UNIVERSITY OF ALBERTA
COLLABORATIVE BACCALAUREATE NURSING PROGRAM

Grande Prairie Regional College
Grant MacEwan College
Keyano College
Red Deer College
University of Alberta

NURSING 2910

COURSE OUTLINE

Fall, 2004

Originally developed by Clinical Experience Development Committee of

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Revision May 2002 by the Clinical Experience Development Committee

Nursing 2910
Course Outline

NURS 2910- Nursing Practice III *7 *(fi 14)* (either term, 0-3s-28c in 7 weeks).
Practice focuses on restoration, rehabilitation and support (including health promotion and disease prevention) of clients with chronic and less acute variances in health across the life span. Practice occurs primarily in primary-level acute care centres and continuing care agencies.

Prerequisites: NURS 1940 or 1950.

COURSE HOURS:
Lecture/Seminar: 21 Lab/Clinical: 196

SEMINARS:
Seminars are every Friday in H225 from 1130-1420. Seminar topics will be discussed and how they relate to clinical practice. Space will also be allotted during these times to present learning plan objectives.

LABS:
Labs will be completed at the beginning of orientation. See lab handouts.

INSTRUCTORS:

Teresa Bilou
H226
539-2805 (O) 513-5115 (H)
email: tbilou@gprc.ab.ca
Office hours are flexible

Fern Christensen
H215
539-2754 (O) 539-3157 (H)
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Office hours are flexible

SICK TIME:
Absences will jeopardize the ability of the instructor to have sufficient data for evaluation of the student's performance. There is no time to make up lost shifts. If you are ill, or unable to attend clinical, you must notify your instructor prior to the shift.

If you are to be on the unit that day, you can call and leave a message with someone from the floor. If you are sick on your off-unit days, please call the unit and then leave a message on your tutor's voice mail at work to advise them of the situation.

3 North	538-7200
5 North	538-7650
Outpatients' Department	538-7480
Diagnostic Imaging	538-7440
Emergency	538-7493
Physiotherapy/Rehabilitation	538-7360
Respiratory Therapy	538-7354

WITHDRAW DEADLINES:
The last day to withdraw from this course with permission is **Friday, November 19th, 2004.**

Progression in Clinical Course:
If a student is having marginal performance, the instructor in consultation with the student, will develop a plan of action based on strengths and areas to work on. Students will receive weekly verbal feedback on how they are progressing and ways to improve performance.

CPR certification at the Basic Rescuer Level must be maintained throughout the program.

Refer to GPRC and Nursing Department Handbooks.

Professional Dress: It is expected that all students will follow the dress code of the clinical agency they attend. It is expected all students will wear a Grande Prairie Regional College nametag. Absolutely no jeans.

Preparation for clinical experience: It is expected that you will prepare for each clinical day by researching procedures, medical conditions, medications, etc. Required psychomotor skills may also need to be reviewed prior to the clinical experience. Students should be prepared to discuss their client plan of care (including the client priority needs, nursing diagnoses, medication profiles, any client teaching plan) with the instructor during clinical time. If a student is not adequately prepared for clinical, the instructor may request the student leave the clinical agency. This would be a decision made after considering client safety.

COURSE DESCRIPTION:

This course will provide opportunities for students to continue to participate in health promotion and primary prevention activities while focusing on restoration, rehabilitation and support. Nursing practice will include health assessment and intervention with clients with less acute and chronic variances in health. The student will experience nursing practice over a continuous block of time in institutional settings providing primary care. e.g. med/surg units, day or short stay surgery, subacute units, continuing care or rehabilitation units.

COURSE OBJECTIVES:

In addition to maintaining competency with previous course objectives, upon completion of Nursing 2910, the nursing student will be able to:

1. Demonstrate application of legal and ethical standards in selected nursing situations:
    - Consistently demonstrate:
        - Responsibility and accountability
            - Support of colleagues
            - Decision making
    - With assistance demonstrate:
        - Competency with appropriate documentation.

2. With guidance, demonstrate attitudes and skills for learning:
    - Attitude of inquiry
    - Openness and receptivity to change.

3. Demonstrate an understanding of social and political action at a beginning level:
    - Identify power structures in nursing situations
    - Discuss client responsibilities
    - Apply principles of change theory to a nursing situation.

4. With minimal assistance, utilize a variety of information technology.

5. With minimal assistance, demonstrate effective skills in self-directed, context-based, small group learning.

6. With minimal assistance, utilize selected knowledge related to biological, psychological, sociological**,** cultural and spiritual factors in interacting with clients experiencing chronic and less acute variances in health.

7. With minimal assistance, apply a selected model/theory in nursing practice.

8. With assistance, develop sound clinical judgment in relation to rehabilitation and restoration:
    - Critical thinking.

9. Apply knowledge from research to nursing situations and share findings with colleagues.

10. With assistance, demonstrate competence in understanding ambiguity and diversity:
    - In providing support to clients in transition
    - In selected nursing situations
    - In developing resource networks.

11. With assistance, demonstrate beginning competent leadership and management skills:
    - Decision making
    - Time management
    - Priority setting
    - Performance appraisal.

12. Apply concepts and principles of primary health care in selected nursing situations.

13. Demonstrate caring behaviors in professional situations:
    - Establish caring relationships with clients
    - Recognize effect of caring on health and healing
    - Demonstrate concern for the health of others.

14. With assistance, demonstrate ability to interact with and develop collaborative partnerships with colleagues, clients, registered nurses, and members of other disciplines:
    - Apply principles of change theory.

15. Demonstrates competence in nursing skills required for nursing care of clients across the lifespan in community settings:
    - Consistently demonstrate competence with selected skills:
        - See lab maps.
    - With guidance:
        - Apply nursing process
    - Use appropriate communication skills (verbal and written)
    - Use appropriate teaching skills.

DEPARTMENT OF NURSING EDUCATION
GRANDE PRAIRIE REGIONAL COLLEGE &
PEACE COUNTRY HEALTH REGION
EXPECTATIONS FOR STUDENT CLINICAL EXPERIENCES

The input of the nurse in the Clinical Agency is valued and welcome. GPRC and PCHR can benefit when the nurse:

1. Role models professional nursing behaviours including attitudes, techniques, awareness and adherence to agency policies.
2. Maintains an interest and openness to teaching and learning with faculty and students.
3. Alerts faculty and students to additional learning experiences.
4. Promotes learning opportunities for students as observers in addition to hands on practice.
5. Assists students when faculty is not available if appropriate for level of student and if responsibilities permit.
6. Gives constructive feedback about performance of faculty and student when asked. Receives constructive feedback about self.
7. Shares in open dialogue with faculty, concerns or difficulties related to student assignments.

As a Faculty Member in the Clinical Agency, the Nursing Instructors are expected to:

1. Role model professional nursing behavior including attitudes, techniques and adherence to agency policies.
2. Maintain an interest and openness to teaching and learning with staff and students.
3. Clearly indicate the skills the students are allowed to practice. Ideally supervise students doing any skills or procedures for the first time.
4. Share in open dialogue with nursing staff, concerns and difficulties in the management of student assignments.
5. Assume responsibility for student evaluation and delegate supervision of students appropriately, after consultation with staff.
6. When asked by the unit manager, give constructive feedback about performance of staff. Receive constructive feedback about self.
7. Discuss student individual learning needs and assignments with nursing staff as appropriate.

Students in the Clinical Agency are expected to:

1. Demonstrate professional behavior including attitudes, techniques and adherence to agency policies.
2. Maintain an interest and openness to teaching and learning with staff and faculty.
3. Prepare for clinical assignment.
4. Complete assignment in collaboration with instructor, assigned nurse and other health care professionals.
5. Document in a timely manner.
6. Communicate with instructor and assigned nurse regarding status of the client(s) and include a concise verbal or taped report when leaving.
7. When requested, provide constructive feedback about performance of faculty and staff. Receive constructive feedback about self.
8. Demonstrate an appropriate level of independence.

U***sed with permission of Red Deer College Nursing Faculty.***
Revised: August 28, 2003 C:\WINDOWS\TEMP\expectations revisions.wpd

Grading System

A grade will be assigned for each assignment using the marking criteria and then based on the grade descriptors (excellent, good, satisfactory, poor). Rationale will be given as to the assigned grade. Grading descriptors will be provided for each assignment.

Effective July 1, 2003 Grande Prairie Regional College uses the alpha grading system and the following approved letter codes for all programs and courses offered by the College.

Alpha Grade	***4-point Equivalent***	***Designation***
A+	4.0	Excellent
A	4.0	
A-	3.7	First Class Standing
B+	3.3	
B	3.0	Good
B-	2.7	
C+	2.3	Satisfactory
C	2.0	
C-	1.7	

The above are considered passing grades in Nursing courses

Alpha Grade	***4-point Equivalent***	***Designation***
D+	1.3	Minimal Pass
D	1.0	
F	0.0	Fail

These are NOT considered passing grades in Nursing courses.

Students ***may*** receive a grade of D or D+ in an assignment or component of a course, but must have an overall grade of C- to achieve a passing grade in a nursing course.

****Note: Refer to the 2003-04 College calendar p. 32 for further details regarding the grading policy and p. 146 and 147 regarding Progression Criteria in the Bachelor of Science in Nursing program.**

Grade Distribution
NS 2910

Student Name: _____ Tutor: _____

Alpha Grade	*4-point Equivalent*	*Designation*
A+	4.0	Excellent
A	4.0	
A-	3.7	First Class Standing
B+	3.3	
B	3.0	Good
B-	2.7	
C+	2.3	Satisfactory
C	2.0	
C-	1.7	

The above are considered passing grades in Nursing courses

D+	1.3	Minimal Pass
D	1.0	
F	0.0	Fail

These are NOT considered passing grades in Nursing courses.

Students ***may*** receive a grade of D or D+ in an assignment, but must have an overall grade of C- to achieve a passing grade in a nursing course. If you receive a D in your DCO, this constitutes a clinical failure.

Evaluation	Grade	4-point Equivalent	Percentage of Total Mark	Value
Learning Plan			10%	
Critical Incident Journals			15%	
Direct Clinical Observation			50%	
Nursing Care Plan			25%	
				Total:

Total 4-point Equivalent Values: _____

Translated to Final Grade: _____

Grades for each assignment were translated into the 4-point equivalent, were then multiplied by the percentage of total mark for each assignment. To value of those percentages were added up to make a total. That total was converted back into the grade scale to receive your final grade. If you have any questions or concerns, please see your clinical tutor.

LEARNING EXPERIENCES AND EVALUATION*:*

LATE POLICY FOR ASSIGNMENTS:

All assignments are to be passed in at the time and place they are due. Extensions on assignments may be granted and must be negotiated with the instructor prior to the due date and with a date specified for late submissions. A penalty of a letter grade for each working day that an assignment is submitted after the due date will be deducted from the final grade. For example, a paper scored at B+ would receive an adjusted grade of B if handed in one day late.

Assignments are due by 4:00 p.m. and must be verified (stamped with date and time) by nursing office personnel.

In order to pass NURS 2910, students must demonstrate safe, ethical nursing practice; professional behavior; complete the below activities and acquire a passing grade in the Direct Clinical Observation.

Summary of Evaluation:

		Value
1.	Learning Plan	10%
2.	Critical Incident Journal	15%
3.	Direct Clinical Observation	50%
4.	Nursing Care Plan	25%
		100%

1. Learning Plan: Value 10%

Learning plans enable students to combine selected learning objectives for the course with their own learning objectives, considering their own particular learning style and areas of interest. **The intent of the learning plan is to explore a personal learning objective. Learning opportunities which students can reasonably expect to happen during the course of the clinical experience are not to not become part of the learning plan i.e. give an injection safely or do an assessment.**

A learning plan is an agreement between the student and the tutor specifying what the student intends to learn, how this will be accomplished, the time frame for meeting the objectives, and the methods by which achievement of the objectives will be measured.

The learning plan is intended to enable the student to work through the steps of assessing, planning, implementing, and evaluating the learning process. The steps of the process include:

- providing the student with an opportunity to make an individual learning goal within the framework of the objectives for the course. **The learning plan does not repeat the course objectives**;
- allowing students to determine learning objectives in view of their own perception of their strengths and areas for improvement;
- identifying strategies for meeting the objectives;
- identifying evaluation strategies.

The student will provide evidence to support how the goals outlined in the learning plan have been met through the use of student identified methods of evaluation. In your learning plan you must identify what date you are going to do your presentation. When students complete their presentations, please remember to hand back your learning plan revisions to the instructor.

********* Only one learning objective is to be developed **********

Due: Submission of the learning plan for instructor feedback is due: Monday, November 1st at 1600 hrs.

***Dates that are available for you to do a presentation are*:**

November 19th, 2004 and
November 26th, 2004

When presenting the learning plan to the class, students must:

- **Provide the updated/revised learning plan to the tutor**
- **Show which learning strategies they used to complete the learning plan.**

2. Critical Incident Journals **Value: 15%**

Components of this journal will include:

Approximately 800-1000 words in length and typed. Confidentiality must be considered when choosing to share written or verbal information.

Guidelines for writing the Reflective Journal

- Describe a significant event/incident. Write a paragraph describing the incident (example; what you or someone else did in intervention, communication, or other). Be as specific (detailed) and objective as possible. Include thoughts, feelings, and perceptions. Also include what you perceive the other people could be feeling (patient, nurses etc.)
- Reflect on the event/incident. Describe why this event/incident was important to you, and what factors (such as assessments, previously learned experiences, values, beliefs, stereotypes or biases.) influenced yours/someone else's decisions/actions/feelings.
- Evaluate your strengths and areas needing improvement in this situation. Explain why you think those were areas of strength or areas needing development.
- Describe your significant learning. Describe what you would do differently/investigate/maintain if a similar incident should occur. Describe what you would teach someone else (example; a peer) about this incident in order to improve your nursing practice.

Patton, J., & Woods, S. (1997). Enhancing the clinical practicum experience through

journal writing. *Journal of Nursing Education, 36* (5), 238-240.

- Journals will be submitted weekly during clinical of the following week
- Students must keep all journal entries in a binder or duo tang so that the tutor can have access to all the journals written over the clinical period.
- Students will be graded on each journal in answering the above questions and how they respond to the tutor's feedback from previous journals. An average of the total grades will determine final grade for journals (**See Journal Grading Rubric**).

3. Direct Clinical Observation **Value: 50%**

A formative and written summative evaluation of Nursing Practice will be completed by the student and the instructor during the final evaluation. See attached form. A midterm evaluation will also be done on a more informal basis.

This will be accomplished through observation, assessment, and evaluation of the student during clinical practice. Evaluations will be made by the instructor and may be supplemented with input from peers, the staff of an agency, and the client.

***** Grading Guide for the DCO will be given out during orientation *****

In order to pass NURS 2910, students must demonstrate safe, ethical nursing practice; professional behavior and acquire a passing grade in the Direct Clinical Observation.

Students MUST pass the DCO in order to pass the course. If a student does not pass the DCO with a 50%, they will obtain an overall grade of no greater than D. If you receive a grade of "F" in any of the DCO criteria it constitutes a "clinical failure" on the DCO, as the student has then shown unsafe, unprofessional, or unethical nursing practice.

A. Essential

Over the 7 weeks students will have a continuous experience in an institutional setting which will include:

1 Care of adults or children with chronic or less acute variances in health.
Within this experience variations of the following activities might occur:
a) Assessing mental and physical health status of client and family.
b) Providing nursing care.
c) Developing appropriate psychomotor skills:
   i) Students will have completed labs for selected skills prior to performing skills on client. (See Labs)
   ii) Students will demonstrate competence with skills specific to their clinical environment as needed.
d) Participating in a client follow-through during pre and post medical or surgical procedure.
e) Participation in client education
f) Participating in discharge planning/referral from institutional setting:
   i) liaise with home care nurse

ii) follow up visit with client at home (assessment, client education)

2. Collaborate with clients, family, nurses and members of other disciplines.

Students are expected to implement previously learned nursing skills.

Midterm Evaluations will occur on November 18th, 2004
Final Evaluations will occur on December 9th and 10th, 2004.

4. Care Plan Assignment: Value 25%

Application of the OREM Nursing Theory/Model in a Nursing Care Plan.

Students develop a nursing care plan applying a nursing theory/model for a client with chronic or less acute variances in health. This includes plans for care while the client is in the institution as well as the follow up phone call where assessment and client education occurs. Guidelines for the development of nursing care plans are attached to the course outline.

Nursing Care Plan Due: Friday, December 10th, 2004.

LABS

Utilizing previously learned knowledge, the student will make appropriate assessments for each psychomotor skill

Lab 1: Pulmonary Procedures

At the completion of Lab 1, the student will be able to:

1. Demonstrate comprehensive assessment of the thorax (lungs) using inspection, palpation, percussion and auscultation of the adult and the child.

- Determine abnormal chest configuration
- Identify abnormal respiratory patterns
- Detect abnormalities in thoracic expansion and tactile fremitus
- Detect abnormalities in diaphragmatic excursion
- Identify and differentiate abnormal breath sounds
- Analyze and document findings.

2. Assess oxygenation via pulse oximetery.

3. Administer oxygen via
   - nasal canula
   - face mask

4. Teach client re: incentive spirometry.

5. Perform oropharyngeal suctioning and nasopharyngeal suction.

6. Discuss and demonstrate chest physio for more advanced situations.
   a. Precautions and special considerations
   b. Assessment and positioning of client
   c. Landmarking
   d. Technique for vibration, percussion, and postural drainage
   e. Documentation

7. During discussion demonstrate knowledge of care of clients with chest tubes and demonstrate chest tube maintenance:
   a. Assessment
   b. Establish a chest drainage system
   c. Measure drainage
   d. Safe handling of equipment during client movement, transfer, and changing of collection container.
   e. Documentation

Lab 2: Musculoskeletal System

At the completion of Lab 2, the student will be able to:

1. Demonstrate knowledge of related anatomy and physiology.

2. Describe techniques of inspection and palpation and the specific characteristics to be assessed.

3. Explain rationale underlying the examination techniques.

4. Differentiate between expected and unexpected findings; including age related changes.

5. Document signs of health, deviations from health, and age related changes of the musculoskeletal system in adult clients.

    - Record results for inspection and palpation of the musculoskeletal system using the Physical Assessment Performance Checklist, using appropriate terminology and process of recording.

Lab 3: IV Saline Locks and Pumps

At Completion of Lab # 3, the student will be able to:

1. Discuss the lock device as a site for intermittent IV medication administration:
    a. Advantages and disadvantages
    b. Safety concerns
    c. Policy and regulations

2. Demonstrate skill with saline lock devices:
    a. Flush lock with prescribed solution
    b. Establish or discontinue IV infusion via existing lock.

3. Become familiar with the use of IV pumps:
    a. Handle equipment and set commands on at least one pump device.
    b. Discuss advantages and disadvantages.
    c. Calculate intake and volume remaining via the pump system.

Interdisciplinary Collaboration Discussion
2910 Clinical Experience

As part of the NS 2910 experience, students will have the opportunity to spend one-day (8 hours) in either the rehabilitation department (3 North students), or the respiratory therapy department (3 North and 5 North students). Students also have the opportunity to work with staff members in the outpatient's department, emergency and diagnostic imaging.

Goals for the Experience:

1. Students will understand the role of the Respiratory Therapist or members of the Rehabilitative Team (physiotherapists, occupational therapists, speech therapist) in the care of clients in an in-patient setting and their role in the health care team.
2. Students will have a beginning understanding of the different assessments and interventions each member of the health care team performs.
3. Students will be able to identify at a beginning level, ways to improve communication between themselves and other members of the health care team.

Respiratory Therapy Placement

The student will observe RT interventions with clients in a variety of acute care settings including, but not limited to, ICU, emergency, general med/surg units, stress lab, and the OR

1. What are the common assessments and treatments the RT performs?

   Note: The student will be prepared with medication information on the respiratory medications given such as Beta2-adrenergic agonists, epinephrine and anticholinergic drugs used for asthma or COPD (give examples of each). The student will also have prepared information on cardiac stress tests.

2. Summarize your learning related to pulmonary function tests, stress tests, arterial blood gases or other related tests you may have experienced during the clinical day. How will this information be useful to you in your future practice in nursing?
3. Describe the RT's interaction with RNs. Elicit your thoughts about how to improve client care through collaboration with other professions.
4. Summarize your learning related to interventions that you observed or assisted the RT in doing. For example: What medications are given by RTs? What direct client interventions are performed by RTs with in-patients?

Rehabilitation Therapy Placement

The student will observe the members of the rehab team's interventions with clients in a variety of acute care settings including, but not limited to, ICU, emergency, general med/surg units, stress lab, and the OR

1. Describe the role of the rehab team in the acute care setting. Describe how each member of the team works to provide care for the client. Consider the type of clients they care for, their scope of practice, and their role in the health care team.
2. Describe Registered Nurses' interaction with the rehab team. Elicit your thoughts about how to improve client care through collaboration with other professions.
3. Summarize your learning related to the assessments and interventions performed by the rehab team, and anything else you may have experienced during the clinical day. How will this information be useful to you in your future practice in nursing?

Diagnostic Imaging:

1. Who are the different members working in Diagnostic imaging?
2. What types of diagnostic tests were performed?
3. What teaching was done about the tests? How does the technician prepare the client for what is going to happen? As a patient receiving these tests, what would you appreciate being done for you during the test?
4. Look up two tests that you saw that day (IVP, ERCP, x-ray, ct-scan, MRI, etc.) in a lab and diagnostic book and identify:
    - What the test is and what they could be looking for.
    - Some patient teaching you could give a client concerning this test
    - Nursing considerations

Emergency Department:

1. Who works in emergency? What did you notice about the difference in roles?
2. What experiences did you have while in the ER? What skills do you feel an emergency nurse needs to have in order to be effective in the emergency department?
3. What did you notice about the assessments that were performed in the ER, how do they differ from being on the other units? What is critical thinking and why is that so important in the ER?
4. What were the nurses' interactions with the patients? How can a nurse incorporate health promotion strategies into their nursing care?

Outpatient's Department:

1. What procedures did you see on the floor? What was interesting to you?
2. What is an important role the nurse has in this area?
3. Look up gastroscopy and colonoscopy as well as TEE (transesophageal echocardiogram) prior to your observational day. What teaching would need to be done to help relieve anxiety? What should the nurse do before and after each procedure?
4. May wish to look up Versed, Ancef, Fentanyl and Clindamycin as they are common drugs given on the floor.
5. How does the role of the OPD nurse differ from what you have seen in your clinical rotations?

Discussion Questions for Seminar

1. Who in our group observed an interdisciplinary team meeting? What were some of your observations? What were some positive actions of the members? Any actions that hindered group functioning? How did they problem solve as a group?
2. When is it beneficial to work as a team? What are the advantages and disadvantages of working as a team?
3. Who should lead a health care team?
4. Complete the following statement…"I believe that we would be a more effective team if each of the members of the health care team…"
5. What did we learn from our experiences with RT and the rehab team?

Eleven Competencies for Effective Teamwork

Competencies were derived from Developing Health Care Teams: A Report by the Academic Health Center Task Force on Interdisciplinary Health Team Development, University of Minnesota, 1996.

1. DEMONSTRATE A CLIENT-CENTERED FOCUS

A good team has as its first priority meeting the client's needs. The client may be the patient, a family, a community or an audience. A team with a patient-centred focus considers and respects the client's values and preferences when making care decisions.

Positive Example: Team encourages the patients to express their needs.
Negative Example: Team disregards statements made by the patient.

2. ESTABLISH COMMON GOALS

A good team sets common goals to guide their actions and outcomes. This may include short and long-term goals. If the patient's needs are to be the focus, it is critical that all team members, which includes the patient and family, agree about what constitutes a successful outcome.

Positive Example: Team, including the patient and family, agrees on therapeutic goals for the patient.
Negative example: Members develop their own goals independently.

3. DESCRIBE THE ROLE OF EACH PROFESSION

Team members must be familiar with professional capabilities of all persons on the team and must be willing to acknowledge greater expertise and, in some instances, defer to other team members.

Positive Example: Appreciates and uses the contribution which can be made by all team members.
Negative Example: Insists on their own approach to patient care.

4. SHOW FLEXIBILITY IN ROLES

While understanding and respect for each person's specific role (scope of practice) is necessary, flexibility in assignments is important. Using hockey as an example, a defenceman is not expected to score many goals bu should be able to take a good shot if he gets a breakaway.

Positive Example: Recognizes differences and overlap in the approach of each discipline to achieve common goals.
Negative example: Unwilling to explore in areas outside of won field, is territorial.

5. DEMONSTRATE CONFIDENCE IN OTHER TEAM MEMBERS

Confidence in other team members develops with time, and most certainly requires an understanding of the other member's roles. Each member considers and values the opinion of others. Each member must be able to trust the work of others.

Positive Example: Trust others on the team will provide their portion of the work.
Negative Example: Disregards the competence of other team members.

6. SHARE EXPECTATIONS OF GROUP NORMS/RULES

Members of successful teams will be aware of the expectations of others in the group. The expectations are often behavioural, e.g. punctuality, equal participation and staying current in one's field.

Positive Example: Identifies group rules and consequences for deviation from the rules. Ensures rules are followed.
Negative Example: Individual members routinely violate team rules without consequences.

7. EFFECTIVELY RESOLVE CONFLICT

Every health care team will experience conflict. A successful team will identify a specific mechanism, clearly understood by all, for resolving conflict, through a team leader, outside leader, or other process.

Positive Example: Acknowledges conflict and works to resolve it.
Negative Example: Avoids or ignores disagreement with the team.

8. COMMUNICATE EFFECTELY WITH OTHER TEAM MEMBERS

Good team communication involves at least two components-what information is shared and how it is shared. Team members listen attentively and focus on the task at hand. Teams develop an efficient and effective record keeping system, electronic or other, and use a common vocabulary.

Positive Example: Team members share information and or concerns in a timely manner without using jargon
Negative example: Team members withhold pertinent information.

9. SHARE RESPONSIBILTIY FOR TEAM ACTIONS

Effective team functioning can occur only if each team member shares fully the responsibility for actions of the team as a group and is willing to be held accountable for actions.

Positive Example: Uses "we" in communication when discussing team decisions.
Negative Example: Does not support team decisions.

10. BE CONFIDENT IN THE PROCESS OF GIVING AND RECEIVING FEEDBACK

Team design must be dynamic – open for evaluation and revision on a continuing basis. A specific mechanism must be developed for ongoing evaluation of team's effectiveness and redesign as needed.

Positive Example: Regularly monitors team performance calmly and objectively and makes changes as a result.
Negative Example: Becomes hostile, defensive or personalizes comments made.

11. MAKE TEAM DECISIONS EFFECTIVELY

The team establishes a decision-making process acceptable to members and appropriate to the needs and goals of the task.

Positive Example: Team makes timely decisions appropriate to the situation.
Negative Example: Does not follow a decision making process, makes decisions on a whim.

What is Client-Centred Care?

(Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam, CL, Freeman TR. Patient-Centred Medicine: Transforming the Clinical Method.Thousand Oaks: SAGE Publications, 1995, p. 25).

Six Interactive Components of the Patient-Centred Process:

1. **Exploring both the disease and the illness experience**
    a. *differential diagnosis*
    b. *dimensions of illness (ideas, feelings, expectations and effects on function).*

2. **Understanding the whole person**
    a. *the "person" (life history and personal issues)*
    b. *the context (family and anyone else involved in or affected by the patient's illness, the physical environment).*

3. **Finding common ground regarding management**
    a. *problems and priorities*
    b. *goals of treatment*
    c. *roles of (health professionals) and patient in management.*

4. **Incorporating prevention and health promotion**
    a. *Health enhancement*
    b. *Risk reduction*
    c. *Early detection of disease*
    d. *Ameliorating effects of disease*

5. **Enhancing the patient-practitioner relationship**
    a. *Characteristics of the therapeutic relationship*
    b. *Sharing power*
    c. *Caring and healing relationship*
    d. *Self-awareness*
    e. *Transference and counter transference*

6. **Being realistic**
    a. *Time*
    b. *Resources*
    c. *Team building*

Nursing 2910
Direct Clinical Observation

A; Excellent B: Very Good C: Good, Average, Satisfactory D: Minimal Pass F: Fail

In order to pass NURS 2910, students must demonstrate safe, ethical nursing practice; professional behavior and acquire a passing grade in the Direct Clinical Observation.

Students MUST pass the DCO in order to pass the course. If a student does not pass the DCO with a 50%, they will obtain an overall grade of no greater than D. If you receive a grade of "F" in any of the DCO criteria it constitutes a "clinical failure" on the DCO, as the student has then shown unsafe, unprofessional, or unethical nursing practice.

Professional Responsibility and Ethical Practice:	A	B	C	D	F
Demonstrate application of legal and ethical standards in selected nursi situations by consistently demonstrating: ➢ Responsibility and accountability through: - support of colleagues - effective decision making And by demonstrating, with assistance, ➢ Competency with appropriate documentation With guidance, demonstrate attitudes and skills for learning through ➢ An attitude of inquiry ➢ Openness and receptivity to change Demonstrate an understanding of social and political action at a beginn by: ➢ Identifying power structures in nursing situations ➢ Discussing client responsibilities ➢ Applying principles of change theory to nursing situations With minimal assistance, utilize a variety of information technologies. With minimal assistance, demonstrate effective use of skills in self-directed, context-based, small group learning.					

Comments:

Knowledge Based Practice	A	B	C	D	F
With Minimal assistance, utilize selected areas of knowledge related to biological, psychological, sociological, cultural, and spiritual factors in interacting with clients experiencing chronic and less acute variances in health. With minimal assistance, apply a selected model/theory in nursing practice. With assistance, develop sound clinical judgment in relation to rehabilitation and restoration through use of critical thinking skills. Apply knowledge from research to nursing situations and share Findings with colleagues. With assistance, demonstrate competence in understanding ambiguity and diversity by: ➢ Providing support to clients in transition ➢ Developing resource networks With assistance, demonstrate beginning competence in leadership and management skills through: ➢ Using effective time management skills ➢ Applying decision making processes					

Comments:

Provision of Service to the Public	A	B	C	D	F
Apply the concepts and principles of primary health care in selected nursing situations. Demonstrate caring behaviors in professional situations by: ➢ Establishing caring relationships with clients ➢ Recognizing the effect of caring on health and healing ➢ Demonstrating concern for the health of others. With assistance, demonstrate ability to interact with and develop collaborative partnerships with colleagues, clients, registered nurses, and members of other disciplines by applying principles of change theory. Demonstrate competence in nursing skills required for nursing care of clients across the lifespan in acute settings by: ➢ Demonstrating competence in selected skills indicated in the Lab Map And by demonstrating, with guidance, ➢ Application of the nursing process ➢ Use of appropriate verbal and written skills ➢ Use of appropriate teaching skills					

Comments:

Student Comments:

Tutor Signature: _____ Date:_____

**Student Signature:_____

**Signature indicates that the student has read the above information.

Journal Writing Grading Criteria

Characteristic	Excellent A	Very Good B	Good C	Marginal D	Unsatisfactory F
Dialogue	Responds to instructor feedback or questions in depth and poses questions or provides feedback to the instructor	Responds to instructor feedback or questions in depth	Responds briefly to instructor feedback or questions	Responds in yes/no format to feedback or questions posed by instructor	Does not respond to instructor feedback or questions in journal
Critical Thinking Reflective Practice	Recognizes critical clinical events and reflects on them substantively as they relate to clinical practice Includes thoughts, feelings, and perceptions of all people involved. Describes why event is important to them.	Recognizes critical clinical events and reflects on them to a large degree as they relate to clinical practice. Information is thorough, includes information on how they personally were feeling, and thoughts and feelings	Recognizes key clinical events and reflects on them superficially as they relate to nursing practice.	Able to recognize critical clinical events but does not reflect on those events as they relate to nursing practice. Is not specific with the events or why the incident is significant	Is not able to recognize or reflect on critical events in nursing practice
Identification of Strengths and Areas to Work on	Able to identify and critically analyse their strengths and areas to work on in great detail and how this can affect the client.	Able to analyse the strengths and areas to work on in some depth.	Provides some strengths and areas to work on. Does not explain why these are strengths or weaknesses.	Minimal analysis of strengths and weaknesses	No analysis.
Connection of Abstract to Practical	Recognizes actions are based on values and identifies values they are based on. Uses previous experiences and learning to apply to this situation. Critiques behaviours in clinical practice and examines and questions values and beliefs related to behaviours	Recognizes actions are based on values and identifies values they are based upon. Critiques behaviours in clinical practice as they relate to values and beliefs	Recognizes actions are based on beliefs Ties some personal values and beliefs to behaviours	Recognizes actions are a choice but no justification of actions given Mentions personal beliefs but does not tie them to behaviours	Does not take responsibility for own actions No references to personal values or beliefs in journal
Application of Knowledge	Is able to utilize knowledge from nursing and other disciplines and apply it to nursing practice now and for the future. Able to provide specific information and examples of what they would teach a peer about this incident. Identifies what they would do differently in the situation	Consistently applies them to nursing practice. Describes what they would do differently in the next situation.	Includes appropriate information and occasionally applies content to nursing practice. Briefly focuses on how they would teach a peer about this situation and how this is meaningful to them.	Includes occasional theory information in journal but does not apply the content to own practice. Shows minimal insight into how this incident has taught them to do something different. Does not discuss what they would teach a peer about this incident.	Does apply theoretical knowledge to practice. Does not describe what they would do differently or what they would teach a peer.

How to Make a Learning Plan

Learning plans enable students to combine selected learning objectives for the course with their own learning objectives and consideration of their particular learning style and areas of interest. A learning plan is an agreement between the student and the tutor specifying how the student intends to enhance learning, how this will be accomplished, the time frame for meeting the objectives and the methods by which achievement of the objectives will be measured. The learning plan is to be used by the student and tutor to select learning opportunities that will assist the student to meet the objectives It also contributes to both formative and summative evaluation, and is submitted once in each clinical course.

The intent of the learning plan is to explore personal learning objectives. That is, in a specific practice course there are learning opportunities which students may have a reasonable expectation of experiencing. For example, on an orthopedic unit or in the community, students would have opportunities to assist with ADL's, learn about problems of mobility, and/or to teach clients/families. Therefore, students would not write learning plans related to these expected experiences; these would be assessed by using the Direct Clinical Observation (DCO) form.

In the Learning Plan students are expected to develop objectives related to the course objectives but very specific to their own learning needs and considering the uniqueness of the practice setting. Therefore, students would have the opportunity to meet the course objectives in a very particular and self-directed way. One approach is to develop the learning plan according to the major headings of the DCO: professional development, helping relationship, knowledge, skills and nursing practice.

Name:_____

Learning Plan Exercise
NS 2910

Look back on your last clinical rotation to perform a quick self-evaluation of yourself and where you want to go this semester.

1. **My strengths in clinical last semester were:**

2. **What attitudes do I have that will help me with my career as a nurse?**

3. **What areas in the course objectives do I need to work on?**

4. **Where do I want to be at the end of the course?**

5. **How do I plan to accomplish this?**

Grading Guide for Learning Plans

	A (10)	B (8)	C (6-7)	D (5)	F (3)
Objectives	Clear, detailed description of what the student intends to learn, how this will be accomplished, the time frame for meeting objectives & methods by which this will be evaluated are identified. Objectives are specific , concise & do not repeat the course objectives. Objectives are reasonable, measureable & attainable.	Some detail missing but a clear direction is established by student in terms of what is to be learned, how this will be accomplished, the time frame & methods of evaluation to be used. Objectives are specific but occasionally repeat the course objectives. Objectives are reasonable, measureable & attainable.	Description of what the student intends to learn requires more detail in order to address what will be learned, methods or strategies by which this will be accomplished in what time frame, & how this will be evaluated. Objectives are adequate but frequently repeat the course objectives. Objectives are reasonable, measureable & attainable.	Description of what the student intends to learn lacks enough detail to clearly identify the intent of the learning plan, how & when it will be accomplished, & how this will be evaluated. Objectives are vague or ambiguous, difficult to measure. Repetition of course objectives.	Ambiguous /superficial plan of what the student intends to learn, few or inappropriate strategies, unrealistic time frame provided. Evaluation strategies inappropriate, lack specificity or are difficult to measure. .
Resources	Resources used to address objectives are varied, current, credible & appropriate to goals set by student.	Resources used are appropriate & reflect student's intent re: meeting objectives	Resources are limited but adequate.	Resources identified are limited, not specific to objectives set by student.	Inappropriate &/or minimal resources selected.
Evaluation	Clear description of extent to which the objectives were met including specific examples of activities. If objectives not met, revised in order to be attainable. Substantive, insightful, comprehensive comments.	Clear description of extent to which the objectives were met including some examples of activities. If objectives not met, revised in a realistic way. Thorough analysis addresses Significant points. Some Specificity missing.	Description of extent to which the objectives were met included but examples of relevant activities done superficially. If objectives not met, are revised in an unrealistic or attainable manner. Adequate analysis of major points. Some essential information missing.	Description of extent to which the objectives were met given but brief, lacks detail &/or specificity. Unmet objectives not addressed. Key information missing. Minimal analysis, little insight.	Extent to which the objectives were met is superficial, significantly lacking in detail &/or examples. Incorrect or inappropriate information. No analysis or insight. Superficial.

The Learning Plan

The Learning Plan:

- Is an agreement between the student and the tutor.
- Is where both the student and the tutor work on ways of meeting the student's objectives
- Should not repeat the course objectives
- Is based on the student's individual needs, and to some extent, where they are working in the community agency
- Will be different for each student. The student works on looking at their own strengths and limitations
- Is used with the reflective journal to help you reflect on what you have learned throughout the clinical experience
- Is a way of evaluating your progress throughout the clinical experience. You will be evaluated based on how you have worked at achieving the objectives you made in your learning plan.

Components of a Learning Plan:

1. Student writes what they wish to learn or work on throughout the clinical experience.

This is called the **LEARNING OBJECTIVE**

Example: *To increase my ability to ask clients more questions and to get more pertinent information*

2. Next, the student writes how they intend to enhance their learning of this objective. How is learning going to be accomplished? How are you going to achieve your goal?

This is called your **LEARNING RESOURCE AND STRATEGIES**

Example: *To increase my ability to ask clients more questions to get more pertinent information, I will:*

- *Read three articles or chapters on interviewing techniques in regards to a health history*
- *Watch a video in the library on the health history*
- *Practice with classmates in the lab on interviewing techniques based on my OSCE*

3. You then need to write how you will know you have met or accomplished your goal. What proof will there be to show you have met your objective? You need to also determine what date you will have this accomplished.

This is called **EVIDENCE OF ACCOMPLISHMENT**.

Example: *I will know I met my goal of asking more pertinent information by:*

- *Applying 3 concepts from my readings during the health history*
- *Discuss in seminar group what I learned from my articles or readings and how those 3 concepts worked*
- *Prepare a handout on how to improve communication when taking a health history*
- *I will complete this learning objective by April 3.*

4. Finally, the student needs to write how they are going to evaluate evidence of meeting their objectives:

This is called: **CRITERIA AND MEANS OF VALIDATING EVIDENCE**

Example: *To show that I have met my objective of finding more pertinent ways of asking health history questions, I will*

- *Have my classmates/tutor evaluate my presentation during seminar.*
- *I will develop a questionnaire for my tutor and peers to evaluate my presentation on.*

Full Example:

Learning Objectives	Learning resource and Strategies	Evidence of Accomplishment	Criteria and means of Validating Evidence
To increase my ability to ask clients more questions to get more pertinent information	• Read three articles or chapters on interviewing techniques in regards to a health history • Watch a video in the library on the health history • Practice with classmates in the lab on interviewing techniques based on my OSCE	• Applying 3 concepts from my readings during the health history and discuss the effectiveness of each in my journal. • Discuss in seminar group what I learned from my articles or readings Learning Plan objective will be completed by April 3.	Have my classmates/tutor evaluate my presentation during seminar.

After the student has completed the learning plan, the tutor will:

- Review the learning plan and make sure the student has made realistic goals, give any feedback on the learning plan and gives suggestions as to how the student could make revisions
- Be responsible for evaluation of student outcomes toward achievement of the course objectives

Learning Plan
Assessment

1. What are my strengths and those needing improvement?
    - What skills, knowledge, and attitudes do I already have
    - What resources and competencies can I bring to this learning situation?

2. What areas in the course objectives do I need to work on?
3. Where do I want to be at the end of the course?
4. What do I hope to learn from my community agency?

Planning:

1. Are my objectives clear? (can also get a peer to look at your objectives). Should be in your own words. Learning objectives should clearly describe your desired knowledge, skills and attitudes.
2. What resources are their to help me?
    - Resources from the community agency?
    - How will I gain the relevant knowledge, skills and attitudes?
    - Why select a particular learning strategy?
    - What other strategies have you considered?
    - Are they realistic? How will you acquire these resources
3. How is the learning going to measured?
4. How am I going to evaluate to see if I met my objectives?

Implementation

1. Are there other ways you could have achieved your objectives?
2. Make target dates as to when you will have met this objective
3. What learning activities am I going to use?
    - Project
    - Using journal articles and texts
    - Accessing AV materials from the learning resource center
    - Meeting with resource people
    - Attending tutorials
    - Writing an essay or paper
    - Demonstrating skills and attitudes in clinical

- Completing a case study or simulation and interviewing

4. Use evaluation methods to see how you are doing in meeting your objectives:
    - Verbal dialogue
    - Journal/log
    - Case study
    - OSCE
    - Demonstration
    - Presentation
    - Performance evaluation

Summary/Evaluation

1. What learning has occurred in terms of the initial objectives?
2. What value has this learning had for you?
3. What have you gained professionally and personally?
4. How has this stimulated your interest in this or other related topics?

Learning Plan Contract

Name: _____ Date I will Be Presenting:_____

Learning Objective	Learning Resources and Strategies	Evidence of Accomplishments	Criteria and Means of Validating

Nursing Care Plan Guidelines
NS 2910

1. **General Information**

Client initials
Diagnosis - brief description of pathophysiology
Pertinent history (what brought them in to the hospital, presenting signs and symptoms, what could contribute to their being in the hospital)
Admission date/discharge date

II. **Health Assessment (according to D. Orem)**

Remember to include relevant lab data, consults/histories, subjective information from the client, reports from radiology, presence of IV/NGs/catheters or other therapies, data from physio/OT/rec therapy/dietician etc. and, of course, your assessment. Give a brief explanation about D. Orem and her beliefs around nursing and the self-care theory.

III. **Care Plan**

Develop **three priority diagnoses** from the data. You may use nursing diagnoses Eg. Pain related to the effects of surgery or develop collaborative problems eg. Hypoxemia related to bronchial obstruction. You need to explain why you chose these each as a priority.

Develop **goals** or **outcome criteria** for each of the problems. If using Orem, assess the clients self-care agency to meet these goals (do they have the knowledge, skills, motivation to meet the goals). Goals can be long-term or short-term. Keep in mind that some goals can be assessed at the home visit.

Implementation phase consists of listing the **interventions** used to help these clients meet the goals. Note administration of meds and other therapies (dependent interventions) and the interventions that are done independently by nurses (assessment, physical care, communication, support etc.). Include a short but comprehensive rationale for the interventions.

Reassessment/discharge: evaluate your interventions. Ask the client what interventions worked and did not work. What would you do differently next time? Were the discharge needs/requisites of the client met?

Tip: Think about your day and what you did. Are these interventions reflected in your care plan? Keep in mind the holistic nature of nursing when writing care plans. Apply Orem and what she believes to be nursing interventions for the client.

Name:

Care Plan Marking Guideline

A. General Information /6

1. Client Initials
2. Diagnosis – brief description of Pathophysiology that is pertinent to the client
3. Pertinent History
4. Admission Date/Discharge Date

B. Health Assessment /25

1. Related the health assessment to the theorist – gives a brief description of Dorothy Orem's Self Care Model and it's relevance to the patient's plan of care.

2. Included relevant data for health assessment

3. Develops appropriate Nursing Diagnosis from each Self-Care Requisite that potentially affects the client (5-10).

C. Care Plan /40

1. Develop 3 ***priority diagnoses*** from the data. Need to give ***rationale*** as to why you feel this was the priority diagnosis.

2. Develops ***goals*** for each of the problem. Integrates theorists assumptions related to the goals. Determined if goals were long-term, or short term.

3. ***Implementation*** – listed interventions used to help these clients meet the goals. Included whether they were dependent interventions or independent interventions. Included rationale for each intervention.

4. ***Reassessment/Discharge*** – evaluation of interventions. Ask the client what interventions worked and what did not. What would you do differently next time? Were the discharge needs/requisites of the client met?

D. Organization /4

1. Includes references used to develop care plan.
2. Care plan is organized, clear and understandable.

Total Raw Score: /75

Orem Care Plan
Grading Criteria
NS 2910

A (Excellent)

General information is extensive, gives a detailed description of why the patient is in the hospital. Thorough and specific description of pathophysiology and discusses how it pertains to the client and what they are presenting. Describes in detail what S & S the patient had when coming to the hospital. Patient assessment involves a comprehensive approach of an extensive nature. Provides a detailed, concise and in-depth description of Orem and how it applies to nursing, what the nurse's role is in patient care and how it is applicable to their clinical area. Describes in detail the theory in a way that is easy to understand. Data collected is concise, identifies which requisite, able to identify if the patient has the knowledge, skill or motivation. Able to identify if data is objective or subjective. Very detailed information. Provides well-written diagnosis, which includes the problem statement, as evidenced by and related to. The patient diagnosis is accurately derived from the assessment data. This patient diagnostic statement is verified utilizing defining characteristics and related factors. The patient's desired outcome is derived from the identified diagnosis and is realistic and attainable. The outcome, which has been formulated is developed in relation to the patient's current and potential resources/capabilities. The goals are identified as long term and short term goals and the interventions will help to achieve those goals. The student also incorporates Orem's model into the goals and plan of care. The plan of care includes nursing interventions based on the identified patient diagnosis statement and desired outcomes. Selected nursing interventions are documented in the care plan and assist the patient in attaining the desired outcome, are detailed and numerous. The nursing interventions are implemented in a safe manner, and include monitoring the patient's response toward the outcome. Rationale is detailed and in-depth. The evaluation component of the care plan will include the patient's progress toward the desired outcome attainment, and the patient's response to the interventions. Care plan is well organized, easy to read, uses an extensive amount of resources to support care plan and provides references in written portion of paper. Reference page follows APA guidelines.

B (Very Good)

Includes a description of the pathophysiology of the major problems the patient has and describes briefly the pertinent history. Gives a detailed overview of Orem and its application to nursing. Able to identify subjective and objective data with minimal assistance. Identifies if the patient has the knowledge, skill, or motivation to perform the self care demand. Missing minimal assessment information. Diagnoses made are clear and represent the data. Some difficulty with wording of the diagnosis but they are comprehensive. The data which is used for patient assessment includes biophysical, psychosocial, environmental, self-care and/or discharge planning. This patient diagnosis is verified utilizing defining characteristics and related factors. The patient's outcome is identified in the diagnosis, and is realistic and achievable, but does not show knowledge of Orem to a large degree. The plan of care includes nursing interventions based on the identified patient diagnosis statement and desired outcomes. Nursing interventions are documented in the care plan, and assist the patient in attaining the desired outcome. These interventions may not be of an extensive nature, but will project a focus toward achieving a desired outcome. The nursing interventions which are suggested are safe, and include monitoring the patient's response to the outcome. Provides adequate rationale for interventions. Evaluation is clear and reflects the goals, identifies areas to work on. Care plan is well organized, easy to read, uses an varied amount of resources to support care plan and provides references in written portion of paper. Reference page follows APA guidelines with few corrections.

C (Good)

Gives a little pathophysiology but does not relate it to the patient's current status. Little pertinent history included. Provides a definition of Orem but does not go in-depth nor explains the nurse's role in patient care. Needs some assistance identifying what data is subjective and objective. The data does not reflect if the patient has the knowledge, skill, or motivation. Some assessment data missing from forms. Does not show knowledge of Orem in the careplan (i.e. deciding goals that are wholly compensatory, partially compensatory or supportive/educative). The problems have been identified from the assessment data but are not formed into a concise manner as a diagnosis should be written. Goals are not identified as short term or long term and they are not measurable. The nursing interventions are documented in the care plan, focus on desired outcome, and will suggest a safe approach to care. Rationale is not extensive. Evaluation is brief and concentrates on if the patient met the goal with minimal focus on interventions that worked, what didn't and what they would do differently next time. Care plan needs some more organization, includes a reference list, although some APA discrepancies and not a varied amount of references.

Marginal (D)

Provides inadequate information to describe why the patient was in the hospital or why they were admitted. Provides a definition of Orem's model of nursing but does not show how to apply this to their clinical setting. Patient assessment will involve the inclusion of data pertaining to the health state of the patients' needs. This data may not reflect pertinent details of the patient's health state, and may not be inclusive of all aspects of care. The data collected may be related to the patient's current resources, may not consider the patients capabilities. Minimal reference to desired patient outcomes are included, and the patient's response to these outcomes are not included in this data. Little reflection noted as to what they would have done differently with their interventions. The evaluation component of the care plan does not consider the patient's responses to their progress. Limited references used and care plan is unorganized.

Unsatisfactory (F)

Does not provide general information about the client. Little or no evidence to show there is knowledge of Orem's model of nursing. The patient assessment does not include data which pertains to the health state of the patient. The data collected is lacking major assessment data. No reference to the patient capabilities or resources are mentioned. The care plan does not include a component which involves patient progress or response to care. Little effort in providing rationale for interventions. No or limited evaluation, but does not reflect goals. Lack of references and care plan is unorganized.