Name:

Care Plan Marking Guideline

A. General Information /5

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 /35

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 /50

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 /10

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

Total Raw Score: /100

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.

Learning Plan Contract

Name: ___________________　　　　**Date I will Be Presenting:_______________**

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

- 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?

- 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

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*
- *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.*

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 • 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:

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*

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.

Name:____________

Learning Plan Exercise

NS 2910
Fall, 2003

Look back on 2950 last semester 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?

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.

• Evidence-based practice	Demonstrates clear recognition of significance of evidence-based practice. Incorporates research findings at an exceptional level for this point in the program.	Able to describe the importance of evidence-based practice, incorporates relevant research findings at an above average level.	Able to describe how research may be used to improve practice. With assistance incorporates relevant research findings at an appropriate level.	Able to describe how research may be used to improve practice, but incorporates relevant research only with encouragement, or uses irrelevant or inappropriate findings. Not committed to evidence-based practice.	Does not acknowledge the significance of research and/or does not incorporate research in nursing situations.
• Models/theories	Applies knowledge of a nursing model as well as knowledge from other disciplines in selected nursing situations.	Applies knowledge of a nursing model as well as knowledge from other disciplines in selected nursing situations with minimal assistance.	Applies knowledge of a nursing model as well as knowledge from other disciplines in selected nursing situations with some assistance, needs to be reinforced frequently.	Rarely able to apply knowledge of a nursing model or knowledge from other disciplines in selected nursing situations, requires much assistance.	Unable to satisfactorily apply knowledge of a nursing model or knowledge from other disciplines in nursing situations.

Skills: •Teaching	Completes comprehensive assessment of client learning needs; creatively and thoroughly designs learning plan; addresses specific individual needs; implements plan attending to verbal & non-verbal cues of client(s); completes appropriate evaluation following activity.	Completes thorough assessment of learning needs; develops a learning plan that addresses identified needs at an above average level; complete teaching with confidence, attending to input from client(s); completes appropriate evaluation following activity.	Completes client-centered assessment of needs at an acceptable level; develops a learning plan that addresses identified needs; completes teaching satisfactorily, may attend to response from client(s) during activity; completes evaluation following activity with focus on most obvious features, may miss subtle cues from client(s)	Assessment lacks specificity or detail; assesses only most obvious factors; ideas may focus more on student than client; develops sketchy, incomplete teaching plan with general objectives; teaching activity may reflect poor preparation, lack of knowledge, minimal response to learner cues; evaluation of activity is superficial &/or inaccurate.	Assessment of learning needs is done poorly or not at all; teaching plan is superficial, disorganized, lacking specific goals or activities; activity carried out at an unacceptable level; evaluation of activity is inaccurate, lacking awareness of client response.
Knowledge: •Application	Analyzes & applies knowledge of bio-psycho-socio-spiritual and cultural factors at an exceptional level.	Analyzes & applies knowledge of bio-psycho-socio-spiritual and cultural factors at an above average level.	Analyzes & applies knowledge of bio-psycho-socio-spiritual and cultural factors at an average level. May require assistance to identify/incorproate significant factors.	Analyzes & applies knowledge of bio-psycho-socio-spiritual and cultural factors at a marginal level. Requires more assistance than usual to achieve an acceptable level.	Unacceptable level of knowledge with minimal application. Requires inordinate amount of assistance to achieve basic understanding of significant factors.

Skills: • Communication • Documentation	Communicates in a confident manner. Consistently develops collaborative partnerships with clients, families, nurses, members of other disciplines & members of the community. Documents/reports clearly, concisely, completely and accurately.	Communicates in an appropriate manner. Develops collaborative partnerships with clients, families, nurses, members of other disciplines & members of the community, with few exceptions. Documents/reports clearly, concisely, completely & accurately with minimal guidance.	Generally communicates appropriately but some feedback necessary to foster consistency. Develops collaborative partnerships with clients, families, nurses, members of other disciplines & members of the community with minimal guidance. Documents/reports clearly, concisely, completely & accurately with assistance.	Requires frequent feedback re: appropriateness of communication. Requires feedback/assistance to develop collaborative partnerships with clients, families, nurses, members of other disciplines & members of the community. Documentation/reporting lacks clarity, conciseness, accuracy and/or is incomplete; needs assistance to reach satisfactory level.	Inappropriate and unacceptable communication. Does not respond to constructive feedback. Fails to develop collaborative partnerships with clients, families, nurses, members of other disciplines or members of the community. Poor/unacceptable level of documentation and/or reporting; lacks accuracy, conciseness, clarity and/or is incomplete and/or irrelevant.

Skills: •Critical thinking (problem-solving)	Engages in creative, reflective thinking; thoughtfully analyzes & evaluates other points of view. Examines assumptions in a non-threatening manner; open-minded. Demonstrates sound clinical judgement in situations involving acute & complex variations in health.	Interprets evidence accurately; identifies relevant arguments; evaluates obvious alternate points of view. Provide rationale for conclusions; open-minded. Generally demonstrates sound clinical judgement in situations involving acute & complex variations in health.	Generally able to interpret evidence, may require assistance to fully appreciate alternate points of view. Occasionally reaches conclusions without examining all relevant information. Aware of some assumptions made by self & others; able to achieve sound clinical judgement with some assistance from tutor and/or others.	Reaches conclusions prematurely or without consideration of all salient information. Accepts things as they are; fails to generate viable alternatives. Unaware of own assumptions, beliefs, values. Demonstrates questionable clinical judgement and r equires assistance to realize significance of actions.	Makes biases judgements based on opinion and/or limited examination of reliable resources. Fails to identify and/or dismisses relevant information. Unaware of own assumptions, beliefs, values; argumentative and or narrow-minded. Does not demonstrate sound clinical judgement.
Skills: • Assessment: •physical •psychological •family •community	Consistently completes in-depth, comprehensive assessment of clients & families with more complex & acute variations in health; health/illness status, physical/mental status. Consistently assesses environment for safety of self & others.	Usually completes in-depth, comprehensive assessment of clients & families with more complex & acute variations in health: health/illness status, physical/mental status. Usually assesses environment for safety of self & others.	With no or few omissions, completes comprehensive assessment of clients & families with more complex & acute variations in health: health/illness status, physical/mental status. Occasionally assesses environment for safety of self and others.	Requires assistance to ensure adequate completion of assessment of clients and families with more complex & acute variations in health: health/illness status, physical/mental status. Rarely assesses environment for safety of self & others.	Consistently omits significant data in assessment. Does not assess environment for safety of self & others.
Skills: • Psychomotor	Prepares for labs or performance of skills to an exceptional level. Performs required skills with confidence.	Completes in-depth preparation for labs and skill performance in clinical practice. Performs skills at an above average level.	Prepares adequately for labs or skill performance in clinical practice. Performs skills at an acceptable or average level.	Preparation for labs or skill performance in clinical practice is inconsistent. Skills are performed at a borderline safe level.	Preparation for labs or skill performance in clinical practice is unacceptable or not evident. Skills are performed unsafely.

•Develops effective relationships with other health team members	Develops cooperative relationships with others to a degree that exceeds expectations for this level of student. Conveys concern appropriate to situation. Consistently sensitive to & supportive of clients in transition.	Develops cooperative relationships with others at an above average level for this point in the program Consistently sensitive to and supportive of clients in transition.	Develops cooperative relationships with others at an expected level for this point in the program. May be sensitive to and supportive of clients in transition, but needs assistance to recognize nuances.	Develops cooperative relationships with others at a minimal level for this point in the program. Frequently fails to assist client to exercise autonomy. Tends to "take over" for client. Relationships may tend to be social in nature. Inconsistent in sensitivity to and support for clients in transition. Tends to overlook significance of change in selected nursing situations.	Develops cooperative relationships with others at a minimal level for this point in the program. Insensitive to impact of transitions on clients.
•Deals with ambiguity and diversity	Consistently recognizes situations of ambiguity & diversity for client(s) & identifies pattern of dealing with same.	Usually recognizes situations of ambiguity & diversity for specific clients & identifies pattern of dealing with same.	With assistance recognizes situations of ambiguity & diversity for specific clients. May need help to identify how the client deals with this.	Needs a great deal of assistance to identify ambiguity & diversity in clients, & to identify how client(s) deal with this.	Does not acknowledge or understand client(s) situations producing ambiguity & diversity, not client(s) pattern of dealing with same.

•Establishes helping relationships with clients	Consistently demonstrates valuing & caring behaviors in clinical & seminars by recognizing the uniqueness, dignity & worth of others. At all times promotes client autonomy.	Consistently demonstrates valuing and caring behaviors in clinical and seminar by recognizing the uniqueness, dignity & worth of others. Promotes client autonomy.	Demonstrates valuing & caring behaviors in clinical and seminars; may require feedback to achieve expected level in recognizing the uniqueness, dignity & worth of others. Usually promotes client autonomy, but may need assistance to recognize significance of this.	Demonstrates valuing & caring behaviors in clinical and seminars; requires feedback to achieve expected level of acknowledging uniqueness, dignity & worth of others.	Demonstrates insensitive/indifferent or unacceptable behaviors in clinical and seminars; required an unusual amount of feedback and/or does not respond to feedback with appropriate change in behavior to acknowledge the uniqueness, dignity & worth of others.
•Therapeutic use of self	consistently demonstrates therapeutic use of self (empathy, therapeutic conversation) Consistently enables client(s) to identify/mobilize their personal power. Establishes, maintains & terminates relationships in a mature & supportive way.	almost always demonstrates therapeutic use of self (empathy, therapeutic conversation) Generally enables client(s) to identify/mobilize their personal power. Establishes, maintains & terminates relationships in a manner that reflects concern for the client.	Usually demonstrates therapeutic use of self (empathy, therapeutic conversation) Requires some assistance to enable client(s) to identify/mobilize their personal power. Establishes, maintains & terminates relationships in a manner that reflects concern for the client, but requires assistance to do so.	Inconsistent in demonstrating therapeutic use of self (empathy, therapeutic conversation) Requires much assistance to recognize & assist clients to identify/mobilize their personal power. Establishes, maintains or terminates relationships in a manner that does not recognize impact on client. Needs assistance to achieve a satisfactory level.	Rarely demonstrates therapeutic use of self (empathy, therapeutic conversation) Blocks or is unaware of need for client(s) to identify/mobilize their personal power. Does not establish, helping relationships without a great deal of assistance.

• use of nursing process • coordinating client care • problem-solving, clinical judgement •mobilizing power structures	Consistently engages in a problem-solving process; applies the nursing process to provide in-depth, comprehensive care to individuals & their families. Consistently coordinates care using sound clinical judgement & innovation. Mobilizes formal & informal power structures independently	Engages in a problem-solving process & coordinates care using sound clinical judgement either independently or with minimal assistance. Applies steps of nursing process to give a high level of care. Demonstrates above average competence in delegation. Mobilizes formal & informal power structures with minimal assistance.	Usually engages in a problem-solving process & coordinates care using clinical judgement buty may require some assistance to ensure all aspects of care are addressed. May require some assistance to apply all steps of the nursing process. Able to delegate appropriately. With some assistance, mobilizes formal & informal power structures.	Requires assistance to engage in a problem-solving process and to coordinate care. Requires considerable assistance to exercise sound clinical judgement. Requires assistance in order to implement the nursing process at an acceptable level. Needs assistance to fulfull duties re: delegation. Has minimal understanding of how to mobilize formal or informal power structures.	Does not engage in a problem-solving process at an acceptable level. Unable to coordinate care effectively; lacks sound clinical judgement. Demonstrates minimal ability to delegate or delegates inappropriately. Unable to identify, describe or mobilize formal or informal power structures.
• demonstrates safe care for 2-3 clients	Fulfills course objectives at an exceptional level for a student at this point in the program.	Meets objectives outlined in DCO at an above average level. All objectives met.	Meets course objectives outlined in DCO at an acceptable level.	Borderline performance; barely meeting some objectives for nursing practice as outlined in DCO.	Unacceptable and/or unsafe practice. Does not meet most objective for nursing practice as outlined in DCO.

•responsibility and accountability for learning: • self-awareness • self-appraisal and implementation of strategies to address strengths and weaknesses	Consistently identifies own strengths & areas for improvement & is open to/seeks feedback; generates creative, concrete and complete strategies to meet own learning needs. Course requirements submitted on time & completed at a level exceeding expectations for a student at this level in the program.	Identifies own strengths and areas for improvement with minimal assistance; generates comprehensive plans to achieve own learning needs. Course requirements are completed at an above average level for a student at this point in the program.	Identifies strengths & areas for improvement with some tutor/preceptor assistance. Identifies own learning needs & strategies for meeting same. Course requirements are completed at an expected level for this point in the program.	Identifies strengths & areas for improvement but only with considerable consultation with tutor/preceptor. Identifies most obvious learning needs but requires more initiative to do a more thorough assessment. Quality of work done to complete course requirements is below expected level for this point in the program.	Demonstrates little or no awareness of strengths and areas for improvement.. Able to identify learning needs at a minimal level. Requires input to generate adequate learning goals and/or strategies. Quality of work submitted as course requirements is unacceptable for a student at this point in the program.
•open and receptive to change •attitude of inquiry	Is open to/seeks feedback; is receptive to change.	Is open to/seeks feedback; is receptive to change.	Is open to/seeks feedback; is generally receptive to change, but may require added assistance to accomplish same.	Frequently not open or does not seek feedback for change.	Defensive and/or unreceptive to feedback for change.
Nursing Practice: •applies concepts of health promotion, primary health care	Consistently applies concepts of primary health care in acute & complex nursing situations in a variety of settings.	Applies concepts of primary health care in acute & complex nursing situations in a variety of settings at an above average level with minimal assistance.	Applies concepts of primary health care in acute 7 complex nursing situations in a variety of setting with some assistance.	Applies concepts of primary health care in acute & complex nursing situations in a variety of settings at a marginal level, requiring much assistance and guidance.	Applies concepts of primary health care in acute & complex nursing situations at an unacceptable level. Requires continual guidance and/or assistance.

• integrity	Demonstrates integrity and honesty at all times.	Usually demonstrates integrity and honesty.	Usually demonstrates integrity & honesty, but may need assistance to recognize situations in which these traits are significant to practice.	Demonstrates integrity & honesty at all times although may be unaware of own misconceptions of integrity in clinical practice.	Fails to demonstrate integrity and honesty in clinical practice and/or seminars.
•responsibility and accountability for own practice	Always accepts responsibility for own clinical judgements. Demonstrates commitment to nursing as a profession. Fulfills commitments to self and others.	Accepts responsibility for own clinical judgements. Demonstrates commitment to nursing as a profession. Can usually be counted on to fulfill commitments	Generally accepts responsibility for own clinical judgements but may need assistance to recognize own accountability. Demonstrates commitment to nursing as a profession Does not always follow through on commitments.	Tends to hold others responsible for own errors in clinical judgement. Needs assistance to realize own accountability. Inconsistent in demonstrating commitment to nursing as a profession. Does not always follow through on commitments.	Fails to accept responsibility for own clinical judgements. Does not recognize own accountability for practice. Fails to demonstrate commitment to nursing as a profession. Does not meet commitments to clients and/or colleagues.

•Preparing for clinical practice •practicing within agency policies	Consistently prepares for clinical assignments; demonstrates thorough research of client condition, medications, treatments and appropriate nursing interventions. Consistently follows the policies of the agency.	Generally well prepared for clinical assignments; fairly in-depth research of client condition, medications, treatments and appropriate nursing interventions. Follows the policies of the agency.	Adequately prepared for clinical assignments. Some areas of client condition, medications, treatments and appropriate nursing interventions not thoroughly reviewed. With minimal guidance, follows the policies of the agency.	Inadequate or inconsistent preparation for clinical assignments. Unable to respond appropriately to questions about client condition, medications, treatments or appropriate nursing interventions when questioned. Needs frequent guidance/direction to follow policies of the agency.	Unacceptable level of preparation or no evidence of preparation for clinical assignments. Does not demonstrate knowledge of client's condition, medications, treatments and/or appropriate nursing interventions. Unaware of agency policies or consistently does not follow agency policy.
Professional Development: • respect • communication	Consistently demonstrates the professional behaviors of respect and responsibility towards clients, peers & others. Communication in clinical and tutorial/seminars is always appropriate.	Respectful & responsible in relationships with clients, peers & others. Communication in clinical and tutorials/seminars is generally appropriate to the situation.	Usually respectful & responsible in relationships with clients, peers & others but occasionally needs feedback re: same. Communication in clinical and tutorials/seminars appropriate.	Needs frequent feedback re: behaviors of respect & responsibility towards clients, peers & others. Communication in clinical and tutorials/seminar adequate, but needs improvement.	Communication with clients and/or peers is inappropriate, disrespectful or unprofessional.

NS 2910
Direct Clinical Observation (DCO)
Grading Guide

	Excellent/5 (A)	**Very Good/4 (B)**	**Good/3 (C)**	**Marginal/2 (D)**	**Unsatisfactory/1 (F)**
<u>Professional Development</u>: **Legal and Ethical Standards** •Support for colleagues	Supports colleagues at all times.	Usually supportive of colleagues	Generally supportive of colleagues but occasionally fails to consider significance of context for others.	Needs frequent feedback re: support of colleagues.	Support of colleagues is inconsistent or non-existent.
•Ethical behavior	Consistently maintains confidentiality. Behaviors are always consistent with the CNA Code of Ethics.	Usually maintains confidentiality. Behaviors are consistent with the CNA Code of Ethics.	Maintains confidentiality with few significant errors. Behaviors are generally consistent with the CNA Code of Ethics.	Maintains confidentiality but needs reminders re: same. Behaviors are generally consistent with the CNA Code of Ethics but deeper considerations re: ethical behaviors is warranted.	Does not maintain confidentiality on a consistent basis. Behaviors are inconsistent with guidelines of CNA Code of Ethics.
•Protecting values, beliefs and rights of clients	Always involves client in decision-making & incorporates client's values, beliefs and rights.	Almost always involves client in decision-making & incorporates client's values, beliefs and rights.	Usually involves client in decision-making but is inconsistent in this & in incorporating client's values, beliefs & rights.	Tends to make decisions for clients, does not seek client input consistently. Frequently neglects to incorporate client's values, beliefs & rights.	Does not consult client in any part of decision-making process. Does not incorporate client's values, beliefs & rights.

student demonstrates minimally safe practice requiring frequent supervision and instructor intervention, and focuses on performance tasks rather than on the client. The student has a number of areas for improvement but does attempt to change performance following feedback. The student demonstrates responsibility and self direction some of the time. The student is inconsistent in demonstrating clinical judgment and is not receptive to examining alternate approaches and points of view.

Unsatisfactory

The student demonstrates an unsatisfactory level of knowledge and/or unsatisfactory and disorganized performance of skills and behaviors. Preparation is inadequate and unacceptable. The student requires constant supervision and tutor intervention to ensure client safety. Focus is entirely on tasks rather than on the client, and the student is unable to complete tasks satisfactorily. The student demonstrates minimal evidence of change in response to feedback as well as minimal evidence of responsibility and self-direction. The student lacks clinical judgment.

Evaluation of Student Performance in Clinical Setting

The five categories listed above will be described according to application of knowledge and critical thinking/clinical judgement; preparation for and planning and organization of performance; competence, safety, accuracy in skill performance; ability to focus on the client versus the task; level of supervision required; response to feedback; accountability and responsibility; and self direction. An additional element subsumed in the response to feedback, accountability, responsibility and self direction is the student's attitude in all aspects of the clinical experience.

The student must demonstrate safe, ethical care in order to pass clinical courses.

<u>Excellent</u>

The student consistently demonstrates an excellent, accurate application of knowledge, and safe, accurate performance of skills and behaviours with proficiency, speed, initiative, and adaptability to clinical situations. Preparation, planning, and organization are thorough and the student demonstrates depth of understanding of significant factors and the implications of clinical situations. The student may require supervision but no instructor/preceptor intervention, and focuses more on the client than on the skills being performed. The student responds immediately and positively to feedback regarding performance and consistently demonstrates responsibility and self-direction. The student consistently demonstrates sound clinical judgment.

<u>Very Good</u>

The student consistently demonstrates a strong knowledge base and safe, accurate performance of skills and behaviors. Preparation is complete and the student demonstrates an appropriate level of organization, understanding of significant factors, as well as implications in a clinical situation. The student may require supervision with occasional intervention. The student appears confident but can be distracted from focus on the client as skills become more complex. The student responds quickly following feedback and demonstrates responsibility and self-direction in all clinical situations. The student usually demonstrates sound clinical judgment.

<u>Good</u>

The student consistently demonstrates an acceptable knowledge base, yet may need assistance in application. The student demonstrates safe, accurate performance of skills and behaviors. Preparation is adequate for safe care, yet the student may require occasional assistance with organization and planning. The student recognizes obvious elements in clinical situations and demonstrates a basic understanding of implications of significant factors. The student requires a moderate amount of assistance and frequent intervention, and generally focuses more on tasks or skills being performed than on the client. The student generally responds positively to feedback and demonstrates responsibility and self-direction most of the time. The student is able to exercise a satisfactory level of clinical judgment but needs assistance to recognize and examine all aspects of a clinical situation.

<u>Marginal</u>

The student demonstrates a poor knowledge base and /or poor performance of some skills and behaviours. Student needs regular assistance in planning and organization. Preparation is superficial and/or incomplete. The

Knowledge

	(5)	(4)	(3)	(2)	(1)
Applies knowledge from nursing and other disciplines related to bio-psycho-social-cultural-spiritual factors.					
Demonstrates the use of selected elements of evidence-based practice: • identifies and examines findings related to specific nursing situations • describes relevance of research to practice .					
Applies knowledge of selected models/theories.					

Comments:

Summary Comments

Faculty:

Student:

Faculty: ______________________________ **Student: *** ______________________________

Date: ______________________________

•The student’s signature indicates that the student has read the evaluation.

Nursing Practice

	(5)	(4)	(3)	(2)	(1)
Applies concepts of health promotion, primary prevention, support, restoration and rehabilitation, palliation and death in selected practice setting by: • exercising sound clinical judgment. • demonstrating critical thinking • coordinating client care • using innovative approaches					
Identifies formal and informal power structures at a beginning level.					
Engages in safe practice in selected clinical settings.					
Demonstrates understanding of ambiguity and diversity in selected practice settings.					
Develops collaborative relationships with clients, nurses, community members and members of other disciplines by : . • demonstrating valuing, caring and compassion • respecting autonomy					
Demonstrates critical thinking skills: - attitude of inquiry.					
Demonstrates competence in teaching skills.					
Demonstrates competence in selected psychomotor skills.					
Demonstrates assessment skills in the following areas: • physical • psychological • family • community					
Demonstrates competence in communication skills and informatics.					

Comments:

DIRECT CLINICAL OBSERVATION
NURSING 2910

Student:
Dates:
Clinical Placement:
Grade:

Students MUST pass the DCO in order to pass the course. Students must demonstrate safe, ethical nursing practice. If a student does not pass the DCO with a 50%, they will obtain an overall stanine of no greater than 3. If you receive a mark of "1" 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.

Excellent 5/A
Very Good 4/B
Good 3/C
Marginal 2/D
Unsatisfactory 1/F

Professional Development

	(5)	(4)	(3)	(2)	(1)
Demonstrates application of legal and ethical standards in nursing practice setting by: • supporting colleagues. • incorporating clients' values, beliefs and rights into care. • preparing for clinical practice. • practicing within policies and procedures of agency. • demonstrating beginning understanding of the role of the professional association. • demonstrating an attitude of inquiry.					
Demonstrates professional behaviors in nursing practice through: • respect • integrity • communication • responsibility & accountability: decision-making, learning • self-awareness/self performance appraisal: strengths/limitations, • implementing strategies to meet identified learning needs					
Demonstrates openness and receptivity to change.					

Comments:

3. Neurocirculatory assessments.
4. Assessments for potential infection and pressures areas.
5. Discuss specific nursing care of a patient in an immobilization device.
6. Cast removal.
7. Discharge teaching.

Lab 4:Traction, Casts, Canes, Crutches

Upon completion of the lab # 4, the student will be able to:

-differentiate the various traction devices and their purposes
-demonstrate care of skin and traction device
-demonstrate positioning of patients in traction
-discuss and demonstrate the use of canes and crutches
-discuss nursing assessments and care of a patient in an immobilization device

Ambulatory Assists:

1. Discuss the use of canes as mechanical walking aids according to:
    a. Measurement.
    b. Placement of cane in relation to body.
    c. The side the cane is used on in relation to affected body part.
    d. Walking pattern with use of one cane.
2. Discuss crutches according to:
    a. Rationale for use.
    b. Method of measuring crutch length.
    c. Exercises done to prepare for crutch walking.
    d. Gaits for crutch walking.
    e. Safety measures used during crutch walking.
    f. Patient instruction upon discharge.
3. Describe how a patient who is unable to weight bear on affected leg should be taught to:
    a. Ascend and descend stairs.
    b. Sit down and rise from a chair.

Traction:

1. State the purpose and method of achieving the following traction systems:
    a. Pull (traction)
    b. Counterpull (countertraction)
    c. Suspension
    d. Balance
2. Traction Principle
3. Compare skin and skeletal traction.
4. Discuss the purpose of and demonstrate the method of performing the following exercises:
    a. Isotonic
    b. Isometric
    c. Quadriceps setting
5. Discuss the nurse's responsibility in caring for an adult patient in traction.
6. State the potential complications that can occur with skeletal and skin traction.

Casts:
1. Compare and contrast synthetic vs. plaster immobilizers.
2. Nursing assessments.

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.

Lab 2: Pre and Post-Operative Care

This lab is designed to assist the student to learn how to prepare and care for clients pre and post medical or surgical procedures.

I Preparation of a client for a diagnostic or surgical procedure.

1. Assessment
2. Teaching
    - Procedure
    - deep breathing and coughing
    - turning
    - leg exercises
    - ambulation
    - pain control

3. Physical preparation
    - skin preparation
    - fasting
    - specific to procedure
    - ambulation
    - pain control

4. Documentation

II. Care for client after a diagnostic or surgical procedure

A. Assessment
B. Physical care
C. Teaching
D. Documentation

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

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 mark of "1" 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. the use of a nursing model to guide nursing practice with adults or children experiencing chronic or less acute variances in health.
2. collaboration with clients, families, nurses and members of other disciplines.

Experiences that could be incorporated to assist in meeting course requirements include:

1. Participating in the client experience during pre and post medical or surgical procedure (e.g. follow through).
2. Participating in discharge planning/referral from institutional setting:
   - liaise with home care nurse where possible
   - follow-up visit with the client at home (assessment, client education) which may include a telephone follow-up or home visit.

Midterm Evaluations will occur on November 21st, 2003.

Final Evaluations will occur December 12th, 2003.

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 visit to the client's home where assessment and client education occurs. Guidelines for the development of nursing care plans are attached to the course outline.

Nursing Care Plan Due: Monday, December 8th, 2003.

Approximately 1500 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 number of paragraphs 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 every Monday by 1600 hrs with the last journal submitted on December 8th (total of 6). Journals will not be requested for the last week. Students must keep all journal entries in a binder or duo tang.

- Students will be graded on answering the above questions and how they respond to the tutor's feedback from previous journals.

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.

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.

Nursing Practice

Nursing practice will be evaluated by means of the following:

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.**

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: Wednesday, November 5th, 2003

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

November 14th, 2003
November 21st, 2003
November 28th, 2003

2. Critical Incident Journal Value: 15%

Components of this journal will include:

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. 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.

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 a D. If you receive a mark of "1" 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.

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

1. Use of a nursing model to guide nursing practice with adults or children experiencing chronic or less acute variances in health.

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

Students are expected to implement previously learned nursing skills.

Summary of Evaluation:

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

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 First Class Standing
A	4.0	
A-	3.7	
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.**

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.

Used with permission of Red Deer College Nursing Faculty.

Revised: August 28, 2003

C:\WINDOWS\TEMP\expectations revisions.wpd

5. Apply concepts related to health promotion, primary prevention, support, restoration, rehabilitation, and death in selected practice settings with clients by:
    - demonstrate safe nursing practice
    - practice according to policies and procedures of clinical agencies
    - collect and record client data using appropriate technology
    - at a beginning level, use effective time management strategies
    - coordinate client care using clinical judgment, critical thinking and innovation
    - at a beginning level, apply principles of change theory in nursing situations
    - understand diversity and ambiguity
    - support clients in transition
    - identify power structures in nursing situations
6. Demonstrate beginning ability to interact with and develop collaborative partnerships with clients, nurses, and members of other disciplines, displaying valuing, caring, compassion and respecting autonomy.
7. Demonstrates competence in selected skills required for nursing care of clients experiencing chronic and less acute variances in health.

WITHDRAW DEADLINES:
The last day to withdraw from this course with permission is **Friday, November 21st 2003.**

Progression in Clinical Course:
Whenever a student's clinical performance is considered marginal in a nursing course, the student's total academic and clinical performance in the program is reviewed at the end of each term and considered in determining continuation in the program. 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.

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

Refer 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.

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:

Upon completion of Nursing 2910, the nursing student will be able to:

1. Apply nursing knowledge as well as knowledge from other disciplines (research, models and theories) related to bio-psycho-socio-cultural-spiritual factors to nursing practice with clients experiencing chronic and less acute variances in health.
2. Demonstrate application of legal and ethical standards in nursing practice settings by: support of colleagues, decision making, respecting clients' values, beliefs, and rights within the mandate and the role of the professional association.
3. Demonstrate professional behaviors in nursing practice (respect, communication, integrity, responsibility, accountability, self-awareness, self-performance appraisal.)
4. Demonstrates openness and receptivity to change and an attitude of inquiry in nursing practice.

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:
You will receive an individual schedule on your first orientation day, October 27th, 2003 outlining your exact seminar schedule.
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

Stephen Deline
H218
539-2758 (O) 539-3998 (H)
email: sdeline@gprc.ab.ca
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 observational 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

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, 2003

Originally developed by Clinical Experience Development Committee of

Caren Clouston, RDC | Barb Gibson, UofA | Pat McMullin, Keyano
Monique Sedgwick, GPRC | Ruth Stewart, MacEwan | Marina Vettergreen, MacEwan

Revision May 2002 by the Clinical Experience Development Committee

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