesthesia.
2. Demonstrate a basic knowledge of anatomy and physiology.
3. Administer regional anesthesia with guidance.
4. Assess adequacy and level of regional blockade and manage side-effects with guidance.

G. MAC:

1. Assure appropriate level of sedation.

2. Recognize signs of airway obstruction, and intervene appropriately.
- H. Postoperative Management:
1. Transport patient to PACU with appropriate monitors and oxygen source (as needed).
 2. Provide an accurate/complete report to PACU RN.
 3. Assess patient level of pain and assure stability prior to transfer of care.
 4. Recognize post-operative complications.
 5. Perform post-anesthesia evaluation and consults with clinical faculty when necessary.
- I. Technical Skills:
1. Start IV's.
 2. Insert A-lines with minimal guidance.
 3. Demonstrate proper operation of OR table.
 4. Intubate with minimal guidance.
 5. Apply mask/airway and insert LMA use with minimal guidance.
 6. Demonstrate hand-bag-mask ventilation with minimal guidance
 7. Demonstrate proper use of support equipment such as infusion pumps,
 8. warming devices, and peripheral nerve stimulators with minimal guidance.
- J. Cognitive Skills:
1. Demonstrate and/or articulate an appropriate knowledge base in relation to: anatomy, physiology, pharmacology, anesthesia techniques, and surgical procedures.
 2. Integrate theory into clinical practice.
 3. Establish priorities and respond appropriately.
- K. Professional Attributes:
1. Demonstrate initiative by utilizing the learning environment (for example: researching information, seeking out additional learning opportunities).
 2. Interact well with members of the anesthesia, surgical and nursing team.
 3. Render care in a caring and unbiased manner.
 4. Adhere to clinical responsibilities such as reporting to clinical prepared and in a timely manner and completes assignments as deemed appropriate.
 5. Accept constructive criticism when offered.
 6. Perform routine self-evaluation, identifying strengths and areas for improvement.

Developmental Level – Competent

Clinical Practicum III- January through May

At the completion of the third clinical practicum, the student will be able to perform the following skills related to the associated key area:

- A. Room Preparation:
1. Check all equipment prior to use, including anesthesia machine, all monitors, airway equipment, suction device and be familiar with pediatric breathing circuits.
 2. Have routine, emergency, and case specific equipment available (to include Pediatrics and Obstetrics) Ambu, and warming devices.
- B. Pre Anesthesia Assessment:
1. Identify patient, surgical procedure and confirm surgical and anesthesia consent forms validated.
 2. Establish rapport with the patient, including identifying oneself as a registered nurse training in anesthesia.

3. Respond to patient's questions appropriately.
 4. Review the chart and identify pertinent information, including height, weight, NPO status, allergies, current medications (along with those taken the morning of surgery), co-morbidities, previous surgical history, airway assessment, pertinent lab values/diagnostic tests/availability of blood, and any complications related to anesthesia in the past.
 5. Perform interview, assess physical status to include airway, lungs, and heart, assign ASA classification and document findings.
- C. Anesthesia Plan:
1. Research information that is pertinent to the case.
 2. Formulate a written care plan on each patient which takes into consideration the following: patient, pathophysiology, pharmacology, physical exam, procedure, positioning, pain and postoperative considerations.
 3. Discuss care plan with clinical faculty.
 4. Discuss care plan with clinical faculty.
 5. Adapt readily to changes in the care plan.
- D. Intraoperative Case Management:
1. Prepare the patient for general, regional or MAC anesthesia to include pediatric and obstetric patients. (please refer to E, F, and G for specific competencies).
 2. Ensure appropriate positioning and safety of the patient.
 3. Chart accurately and legibly.
 4. Interpret monitor values with minimal guidance.
 5. Manage fluids appropriately with minimal guidance.
 6. Provide adequate levels of anesthesia with minimal guidance.
 7. Recognize problems/changes in patient status.
 8. Manage problems/changes in patient status with minimal guidance.
- E. General Anesthesia:
1. Recognize status of airway and be able to manage the difficult airway with guidance.
 2. Follow steps for induction of general anesthesia.
 3. Determine appropriate sequence of emergence from general anesthesia and timing with minimal guidance.
- F. Regional Anesthesia:
1. Recognize the indications for regional anesthesia.
 2. Demonstrate knowledge of anatomy and physiology.
 3. Administer regional anesthesia with minimal guidance.
 4. Assess adequacy and level of regional blockade and manage side-effects with minimal guidance.
- G. MAC:
1. Assure appropriate level of sedation.
 2. Recognize signs of airway obstruction, and intervene appropriately.
- H. Postoperative Management:
1. Transport patient to PACU with appropriate monitors and oxygen source (as needed).
 2. Provide an accurate/complete report to PACU RN.
 3. Assess patient level of pain and assure stability prior to transfer of care.
 4. Manage post-operative complications with guidance.
 5. Perform post-anesthesia assessment and report relevant findings appropriately.
 6. appropriately.

- I. Technical Skills:
 - 1. Demonstrate proficiency in IV placement and insertion of arterial lines
 - 2. Inserts central venous lines with guidance.
 - 3. Demonstrate proper operation of OR table.
 - 4. Demonstrate proficiency in endotracheal intubation and LMA insertion.
 - 5. Demonstrate hand-bag-mask ventilation.
 - 6. Demonstrate basic skills using alternative airway devices (i.e. fiberoptics, light wand, fast-track LMA)
 - 7. Demonstrate proper use of support equipment such as infusion pumps, warming devices, and peripheral nerve stimulators.
- J. Cognitive Skills:
 - 1. Demonstrate and/or articulate an appropriate knowledge base in relation to: anatomy, physiology, pharmacology, anesthesia techniques, and surgical procedures.
 - 2. Integrate theory into clinical practice.
 - 3. Establish priorities and respond appropriately.
- K. Professional Attributes:
 - 1. Demonstrate initiative by utilizing the learning environment (for example: researching information, seeking out additional learning opportunities).
 - 2. Interact well with members of the anesthesia, surgical and nursing team.
 - 3. Render care in a caring and unbiased manner.
 - 4. Adhere to clinical responsibilities such as reporting to clinical prepared and in a timely manner and completes assignments as deemed appropriate.
 - 5. Accept constructive criticism when offered.
 - 6. Perform routine self-evaluation, identifying strengths and areas for improvement.
 - 7. Demonstrate involvement in both departmental CQI process and educational conferences.

Developmental Level – Proficient

Practicum IV – June through August

At the completion of the Practicum IV course of study, the student will be able to perform the following skills related to the associated key area:

- A. Room Preparation:
 - 1. Check all equipment prior to use, including anesthesia machine, all monitors, airway equipment, suction device and pediatric breathing circuits.
 - 2. Demonstrate organizational skills with set-up
 - 3. Have routine, emergency, and case specific equipment available (to include Pediatrics and Obstetrics) Ambu, and warming devices.
- B. Pre Anesthesia Assessment:
 - 1. Identify patient, surgical procedure and confirm surgical and anesthesia consent forms validated.
 - 2. Establish rapport with the patient, including identifying oneself as a registered nurse training in anesthesia.
 - 3. Respond to patient's questions appropriately.

4. Review the chart and identify pertinent information, including height, weight, NPO status, allergies, current medications (along with those taken the morning of surgery), co-morbidities, previous surgical history, airway assessment, pertinent lab values/diagnostic tests/availability of blood, and any complications related to anesthesia in the past.
 5. Perform interview, assess physical status to include airway, lungs, and heart assign ASA classification and document findings.
- C. Anesthesia Plan:
1. Research information that is pertinent to the case.
 2. Formulate a written care plan on each patient which takes into consideration the following: patient, pathophysiology, pharmacology, physical exam, procedure, positioning, pain and postoperative considerations.
 3. Discuss care plan with clinical faculty.
 4. Adapt readily to changes in the care plan.
- D. Intraoperative Case Management:
1. Prepare the patient for general, regional or MAC anesthesia to include pediatric and obstetric patients. (please refer to E,F, and G for specific competencies).
 2. Utilize a variety of anesthetic agents and techniques to include one lung anesthesia (OLA).
 3. Ensure appropriate positioning and safety of the patient.
 4. Chart accurately and legibly.
 5. Interpret monitor values and make appropriate judgments.
 6. Manage fluids appropriately.
 7. Provide adequate levels of anesthesia.
 8. Recognize problems/changes in patient status.
 9. Manage problems/changes in patient status.
 10. Display aptitude in case turn-over time
- E. General Anesthesia:
1. Recognize status of airway and be able to manage the difficult airway with minimal guidance.
 2. Follow steps for induction as required for patient/case. (i.e. OLA, Trauma etc.)
 3. Determine appropriate sequence of emergence.
- F. Regional Anesthesia:
1. Recognize the indications for regional anesthesia.
 2. Demonstrate knowledge of anatomy and physiology.
 3. Administer regional anesthesia.
 4. Assess adequacy and level of regional blockade and manage side-effects.
- G. MAC:
1. Assure appropriate level of sedation.
 2. Recognize signs of airway obstruction, and intervene appropriately.
- H. Postoperative Management:
1. Transport patient to PACU with appropriate monitors and oxygen source (as needed).
 2. Provide an accurate/complete report to PACU RN.
 3. Assess patient level of pain and assure stability prior to transfer of care.
 4. Manage post-operative complications with minimal guidance.
 5. Perform post-anesthesia assessment and report relevant findings appropriately.

- I. Technical Skills:
 - 1. Demonstrate proficiency in IV and arterial line placement.
 - 2. Insert central venous lines with guidance.
 - 3. Demonstrate proper operation of OR table.
 - 4. Demonstrate proficiency in endotracheal intubation and LMA insertion.
 - 5. Demonstrate basic skills using alternative airway devices (i.e. fiberoptics, light wand, fast-track LMA).
 - 6. Demonstrate proficiency in hand-bag-mask ventilation
 - 7. Place double-lumen endobronchial tube and verify proper positioning with guidance.
 - 8. Demonstrate proper use of support equipment such as infusion pumps, warming devices, and peripheral nerve stimulators.
- J. Cognitive Skills:
 - 1. Demonstrate and/or articulate an appropriate knowledge base in relation to: anatomy, physiology, pharmacology, anesthesia techniques, and surgical procedures.
 - 2. Integrate theory into clinical practice.
 - 3. Establish priorities and respond appropriately.
- K. Professional Attributes:
 - 1. Demonstrate initiative by utilizing the learning environment (for example: researching information, seeking out additional learning opportunities).
 - 2. Interact well with members of the anesthesia, surgical and nursing team.
 - 3. Render care in a caring and unbiased manner.
 - 4. Adhere to clinical responsibilities such as reporting to clinical prepared and in a timely manner and completes assignments as deemed appropriate.
 - 5. Accept constructive criticism when offered.
 - 6. Perform routine self-evaluation, identifying strengths and areas for improvement.
 - 7. Demonstrate involvement in both departmental CQI process and educational conferences.

Developmental Level – Novice Practitioner

Clinical Practicum V – September through November

At the completion of the clinical practicum V course of study, the student will be able to perform the following skills related to the associated key area:

- A. Room Preparation:
 - 1. Check all equipment prior to use, including anesthesia machine, all monitors, airway equipment, suction device and be familiar with pediatric, obstetric, trauma emergency and off-site set up.
 - 2. Demonstrate organizational skills with set-up
- B. Pre Anesthesia Assessment:
 - 1. Identify patient, surgical procedure and confirm surgical and anesthesia consent forms validated.
 - 2. Establish rapport with the patient, including identifying oneself as a registered nurse training in anesthesia.
 - 3. Respond to patient's questions appropriately.
 - 4. Review the chart and identify pertinent information, including height, weight, NPO status, allergies, current medications (along with those taken the morning of surgery), co-

morbidities, previous surgical history, airway assessment, pertinent lab values/diagnostic tests/availability of blood, and any complications related to anesthesia in the past.

5. Perform interview, assess physical status to include airway, lungs, and heart, assign ASA classification and document findings.

C. Anesthesia Plan:

1. Research information that is pertinent to the case.
2. Formulate a written care plan on each patient which takes into consideration the following: patient, pathophysiology, pharmacology, physical exam, procedure, positioning, pain and postoperative considerations.
3. Discuss care plan with clinical faculty.
4. Adapt readily to changes in the care plan.

D. Intraoperative Case Management:

1. Prepare the patient for general, regional or MAC anesthesia to include pediatric and obstetric patients. (please refer to E,F, and G for specific competencies).
2. Utilize a variety of anesthetic agents and techniques to include one lung anesthesia (OLA).
3. Ensure appropriate positioning and safety of the patient.
4. Chart accurately and legibly.
5. Interpret monitor values and make appropriate judgments.
6. Manage fluids appropriately.
7. Provide adequate levels of anesthesia.
8. Recognize problems/changes in patient status.
9. Manage problems/changes in patient status.
10. Display aptitude in case turn-over time.

E. General Anesthesia:

1. Recognize status of airway, be able to manage the difficult airway, and recognizes own limitations.
2. Follow steps for induction as required for patient/case. (i.e. one lung anesthesia, trauma etc)
3. Determine appropriate sequence of emergence.

F. Regional Anesthesia:

1. Recognize the indications for regional anesthesia.
2. Demonstrate knowledge of anatomy and physiology.
3. Administer regional anesthesia
4. Assess adequacy and level of regional blockade and manage side effects.

G. MAC:

1. Assure appropriate level of sedation.
2. Recognize signs of airway obstruction, and intervene appropriately.

H. Postoperative Management:

1. Transport patient to PACU with appropriate monitors and oxygen source (as needed).
2. Provide an accurate/complete report to PACU RN.
3. Assess patient level of pain and assure stability prior to transfer of care.
4. Manage post-operative complications.
5. Perform post-anesthesia assessment, report relevant findings appropriately, and ensure referrals are initiated.

I. Technical Skills:

1. Demonstrate proficiency in IV and arterial line placement.
2. Insert central venous lines with guidance.
3. Demonstrate proper operation of OR table.
4. Demonstrate proficiency in endotracheal intubation and LMA insertion.
5. Demonstrate skills using alternative airway devices (i.e. fiberoptics, light wand, fast-track LMA), with guidance.
6. Demonstrate proficiency in hand-bag-mask ventilation
7. Place double-lumen endobronchial tube and verify proper positioning with minimal guidance.
8. Demonstrate proper use of all support equipment.

J. Cognitive Skills:

1. Demonstrate and/or articulate an appropriate knowledge base in relation to: anatomy, physiology, pharmacology, anesthesia techniques, and surgical procedures.

K. Professional Attributes:

1. Maintain high motivation level and continue to utilize the learning environment as student progresses to the graduate level.
2. Interact well with members of the anesthesia, surgical and nursing team.
3. Render care in a caring and unbiased manner.
4. Adhere to clinical responsibilities such as reporting to clinical prepared and in a timely manner and completes assignments as deemed appropriate.
5. Accept constructive criticism when offered.
6. Perform routine self-evaluation, identifying strengths and areas for improvement.
7. Demonstrate involvement in both departmental CQI process and educational conferences.
8. Respond to call situations with urgency and preparedness.

Cases: _____

1= unacceptable performance; 2= has not met expectations, requires improvement; 3= meets expectations; 4= exceeds expectations

CLINICAL SKILL	STUDENT SELF-EVAL	SCORE	INSTRUCTOR COMMENT	SCORE
Room Preparation -machine check,safety equipment, case specific drugs prepared as required				
Preanesthesia Assessment - chart review complete, patient assessment, identification of risk factors, patient rapport, documentation complete, airway assessment, asa assignment				
Care Plan Development - case research completed, careplan complete and case appropriate, appropriate communication with instructor prior to case				
Intraoperative Case management - safety considerations, positioning, documentation, interpretation of monitoring, fluid management, problem recognition, problem management, seeks assistance when appropriate.				
General anesthesia - appropriate management of all aspects of anesthesia, recognition of airway status, airway management, competent induction sequence, appropriate level of anesthesia, competent management of emergence				
Regional anesthesia - knowledge of indications and contraindications for chosen anesthetic, knowledge of anatomy and physiology in relation to chosen anesthetic, assessment of adequacy/level of anesthetic, recognition and management of side effects/complications of the block.				
Mac or deep sedation - assures assessment of level and adequacy of anesthetic, appropriate assessment and airway management				
Post anesthesia management -safe transportation and hand off to recovery area with complete and accurate report, assessment and management of consciousness,pain, stability, surgical complications or requirements. Post op evaluation/assessment and seeks appropriate care/consultation.				
Technical Skill Development - IV, invasive monitoring, airway management to include mask, airway devices, LMA and intubation skills, manual ventilation and ventilator utilization, infusion devices, nerve stimulators and related anesthesia monitors and equipment.				
Knowledge Base and Cognitive Skill - Has researched coexisting disease states, and can articulate knowledge in relation to anatomy, physiology, pharmacology, anesthesia technique and surgical procedure				
Critical Thinking -the student is able to apply evidence, knowledge and judgement in decisions applicable to safe and effective conduct of anesthesia. The student demonstrates appropriate theory transference to clinical care.				
Professional attributes - seeks out learning opportunities. Team interaction, Exhibits cultural competence. Accepts constructive criticism .Reports to clinical prepared and on time. Communicates with clinical faculty and school appropriately. Performs adequate self evaluation and is able to identify strengths, weaknesses, and areas for improvement. Participates in clinical correlation activities.				

Student Signature _____ Date: _____

Instructor Signature _____ Date: _____

UNE - SCHOOL OF NURSE ANESTHESIA

SRNA Post-Operative Patient Evaluation Tool

Date: _____

Student Name: _____

Clinical Instructor Name: _____

Procedure: _____

Type of Anesthesia: _____

Was the anesthetic explained to you sufficiently before your surgery?

Did we help ease your anxiety before your surgery? How?

Do you remember anything unpleasant about your procedure?

What is the last thing you remember?

How has your pain been post-operatively on a scale of 1 to 10 (1=NO pain; 10 = severe pain)

If you have a regional anesthetic for post-operative pain control, has it been managed effectively?

Are you having any side effects from your pain management?

Have you had any post-operative nausea or vomiting?

- * If yes, when did you experience this?**
- * If yes, what treatment did you receive for it?**
- * Did the treatment help?**

Could we have done anything differently to improve the anesthesia experience for you?

APPENDIX

THE 10 P'S OF ANESTHESIA CARE PLANNING

D. Thomas Albee Jr., CRNA, MHS

Clinical Coordinator

Central Maine Medical Center

Quality anesthesia delivery starts with an organized and thorough plan of care. Strong planning drives great anesthesia care.

The issue: How does the beginning practitioner get organized? There is so much that must be considered, pondered, filtered, included, and excluded before the final plan takes shape. There is the stress of time management coupled with information deficits that must be filled before 0700 the next morning. There are multiple patients to plan for. What about performance pressure? The fatigue factor? The fear factor? So much information, so many textbooks, formulas, and so little time.

The **10 P's of Anesthesia Care Planning** can help. It is a systematic process of collecting and evaluating all the pertinent information **before** developing the final plan.

1. **Patient**
2. **Pathophysiology**
3. **Pharmacology**
4. **Physical Exam**
5. **Procedure**
6. **Positioning**
7. **Pain**
8. **Postoperative Considerations**

These **8 P's** lead to an anesthesia care **Plan (9)** which leads to the **Performance (10)** or delivery of anesthesia care.

Planning drives anesthesia care. This **is** the critical step in the entire process. If something was not considered/planned for, then anesthesia performance/delivery will suffer. When our performance suffers bad things can and do happen to our patients.

Critical thinking along with an adequate theoretical knowledge base are the building blocks of the plan. I believe that graduate nurse anesthesia students possess both. Nurses possess critical thinking skills based on their ability to see beyond the task and are called to employ these skills continually. Anesthesia delivery is no different. We must always see the bigger picture and how it interrelates with the patient. The pathophysiology driving the problem we are facing, the pharmacology of the anesthesia medications interacting with the patient's system, and the surgical procedure as it impacts on the homeostasis of the patient are excellent examples of the multiple levels at which the anesthetist is called to think at.

I used to think that critical thinking was very difficult to teach and even harder to assess in anesthesia students. I was wrong. One can quickly evaluate a student's critical thinking skills by simply asking which of 8 P's will impact on their patient today. What are the **anesthesia implications** of these impacts and what is **your plan** for these impacts? If you can answer these questions it is clear that you have critically considered the 8 P's, filtered out the non-factors, understood the impacts,

assimilated all the data, and planned for them.

In the beginning anesthesia care planning is a very formal process. It needs to be. The beginner is faced with new and strange knowledge and the overwhelming task of coming up with a safe anesthesia plan. The 8 P's takes the student through each of the major areas that needs to be considered **prior** to the development of the PLAN. Too often beginners **move right to the plan without** considering all the pertinent data. This is a common problem that definitely degrades performance the next day in the operating room. It is impossible to plan for things that were not even considered. Students are focused on their physical performance but you need to remember that the physical performance aspects of the training come with time. The mental process of planning care is within your scope now. You leave the didactic phase with all the tools...the challenge is accessing and assimilating the data into a comprehensive plan of action.

This is a major focus in the 1st term.....**complete anesthesia care planning**. It forces the students to systematically hit the patient record/books to research the patient, pathophysiology, pharmacology, procedure, positioning, and physical findings **prior** to establishing the plan of care. A care plan that reads "General anesthesia, 200mg propofol, 100mcg fentanyl, LMA, Sevo is not a complete plan of care. It is, of course, an important part but performance of an anesthetic mandates a much larger understanding of all issues that are colliding at the moment of induction. If you follow a systematic approach such as the 10 P's the graduate student will have a much improved view of the entire patient and his problems. More importantly, you will have a plan to deal with his issues.

These skills will serve you well as the complexity of the patients and the procedures increase. You will be better time managers; quickly dissect a complicated patient's chart; and provide better more complete anesthesia care because you have planned for it. Seasoned CRNAs know that these evaluating/planning skills are the very foundation of their professional practice.

That said I will break down the P's as I see them with suggested references.

1. PATIENT (Patient, chart both physical and electronic)

Age.

Developmental stage. (This knowledge will drive induction technique as well as the bedside approach. Developmental stage will help you predict how the patient is coping with the stress of surgery/anesthesia. All patients are stressed and it is our challenge to deal with them appropriately.)

Prior surgeries. (Is this a revision? Increased scar tissue, increased blood loss)

History of anesthesia complications.

Ht/Wt/BMI

Allergies

Family h/o MH

Past medical issues that might impact on your anesthesia care.

MRSA, VRE

2. PATHOPHYSIOLOGY (Stoelting)

Current diseases in major systems: ENT, ENDO, Pulmonary, Cardio, HEP/Renal, GI/GU, NEURO, etc.

Good control vs. poor control vs. no control. Followed by a PCP? Further consultation needed?

Further diagnostic/lab evaluation needed? Cancel or post pone an elective case?

Anesthesia implications if any which then translate to anesthesia actions. Ex. Poorly controlled hypertension but an emergency case. Consider beta blockade, arterial line monitoring, vasodilator or vasopressors adjuncts. Etomidate vs. propofol for anesthesia induction. Expect blood pressure fluctuations during all phases of the case.

3. PHARMACOLOGY (Various text books, internet resources)

Current medications. What are they, how do they work, why are they on them? What are the anesthesia implications? Any drug-drug interactions? Which ones should be continued perioperatively?

Herbal medications. Anesthesia/surgery implications.

4. PHYSICAL EXAM (Patient, physician H + P)

Complete Airway exam. (Need for special equipment? Awake vs. asleep.)

Heart and lungs.

Venous/arterial access sites.

Anatomy as it relates to planned regional techniques.

Pertinent lab values, EKG, Echo, Cath reports, CXR reports, CT/MRI reports.

Missing lab reports that are needed prior to surgery (Up to date INR on previously anticoagulated patients)

Type and screen vs. type and cross.

5. PROCEDURE (Jaffe)

Location of procedure (ENT vs Knee)

Degree of invasiveness speaks to anesthesia technique as well as severity of pain both intra and postop.

Length of procedure, degree of body exposure (hypothermia), EBL (type and cross?), possibility of postoperative mechanical ventilation.

Curative vs. palliative surgery.

Elective vs. emergency surgery.

Physiologic trespass on organ systems (one-lung case, extensive abdominal packing)

6. POSITIONING (Barash, Martin, Warner)

What type of bed (Jackson frame?)

Lithotomy, prone, lateral with kidney rest up.

Padding issues.

Impact on ventilation, circulation, ICP

Physical restrictions that the patient has (TKA, THA, Rheumatoid, Contractures, Obesity)

7. PAIN

Pre existing pain (acute bowel obstruction, fracture, trauma) (Should general anesthesia be induced prior to moving to the OR bed?)

Chronic vs. acute (narcotic tolerance vs. need for more narcotics now) (Chronic pain patient are a particular challenge often requiring a multi-modal approach.)

Pain severity of surgery (consider combined techniques or regional blocks)

Can the case be done under local? Local with sedation?

Patient's response to pain (bullet biters vs. the less tolerant)

Post operative pain plan. PCA vs. continuous epidural vs. regional blockade.

8. POSTOPERATIVE

Disposition: Outpatient vs. inpatient vs. ICU All of these patients require different approaches. The outpatient may require increased emphasis on PONV prevention, increased crystalloid, and local anesthesia for pain control. Regional vs. general anesthesia techniques in the outpatient population.

What is the probability for postoperative mechanical ventilation? Is this patient a direct admit to the ICU? A planned overnight stay in PACU? Is there an inpatient or ICU bed available?

Pain control issues. Continuous epidural vs. PCA? Is this a chronic pain patient with a narcotic tolerance issue?

9. PLAN

Now that all the data has been gathered and evaluated it is time to formulate the plan. The actual format is less important than the content. Each program dutifully supplies students with suggested formats and they are free to use it or choose one to their liking.

The “guts” of an anesthesia care plan should contain the following:

- Patient
- Procedure
- Ht/Wt/BMI
- Medications
- Allergies
- Brief Past Medical/surgical
- ROS
- Lab/diagnostic data
- Physical exam data (airway, heart and lung sounds)

Include anything else that you find helpful (diagrams, anatomy pictures, etc.) Remember, any method used to reinforce learning will be helpful and the methods used are different for each of us.

Expand as required on the procedure, positioning, pain, pharmacology, and pathophysiology. One simple method is to list and prioritize a problem, identify its anesthesia implication, and list what you plan to do about it. For example:

Issue	Anes. Implication	Action
-CO ₂ Pneumoperitoneum	Increased PaCO ₂	Increase minute ventilation

Issue	Anes. Implication	Action
-Smoker	Reactive airways	Deep anesthesia via

IV/inhalation agent before laryngoscopy; IV lidocaine or LTA lidocaine, paralysis with succinylcholine to avoid coughing. Preoperative nebulizer treatment and/or inhaler use. IV lidocaine prior to extubation or deep extubation if appropriate.

As you can see, problem identification leads to anesthesia implications, which leads to action. The previous 8 P's deliver you to this point.

Remember: Prioritized problem/issue identification, anesthesia implications, and actions are the **core** of your plan. It is the result of gathering, evaluating, and filtering all of the data about your patient and the procedure. These are the things that you believe will most impact the care of the patient. The issues that you identify cause you to plan and this planning turns into **action**.

The remainder of the anesthesia care plan also spins off directly from your data gathering, reading, problem identification. Anesthesia medications, doses, fluids, airway management equipment, etc. all depend on the problems/issues that you have identified.

It has been my experience that graduate students have the most difficulty with the problem identification, anesthesia implication, and action area of the plan. What I commonly see is a very complete section detailing medication selection, doses, fluid management, ET tube size. In fact most students have programs that do this work for them (I am reserving comment on this issue) once they input height, weight, age, and gender.

It doesn't take much thought to input data into a program and print out drug doses, fluid requirements, etc. It takes a lot of thought, **critical thought** to scratch below the surface and uncover the essence of what your individual patient requires of you in the operating room.

That is the challenge before you. To gather data, evaluate, filter, and critically process what is important to the patient undergoing surgery/anesthesia. Your patients expect this degree of planning because their life and anesthesia outcome under your care depends on it.

ANESTHESIA PLAN OF CARE

Planned Anesthetic

☐ GA ☐ MAC ☐ Regional (Type/Drugs/Doses _____)

Premeds _____

Midazolam (1-5 mg) _____mg for anxiolytic, sedative

Fentanyl (0.7-2 mcg/kg) _____mcg for analgesia/lower
anes. needs

Propofol (1.5-2.5 mg/kg) _____mg producing
unconsciousness

Etomidate (0.1-0.4 mg/kg) _____mg producing
unconsciousness

Succinylcholine (1 mg/kg) _____mg for rapid muscle
relaxation

Rocuronium (0.6-1.2 mg/kg) _____mg for muscle relaxation

Droperidol (15 mcg/kg) _____mg to treat/prevent PONV

Zofran (2-4 mg) _____mg to treat/prevent PONV

Nondepolarizer Agent _____

Reversal Agent _____

Inhalation Agent _____

Other Gases ☐ O₂ ____L ☐ N₂O ____L ☐ Air ____L

Patient Positioning _____

Notes:

Monitors & Equipment

☐ IV ☐ PA ☐ Agent Analyzer

☐ NIBP/SaO₂/EKG/RR ☐ BIS / EEG ☐ HME

☐ ETCO₂ ☐ Nerve Stim. ☐ Temp ☐ Vent Monitors

☐ A-Line ☐ Esoph. Steth ☐ NGT ☐ Foley Cath

☐ CVP ☐ Precordial Steth ☐ Bair Hugger

Notes:

Airway Management

☐ Spont. Resp. ☐ Assisted ☐ Ventilator Controlled

☐ LTA ☐ Oral Airway ☐ Nasal Trumpet ☐ Soft Bite Block

☐ Mask ☐ O₂ NC ____L ☐ LMA # ____ ☐ ETT Size
____mm

RR ____ PEEP ____ TV (10 ml/kg) ____ml

Notes:

IV Therapy

Wt. ____kg NPO ____hours

Maintenance ____ml/h

Fluid Deficit ____ml

3rd Space ____ml/h

1 st Hr	2 nd Hr	3 rd Hr	4 th + Hrs

EBV (Estimated Blood Volume) ____ml

ABL (Allowable Blood Loss) ____ml

Notes:

Clinical Summary / Perioperative Implications / Anticipated Problems & Concerns – see back

University Of New England Pre-Anesthetic Evaluation							
PATIENT	ASA Physical 1 2 3 4 5 E Status			Anesthesia Permit <input type="checkbox"/> Yes <input type="checkbox"/> No		Date	
	Proposed Operation						
	<input type="checkbox"/> NPO Last Nourishment						
MEDICAL HISTORY							
ALLERGIES							
PAST SURGERY							
MEDICATIONS							
CARDIOVASCULAR							
RESPIRATORY							
HEENT							
RENAL/METABOLIC							
OTHER							
BP	PULSE	RESP	MASS (kg)	HEIGHT	TEMP	HGB	ABG
						HCT	
CHEMISTRY							
X-RAY							
EKG							
ANESTHESIA TYPE	GENERAL	SPINAL	EPIDURAL	MAC	OTHER		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMENTS:							

STUDENT SIGNATURE: _____

**University of New England
School of Nurse Anesthesia**

Student Evaluation of Clinical Affiliation Tool (on Survey Monkey)

Clinical Site: _____ **Dates of Affiliation** _____

In accordance with existing *Council on Accreditation* policies, students are requested to submit critical comments, which will be constructive to the on-going improvement of the anesthesia program

PLEASE RETURN THE COMPLETED FORM TO THE SCHOOL

Please rate this site by checking the column which best describes the adequacy of the following criteria.

	Less than Adequate	Adequate	More Than Adequate	Not Applicable
Clinical experiences				
Supervision in the clinical area.				
Opportunities to make clinical decisions/judgments.				
Reinforcement of didactic knowledge.				
Opportunities for open communication between the student and the clinical instructor.				
Explanations of available equipment.				
Opportunities to perform a pre- and-postoperative assessment.				

What are the strengths of this clinical site?

What recommendations/comments do you have that would improve this clinical site.

**University of New England
School of Nurse Anesthesia**

Student Evaluation of Clinical Instructor Tool (on Survey Monkey)

Clinical Site:

Instructor's Name:

In accordance with existing *Council on Accreditation* policies, students are requested to submit critical comments, which will be constructive to the instructor and assist him/her in on-going instructional improvement of the anesthesia program.

PLEASE RETURN THE COMPLETED FORM TO THE SCHOOL

In reference to the following criteria, the **Clinical Instructor:**

Key: 1=Almost Never, 2=Rarely, 3=Sometimes, 4=Usually, 5=Almost Always

	1	2	3	4	5
Involvement/Receptivity					
Accepts students as important individuals.					
Is available when appropriate.					
Demonstrates confidence in the student.					
Stimulates and involves students					
Explains new/difficult procedures.					
Allows adequate time to accomplish task.					
Lets students explain his/her side of the situation.					
Involves student in decision-making process.					
Clinical Competence					
Remains calm, poised in the clinical situation.					
Exercises good clinical judgment.					
Relates didactic knowledge to good clinical practice.					
Teaching Practices					
Demonstrates flexibility so that learning can take place.					
Explains things in a "user friendly" manner					
Demonstrates new procedures.					
Challenges student's theoretic knowledge appropriately.					
Develops student autonomy.					
Verbally supports students to others in teaching situations.					

Evaluation Practices					
Avoids humiliating students in front of others					
Counsels without humiliation.					
Submits evaluations that reflect student's performance abilities					
Professional Attributes					
Admits limitations honestly.					
Demonstrates understanding/empathy.					
Acts as a role model.					
Comments:					

**University of New England
School of Nurse Anesthesia**

Student Evaluation of Anesthesia Program Tool

In accordance with existing *Council on Accreditation* policies, students are requested to submit critical comments, which will be constructive to the on-going improvement of the anesthesia program

Please rate the anesthesia program by checking the column which best describes the adequacy of the following criteria.

	Less than Adequate	Adequate	More Than Adequate	Not Applicable
<u>Section One:</u> As a student I perceive my didactic preparation in relation to:				
Physiology I				
Pharmacology I				
Physiology II				
Airway Management				
Pharmacology II				
Research Methods				
Professional Aspects				
Chemistry/Physics in Anesthesia				
Anatomy for Anesthetists				
Anesthesia Principles I				
Anesthesia Principles II				
Anesthesia Principles III				
Anesthesia Principles IV				
Research Practicum				
Special Topics in Anesthesia				

Please explain any "less than adequate " ratings.

<u>Section II: As a student I perceive my preparation in relation to clinical experience:</u>				
Selection of cases available.				
Selection of patients assigned to students.				
Time allotted for pre-op and postoperative planning.				
Number of hours in clinical area.				
Support given in clinical area by school faculty.				
Opportunity for students to make clinical decisions.				
Benefits derived from additional clinical rotations.				
Library facilities at clinical sites.				
Benefits derived from learning opportunities at clinical sites: lectures, inservices, case presentations...				

Please explain any "less than adequate " ratings.

Please comment on the following:
Curriculum Strengths:

Opportunities for Improvement:

Additional Comments:

**University of New England
School of Nurse Anesthesia**

Clinical Faculty Self-Evaluation

**Clinical Site:
Instructor's Name:**

In accordance with existing *Council on Accreditation* policies, clinical faculty are requested to submit critical self-reflective comments, which will be constructive in helping him/her assess strengths as well as areas for on-going improvement.

PLEASE RETURN THE COMPLETED FORM TO THE SCHOOL

In reference to the following criteria, I :

Key: 1=Almost Never, 2=Rarely, 3=Sometimes, 4=Usually, 5=Almost Always

	1	2	3	4	5
Involvement/Receptivity Accepts students as important individuals.					
Am available when appropriate.					
Demonstrate confidence in the student.					
Stimulate and involve students					
Explain new/difficult procedures.					
Allow students adequate time to accomplish task.					
Let students explain his/her side of the situation.					
Involve students in the decision-making process.					
Clinical Competence Remain calm, poised in clinical situations.					
Exercise good clinical judgment.					
Relate didactic knowledge to good clinical practice.					
Teaching Practices Demonstrate flexibility so that learning can take place.					
Explain things in a "user friendly" manner					
Demonstrate new procedures.					
Challenge student's theoretic knowledge appropriately.					
Develop student autonomy.					
Verbally support students to others in teaching situations.					

UNE School of Nurse Anesthesia Student Clinical Contract

I have received a copy of the University of New England's School of Nurse Anesthesia Clinical Practicum Handbook. I have had an opportunity to review and discuss its contents and I agree, as a student enrolled in this Program, to adhere to the policies and guidelines set forth. These policies and procedures are subject to change during the course of the Program and it is my responsibility to keep abreast of these changes.

Student Signature

Date

Print Name