BROWARD HEALTH
Clinical Education

Nursing Orientation for Travelers

Please Review this Booklet Prior to Attending Nursing Orientation

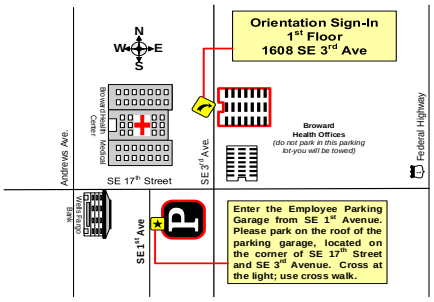
This booklet is designed to assist you in preparing and being successful in Nursing Orientation. It provides general information about each of the components on which you will be assessed.

We recommend that you review the content in this booklet prior to your scheduled date to attend Nursing Orientation so that you are familiar with the assessment. We will then review the assessment with you during the prep class so that you are comfortable with the process. Please print and bring with you to Nursing Orientation.

This booklet also contains information about the Math and the Basic Arrhythmia Assessments given during Nursing Orientation. A list of websites is included for each assessment that you can use to remediate prior to taking the assessment(s).

- All acute care clinical staff will complete the math assessment.
- All nurses working in monitored areas including Pediatrics and that have experience with ECGs will take the basic arrhythmia assessment.

Day	Time	Content
Monday Broward Health ISC Building 1st Floor, 1608 SE 3rd Avenue Ft. Lauderdale, FL 33316 ***Check in with Security***	7:45 am – 4:30 pm	• **ASSESS RX (PBDS) Prep** • **Math Assessment** • **Basic Arrhythmia Assessment (if applicable)**
Wednesday Broward Health ISC Building 1st Floor ***BHMC Travelers ONLY***	8 am – 10 am	***Broward Health Medical Center (BHMC) Travelers ONLY!*** **Point of Care Testing and then report to the BHMC Staffing Office**
Thursday Broward Health ISC Building 1st Floor	8 am – 4:30 pm	**Computer Documentation Training** • ED staff attends Thursday only for FirstNet training ***Remainder of schedule will be set by the manager.*** • All others will attend Thursday & Friday
Friday Broward Health ISC Building 1st Floor	8 am – 4:30 pm	**Computer Documentation Training**

Directions	**From I-95 North or South**	
Broward Health ISC Building 1608 SE 3rd Avenue Fort Lauderdale, FL 33316 www.BrowardHealth.org	Exit Davie Blvd. East. Turn right (south) on SE 3rd Avenue (past Andrews Ave.). Continue south to SE 17th Street. Turn right (west) on 17th Street. Make the first left (south) on SE 1st Ave to access parking garage. Parking garage entrance is on the west side of the building. Please park on the roof/top section of the garage. Proceed to the crosswalk (traffic signals) and cross to SE 3rd Ave. Orientation is held at 1608 SE 3rd Ave. Upon entering the building, please present this document to a member of our security team. You will be directed to your orientation classroom.	

5.14.2019

BROWARD HEALTH
Clinical Education

Broward Health is committed to excellence in patient care, patient safety and nursing competence. To ensure your success we are providing this booklet as an introduction to our nursing orientation process and the Assess RX (PBDS) assessment. Review the contents of this booklet prior to attending nursing orientation and bring it with you for use during nursing orientation.

- Nursing Orientation Highlights
- An overview of the Math and Basic Arrhythmia assessments and websites to be used for remediation prior to taking the assessments
- An Overview of the Assess RX System (PBDS) with examples of the assessment tools:
  - What If
  - Clinical Judgment

Assess RX (PBDS) Results

Results will be communicated to you by your agency representative who receives the results from the Broward Health regional staffing offices.

ASSESS RX (PBDS) Result	Math Test	Basic Arrhythmia Test (if applicable)	Status/Note
Acceptable- "Limited, but Acceptable or Better" (Rating of 5 - 7)	84% or better (passing)	80% or better and no lethal rhythms missed (passing)	Assign to Unit
Acceptable- "Limited but Acceptable" or better (Rating of 5 - 7)	70% to 83%	70% or better, with or without lethal rhythms missed	Evidence of Remediation for Math and/or BA as needed by Agency prior to Unit Assignment (Copy of remediation provided to regional Clinical Education department)
Unacceptable-"Does Not Meet for Problem Management" or better (Rating of 3 - 4)	84% or better (passing)	80% or better and no lethal rhythms missed (passing)	Assign to Unit for 3 shifts for clinical competence assessment and documentation
Unacceptable-"Does Not Meet for Problem Management" or better (Rating of 3 - 4)	70% to 83%	70% or better, with or without lethal rhythms missed	Assign to Unit for 3 shifts for clinical competence assessment and documentation. Evidence of Remediation for Math and/or BA as needed by Agency prior to Unit Assignment (Copy of remediation provided to regional Clinical Education department)
Acceptable and/or Unacceptable-"Does Not Meet for Problem Management" or better (Rating of 3 - 7)	Less than 70%	Less than 70% with or without lethal rhythms missed	Not eligible for assignment at any BH facility.
Unacceptable– Does Not Meet and Inconsistent. (Rating of 1 - 2)	Acceptable or Unacceptable Score	Acceptable or Unacceptable Score	Not eligible for assignment at any BH Facility

8.7.2017

Orientation Highlights

Welcome to our Healthcare Team! We are pleased that you have joined our Broward Health team and will share in our philosophy of healthcare excellence.

Expectations for Anyone Working at Broward Health

Broward Health (BH) is committed to providing a work environment that supports the philosophy of teamwork, collaboration, and professional growth. Broward Health employees, medical staff, contracted staff and vendors shall engage in conduct standards/expectations that support our mission and vision and demonstrate courtesy, dignity, and respect. Your facilitator is here to help you navigate through the program. If you have questions or problems, please discuss them with your facilitator.

Time and Attendance

Arrive on Time	We all have unplanned events but arriving late more than once does not leave a good impression on your new manager or your peers.
Return From Breaks and Meal On Time	If you have an emergency and need to return to class late, notify your facilitator. If you need to leave class, notify your manager and the facilitator.
Sleeping	Broward Health does not allow sleeping during meal periods or rest breaks.

Smoke Free Workplace

- Broward Health facilities are designated as "smoke free." Smoking will not be permitted anywhere on the Broward Health campus, including parking garages and cars located on the property.

Cell Phones

- ***Personal cell phones and communication devices must be turned off, or placed on vibrate while on duty*****.** You may seek approval in advance from the orientation facilitator if you have a family situation that requires an immediate response.
- ***No texting during class time.***

Unit/Department Specific Dress Code

It is the policy of Broward Health that employees present a professional appearance at all times. In addition to having an appropriate appearance, safety concerns are also related to the dress code.

- Contact your supervisor/manager/hospital staffing coordinator for unit designated dress code and colors.
- You may wear clean, pressed scrubs to nursing orientation.

Computer Training

All nursing areas will receive training on our computerized documentation system. You will be given more information on the training schedule during orientation.

If your computer skills are minimal, and you feel that you will need assistance during the computer training sessions please inform your facilitator in advance. We want this to be a positive learning experience for everyone.

Math Assessment

All nurses will complete a Math Assessment. You will be given a handout with drug calculations and conversions and a practice worksheet prior to the math assessment. **Passing score is 84%.** If this score isn't achieved, your contract status will be determined by the results of all the assessments taken during nursing orientation. Please refer to the grid on page 2 of this booklet for further clarification.

To ensure a successful score, it is highly recommended that any of the following math review web sites be reviewed prior to taking the assessment.

Math Review Websites

http://www.rncalc.com/	http://www.testandcalc.com/quiz/testiv.htm
http://www.nurseslabs.com/drug-dosage-calculations-nclex-exam	http://www.dosagehelp.com/practice_questions

You will be provided a copy of the following Drug Calculations/Conversions to use during the math assessment.

DEPARTMENT OF NURSING
Drug Calculations/Conversions
Approved 10/07 for January 1, 2008 Department of Nursing, Associate Deans

Metric System		Apothecary & Metric System	
1 mL	1 cc	gr 1	60 mg
1,000 mL	1 L	gr 1 ½	90 or 100 mg
1,000 mg	1 g	gr 15	1000 mg
1,000 mcg	1 mg	gr 15	1 g
1,000 g.	1 kg	oz 1	30 mL
Metric & Household		**Apothecary**	
1 kg	2.2 lbs	cup 1	oz 8
30 mL	1 oz	pt 1	oz 16
5 mL	1 tsp	qt 1	oz 32
15 mL	1 tbsp	**Household**	
2.54 cm	1 inch	1 lb (#)	16 oz

Rounding Rules

1. Round at the completion of each step of the problem
2. Round the weight of patient prior to working the problem
3. Round everything to the tenth place except the following:
   - **mL**: if less than one mL round to the hundredths
   - **mg**: if less than one mg. round to the thousandths
   - **gr**: if less than one gr. round to the thousandths
   - **gtts**: round to the **whole** number
   - **units**: round to the **whole** number
   - **capsules**: round to the **whole** number

IV Formulas (Required)

FLOW BY GRAVITY

1. If greater than one hour, always calculate the hourly rate first, then

$$\frac{\text{mL/hr} \times \text{gtts/mL}}{60} = \text{gtts/min}$$

2. If infusion is ordered to run for less than one hour, then

$$\frac{\text{mL} \times \text{gtts/mL}}{\text{minutes}} = \text{gtts/min}$$

FLOW BY INFUSION DEVICE

1. If an infusion is ordered to run over a number of hours and the hourly rate is needed for an infusion pump or to plug into formula number 1, then

$$\frac{\text{Total mL ordered}}{\text{Total hours}} = \text{mL/hr}$$

2. If an infusion is ordered to run for less than 60 minutes and an hourly rate is needed, then

$$\frac{\text{Volume} \times 60}{\text{Minutes}} = \frac{\text{mL/hr}}{1}$$

TEMPERATURE: FAHRENHEIT - CELSIUS

F° = 1.8 C° + 32

$$\text{C°} = \frac{\text{F°} - 32}{1.8}$$

98.6° F = 37° C
102.2°F = 39° C

Basic Arrhythmia Assessment

Nurses with experience in Basic Arrhythmia that will be working in areas with cardiac monitoring must achieve a score of 80% and not miss any lethal arrhythmias on the Basic Arrhythmia Assessment. If this score isn't achieved, your contract status will be determined by the results of all the assessments taken during nursing orientation. Please refer to the grid on page 2 of this booklet for further clarification.

Areas required to take the Basic Arrhythmia assessment include: Critical Care areas, Telemetry/PCU, Remote Tele units, Emergency Room, Labor & Delivery, Peds, Peds Emergency Department, Peds Cancer Center (outpatient), Peds Oncology, Peds Sedation, PICU, Post Anesthesia, Endoscopy, Same Day Surgery, Cath Lab, Interventional Radiology, and Nursing Supervisors.

To ensure a successful score, it is highly recommended that the following web sites be reviewed prior to taking the assessment.

Basic Arrhythmia Review Websites

http://uthealth.utoledo.edu/depts/nursing/pdfs/Basic%20EKG%20Refresher.pdf

http://www.skillstat.com/tools/ecg-simulator

http://ekg.academy/ekg-rhythm-analysis-self-test.aspx?tracingid=429

http://www.practicalclinicalskills.com/ekg.aspx

Assess RX (PBDS) Prep

What If

This assessment component reflects your ability to make priority decisions for unplanned events and determine acceptable subsequent interventions.

You will be given a brief clinical situation where you will prioritize the urgency of the action needed. The priorities are identified as:

- "MUST DO" and requires intervention within one hour.
- "SHOULD DO" and requires intervention by the end of the shift.
- "COULD DO" is not urgent, can be delayed until the next shift or another time.

All items that you identify as "MUST DO", you will need to list the specific actions you will take. You will type your response to the "Must Do" rating in the "Action Taken" column. Key points:

- There is no need to type your responses in complete, grammatically correct sentences
- Outline/bullet format is fine
- Your responses reflect the actions you need to take at that time, not during the entire hospital stay

Clinical Judgment

This assessment component validates your ability to:

- Recognize and label clinical problems
- Manage the problem effectively and state the interventions
- Identify the urgency involved
- Explain and state the rationales for your interventions

You will view a short (1-2 minute) video clip of a clinical situation. You will have 5–7 minutes to type your response based on the video simulation and a narrative description. The 5–7 minutes is utilized to add an element of real time to the clinical situation since we routinely have to react quickly. **Key points:**

- There is no need to type your responses in complete, grammatically correct sentences
- Outline/bullet format is fine
- Your responses reflect the actions you need to take at that time, not during the entire hospital stay
- If you think the patient needs: IV access, oxygen, safety precautions, airway assessment, etc., make sure to write it even if you see it on the ASSESS RX (PBDS) vignettes.
- Don't forget to give a frequency for your interventions that need to be repeated. For example, Neuro checks every 15 minutes.

The next page is a Clinical Judgment Aide that you can use when taking your assessment. It will serve as a reminder of the actions you need to take and the format of how to type your responses.

Clinical Judgment Aide

Patient Problem:	**Label the problem:** • *What is wrong with the patient? Example: AMI, renal failure, DKA, pulmonary embolus* • *Keep in mind that you are not diagnosing the patient. You are only indicating what you think is going on with the patient.*

Interventions • *Describe the Priority Actions you would take to manage the problem* • *It is easier to number each response. Your numbers are not intended to reflect the order in which you are doing the intervention; rather they will correspond to your rationales.*	**Rationales for Actions** • *Why did you do what you did?* • *You should have 1 rationale for each intervention, i.e. if you have 3 interventions you should have 3 rationales* • *Ask yourself, am I including the actions needed to take to keep this patient safe?*
1. Call MD – How soon? Write STAT or Now if you need immediate response from the MD. *Note*: LPN – notify RN	**1.** To inform MD of condition changes To get orders Potential complication/emergent situation
2. Paint the Picture - Tell him: Observations, assessment provided in the ASSESS RX (PBDS) script, v/s, lab, x-rays, change in condition, adverse response to therapy. Any history if relevant to identify the problem.	**2.** To give enough information to the MD so he/she can determine what the problem is and provide relevant orders.
3. ANTICIPATE ORDERS: For medications, procedures, etc. (once you have indicated "call MD", it is assumed you will have an order for dependent interventions).	**3.** Medications: i.e., Tylenol = rationale: to reduce temperature Procedures: i.e., Chest x-ray = to confirm diagnosis or evaluate response of treatment
4. Monitor: What are you monitoring? How often? LOC, Glucose, O_2 sat., respiratory status, response to treatment	**4.** Baseline parameters To monitor condition Assess for changes and response to interventions Assess the response to treatment
5. Assess: What system? How often? Be specific. ***Cardiac:*** Heart rhythm, circulation ***Respiratory:*** Breath sounds, rate, depth ***Neuro:*** LOC, movement, reflexes ***GI:*** Bowel sounds, tenderness, distention, ascites ***GU:*** bladder distention, I & O, vaginal bleeding ***Vital Signs:*** Which ones? How often? Be specific, state relevant v/s only. *Note*: Indicate priority by stating how often you will repeat them.	**5.** Baseline assessment/identify symptoms that could differentiate diagnosis Monitor for changes Assess response to treatment/medications
6. Independent Nursing Actions CALL MD Initiate Protocols Elevate HOB Comfort measures – be specific CPR, call a Code Inform other team members	**6.** Inform of condition, Communicate urgency, Get orders for treatment, protocols, tests, transfer To intervene in a timely manner To allow increased chest expansion/improve breathing/decrease workload of heart To provide comfort To maintain circulation/oxygenation To get help, consultation

TIPS TO REMEMBER: If you think the patient needs: IV access, oxygen, safety precautions or airway assessment make sure to write it even if you see it on the ASSESS RX (PBDS) vignettes. **Remember to give a frequency for your interventions that need to be repeated, i.e., Neuro checks every 15 minutes.**