



PRACTICAL NURSE COLLABORATIVE CURRICULUM

KEYANO COLLEGE

COURSE OUTLINE

PN 160

**NURSING PRACTICE I:
CONTINUING CARE**

Winter 2021

March 19, 2021 – April 25, 2021

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**NURSING PRACTICE I:
CONTINUING CARE
Course Outline**

Table of Contents

PRACTICAL NURSING 160.....	
CALENDAR STATEMENT	5
COURSE HOURS	5
TUTOR INFORMATION	5
GENERAL LEARNING OUTCOMES	6
INSTRUCTIONAL METHODS	6
PRACTICAL NURSING PROGRAM POLICIES	7
LATE POLICY FOR ASSIGNMENTS	7
SPECIALIZED SUPPORTS & DUTY TO ACCOMMODATE	8
DISABILITY SUPPORT SERVICES: LEARNER ASSISTANCE PROGRAM.....	8
SPECIALIZED SUPPORTS AND DUTY TO ACCOMMODATE	8
OVERVIEW OF LEARNING EXPERIENCES	8
CLINICAL PRACTICE	8
OVERVIEW OF COURSE ASSESSMENT.....	10
DISTRIBUTION OF MARKS	10
PASSING LEVEL AND GRADING SCALE.....	10
IMPORTANT ADDITIONAL INFORMATION.....	10
INSTRUCTIONS.....	11
CLIENT ASSESSMENT	11
NURSING CARE PLAN.....	11
NURSING ASSESSMENT TOOL: A SYSTEMS APPROACH.....	13
NURSING ASSESSMENT FORM.....	15
NURSING CARE PLAN.....	17
2.REFLECTIVE PRACTICE.....	20
REFLECTIVE JOURNALLING.....	20
GUIDELINES	20
REFLECTIVE PRACTICE CRITERIA	20
STUDENT ASSESSMENT/EVALUATION	21
CODE OF ETHICS.....	22
CLPNA COMPETENCIES.....	22
REQUIRED TEXTS	23
REQUIRED TEXTBOOKS AND RESOURCES	23
Appendix A.....	24
CONTINUING CARE.....	24
Clinical Standard Practices	24
OVERVIEW.....	24
DRESS CODE STANDARDS	24
ATTENDANCE.....	24
DOCUMENTATION OF CLIENT CARE.....	24

ENSURING CLIENT SAFETY	24
LEARNING IMPROVEMENT PLAN	24
REPORTING WHEN LEAVING THE UNIT	25
WORKPLACE INJURY	25
Appendix B	26
CONTINUING CARE.....	26
Student Experience Guidelines for Instructor-Supervised Practice.....	26
Student Experience Guidelines for Instructor-Supervised Practice.....	26
ATTENDANCE	26
PREPARATION FOR CLINICAL ASSIGNMENTS	26
ASSIGNMENTS/TEAM RESPONSIBILITIES.....	26
PERFORMANCE OF SKILLS	27
DOCUMENTATION OF CLIENT CARE.....	27
PRE- AND POST-CONFERENCES AND NURSING ROUNDS	27
Appendix C	28
CONTINUING CARE.....	28
Marking Guide for Nursing Care Plan Assignment.....	28
NURSING CARE PLAN: MARKING GUIDE.....	28
APA AND GRAMMAR: MARKING GUIDE.....	30
Appendix D.....	31
CONTINUING CARE.....	31
Marking Guide for Reflective Practice.....	31
ASSIGNMENT 2: REFLECTIVE PRACTICE MARKING GUIDE.....	31
Appendix E	32
CONTINUING CARE.....	32
Expectations of Students.....	32
Expectations of Students.....	32
KNOWLEDGE	32
NURSING PROCESS AND CRITICAL THINKING.....	32
PROFESSIONALISM	32
COMMUNICATION.....	33
SAFETY.....	33
REFLECTIVE PRACTICE.....	33
LEADERSHIP	33
Appendix F.....	33
CONTINUING CARE.....	33
Marking guide for Nursing Practice Student Evaluation.....	33
NURSING PRACTICE STUDENT EVALUATION	33

**PRACTICAL NURSING I:
CONTINUING CARE
COURSE OUTLINE**

CALENDAR STATEMENT/COURSE DESCRIPTION

PRACTICAL NURSING I: CONTINUING CARE * Semester II

Nursing Practice I: Continuing Care provides opportunities for the learner to gain experience as a member of the interdisciplinary health-care team by providing safe, holistic and evidence informed nursing care within a continuing care setting following the standards of practice for a practical nurse.

Pre-requisites: PN100, PN 101, PN 102, PN 103, PN 105, PN 155; PN 158; N115, Alberta Health Services mandatory certifications, CPR Level C for Health Care providers, Clear Police Information Check and Vulnerable Sector check, up-to-date immunizations

Co-requisite: 130, PN 156

COURSE HOURS

TOTAL HOURS: 194

CREDITS: 5

TUTOR INFORMATION

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GENERAL LEARNING OUTCOMES

Upon successful completion of this course, the learner will meet the following outcomes:

1. Integrate the nursing metaparadigm, nursing theory, and related knowledge into nursing practice to provide safe, holistic, compassionate, and competent care for the Continuing Care client.
2. Apply nursing process, effective problem-solving and critical thinking to make appropriate clinical judgments within a continuing care environment.
3. Demonstrate the ethical, legal, and moral responsibility and accountability for own actions in a Continuing Care setting.
4. Contribute to a culture of safety as it applies to the client and interdisciplinary team in a Continuing care setting.
5. Collaborate with the interdisciplinary health care team to provide nursing care in a continuing care setting.
6. Collaborate with the client to promote self care and synergy in a continuing care setting.
7. Apply principles of teaching and learning and health promotion to the Continuing Care client to promote client health and autonomy.
8. Advocate on behalf of the continuing care client to promote client health and well-being.
9. Demonstrate a developing understanding of culturally appropriate practice.
10. Apply evidence informed research findings into nursing practice in a Continuing Care setting.
11. Demonstrate reflective practice for personal and professional growth and continuous learning

Instructional Methods

This is a supervised clinical practice course. The course activities will include nursing care of assigned clients in the acute-care setting. Other activities may include nursing rounds (conferences), professional development activities, and discussions. These activities provide the opportunity for learners to learn with and from others in the nursing practice setting.

The course emphasizes pre-clinical preparation, participation in nursing care of clients, and post-clinical reflection and review. You are expected to take an active part in clinical discussions and take responsibility for your own learning. The instructor's role is to supervise nursing practice and to facilitate learning.

Statement on Plagiarism

All students must complete the Plagiarism/Tutorial Certificate found on Moodle. To locate this information, sign into Moodle and on the left side of the page under student the tutorial can be located.

Expectations:

1. All students must complete this tutorial. The certificate must be shown to the instructor prior to submitting any written assignment. Failure to show the instructor the certificate of completion could result in a late written assignment penalty.
2. If you have completed this tutorial in a University Studies course you can show your instructor the certificate. The tutorial is required to be completed only once during your time at Keyano unless you have left the program and returned.

Student Code Of Conduct

Please refer to the Student Handbook and review the Student Code of conduct Policy (Policy 110.0), Students Rights policy (Policy 111.0) and Student Code of Conduct Procedure (110.1). It is expected that you will review and be aware of expectations relative to student rights, responsibilities and behaviours

PRACTICAL NURSING PROGRAM POLICIES

Please refer to Keyano College Practical Nurse Handbook for specific Practical Nursing Program policies and to Keyano College Calendar for general College policies.

Please review the Keyano College Nursing Program Policy on Clinical Attire, which is outlined in the student handbook. The following are required items for clinical: nametag, health centre ID, watch, penlight, black pen, bandage scissors and stethoscope.

Withdrawal Dates for Classes:

Students may drop a course without academic or financial penalty within the first 1/8 of the course start date. Students who withdraw between 1/8 and 3/4 the length of a course will receive a grade of “W” (no GPA calculation) for their course(s). After 3/4 into the course length, students are not eligible to withdraw (calculated as 0 in GPA).

LATE POLICY FOR ASSIGNMENTS

Assignments not submitted on the day and time specified will incur a 5% deduction per day including weekends. This will be applied each day until the assignment is received by the instructor. Students can submit assignments by e-mail on weekends, but must provide a paper copy on the first day following the weekend.

SPECIALIZED SUPPORTS & DUTY TO ACCOMMODATE

DISABILITY SUPPORT SERVICES: LEARNER ASSISTANCE PROGRAM

It is the College's goal that learning experiences be as accessible as possible. If you anticipate or experience physical or academic barriers based on disability, please let your instructor know immediately so that we can discuss options. You are also welcome to contact Disability Services (780-791-8934) to establish reasonable accommodations.

SPECIALIZED SUPPORTS AND DUTY TO ACCOMMODATE

Specialized Support and Duty to Accommodate are aligned with the office of Disability Support Services: Learner Assistance Program (LAP) guided by federal and provincial human rights legislation and defined by a number of Keyano College policies. Keyano College is obligated by legislation to provide disability-related accommodations to students with identified disabilities to the point of undue hardship.

OVERVIEW OF LEARNING EXPERIENCES

CLINICAL PRACTICE

In order to pass PN 160: Continuing Care, students must demonstrate safe, knowledgeable, ethical nursing practice, professional behavior, and complete the specified learning experiences. See APPENDIX A for Clinical Standard Practices

Components of this continuous 5-week experience will include:

1. A scheduled nursing practice experience each week in the clinical setting. Clinical practice will take place beginning on May 19 and ending Apr. 25, 2021. Clinical rotation will include two to three twelve (12) hour day shifts each week. (Please see timetable). Client research will take place on the day prior to the scheduled shift. Please see timetable for dates and times.
2. Research will prepare the student to provide safe, knowledgeable, ethical care and is essential to successful completion of this course.

Complete research on assigned client(s) including a detailed plan of care consisting of nursing diagnosis, medications, goals, interventions and rationale for intervention. If caring for a client for more than one day, update the research and nursing care plan on each successive day with the client. Plan of Care for clients are to be submitted to the tutor for review following pre-conferences. See **APPENDIX B** for Student Experience Guidelines for Instructor Supervised Practice

If you are not prepared for clinical practice, you will be asked to leave the unit, this includes not having a plan of care completed on your assigned client(s).

3. Perform initial and ongoing assessments on all assigned clients.
4. Document client care on draft for review by the instructor prior to documenting in the client's chart.
5. Complete a Nursing Care Plan.
6. Complete Reflective Journaling Weekly Assignments to demonstrate written reflection of nursing practice.

If a student is absent from the clinical setting due to illness the following must occur:

- The student will contact their assigned unit;
- The individual instructor will advise students if and how they wish to be contacted, including the number; and
- The Instructor may advise the student to contact the Keyano College Nurse

Students not following these requirements will be considered absent without leave and abandoning their patients this may result in clinical failure

If the student is absent from the clinical setting for other reasons:

- The student will contact their assigned unit;
- The individual instructor will advise students if and how they wish to be contacted, including the number.

OVERVIEW OF COURSE ASSESSMENT

Clinical practice courses are graded as **pass** or **fail**.

To receive credit in Nursing Practice I: Continuing Care, the learner must complete all course requirements which include one written care plan assignment, reflective journaling, and a passing grade on the final evaluation. A passing grade means that the student was able to satisfactorily meet all expectations in the course. Course credit will not be given if only parts of the course have been completed.

DISTRIBUTION OF MARKS

WRITTEN ASSIGNMENTS		
Assignment	Nursing Care Plan (minimum 60% required to receive PASS grade)	Pass/Fail
Reflective Journaling	Written reflection of nursing practice	Pass/Fail
CLINICAL PRACTICE EVALUATION		
	Integration of nursing knowledge and application of nursing skills. Learner must satisfactorily meet all evaluation expectations.	Pass/Fail
	Total	Pass/Fail

PASSING LEVEL AND GRADING SCALE

This is a nursing practice course. A learner must be proficient in the integration of nursing theory and application of nursing skills in a practice setting.

Learners must receive a **pass** grade on the written assignment and successfully demonstrate nursing skills in the nursing practice setting to receive a passing grade.

Refer to the Practical Nurse Program Handbook for information regarding grading scale, extensions, and other program standard practices.

Important Additional Information

All students must have the following prior to attending any nursing practice course:

- Up-to-date immunizations
- Criminal Record Check completed within the last 3 months
- Basic Life Support for Health Care Providers course (BLS) recognized by the Alberta Heart and Stroke Foundation or CPR Level C or Level 3 First Aid
- Some colleges may also require a WHMIS certificate. (See your Student Handbook for details)

Note to all learners: *It is the learner's responsibility to retain course outlines for possible future use in support of applications for transfer credit to other educational institutions*

COURSE ASSESSMENT

1. Nursing Care Plan Assignment

Due Date: Tues, Apr. 6, 2021 by noon

In this assignment, the learner will have the opportunity to do the following:

- Apply the Nursing Assessment Tool: A Systems Approach to a Client
 - Utilize the nursing process
 - Develop a care plan for a client
1. This assignment must be typewritten (word-processed) and follow APA 6th edition format. Nursing Assessment Tool and Nursing Care Plan forms are provided.
 2. The learner will submit the marking guide with the assignment.
 3. This care plan does not have to be in essay format, but is required to follow APA format; title page, body of paper, reference list, and use of correct grammar. A reference list (list of referenced texts) is to be submitted with the care plan. References may include your textbook, journal articles or reputable websites. Use the web links and references at the end of the chapters in the textbook to guide your search for information. The marking guide provides a clearer description of the APA expectations.
 4. See **Appendix C for Marking Guide**

Instructions

CLIENT ASSESSMENT

Select a continuing-care client to whom you have been assigned. Complete a nursing assessment using the nursing metaparadigm concepts of client, environment, and health.

- Follow the “Nursing Assessment Tool: A Systems Approach” to insert assessment findings
- Use the “Nursing Assessment Form” to organize your data

NURSING CARE PLAN

Use the “Nursing Care Plan” form to complete your care plan. The following elements should be included in your care plan:

- **Nursing Diagnosis and Planning**

Write three (3) nursing diagnoses. Prioritize your nursing diagnoses in order of most important to least important.

Write one (1) client goal/expected outcome for each nursing diagnosis. The client goal must be measurable and include a specific time frame.

- **Implementation of Nursing Interventions**

Write three (3) nursing interventions for each client goal/expected outcome.

Provide evidence from the literature to support your rationale for each nursing intervention.

- **Nursing Evaluation**

Write evaluation criteria for each nursing intervention that would be used to determine if the client achieved each client goal/expected outcome.

Nursing Assessment Tool: A Systems Approach

SYSTEM	ASSESSMENT	FINDINGS
Respiratory System	<ul style="list-style-type: none"> • Respiratory rate and rhythm • Chest movements • Breath sounds • Shortness of breath 	
Cardiovascular System	<ul style="list-style-type: none"> • Pulse rate and rhythm • Heart sounds • Blood pressure • Skin colour • Nail bed colour • Signs of oxygen deprivation • Tissue turgor • Edema • Lab test findings 	
Nervous System	<ul style="list-style-type: none"> • Level of consciousness –Glasgow Coma Scale • Orientation to person, time, place • Cognitive ability • Reflexes • Vital signs • Sensory deficits • Altered sleep • Evidence of pain – acute or chronic • Description of pain experience – location, source, onset, duration 	
Gastrointestinal System	<ul style="list-style-type: none"> • Eating Patterns • Food intake • Appetite • Weight • Height • Body Mass Index(BMI) • Bowel sounds • Pain • Altered bowel patterns • Consistency of stool • Fluid intake & output 24 hours 	
Urinary System	<ul style="list-style-type: none"> • Urine –amount, colour, transparency, odour • Frequency, urgency, effort • Pain, burning • Incontinence 	

SYSTEM	ASSESSMENT	FINDINGS
Musculoskeletal System	<ul style="list-style-type: none"> • Posture, gait, coordination • Body alignment • Range of motion • Muscle strength • Evidence of injury/trauma 	
Integumentary System	<ul style="list-style-type: none"> • Condition of skin, scalp, nails, mucous membranes • Tissue turgor • Lesions • Perspiration • Sensitivity to temperature change • Body temperature • Presence of sensation 	
Endocrine System	<ul style="list-style-type: none"> • Structural change in skeleton, adipose tissue, integument • Functional change in: <ul style="list-style-type: none"> ○ Vital signs ○ Neuromuscular system ○ Renal function ○ Emotions ○ Sexual development ○ Menstruation ○ Pregnancy changes ○ Labour and delivery ○ Lab test findings 	
Senses	<ul style="list-style-type: none"> • Degree of function and effects of altered sensation in each of the senses: vision, hearing, touch, smell, taste • Client perception and feelings about altered senses 	
Environmental Factors that Affect Function of Systems	<ul style="list-style-type: none"> • Self-concept • Support systems • Roles • Developmental changes • Lifestyle factors • Family background, strengths, coping abilities • Health status • Pathophysiology (disease) • Medical diagnoses • Related medical treatment • Medications • Mental health/illness • Determinants of health 	

Nursing Assessment Form

Client Name: _____ Medical Diagnosis: _____

Client Perception of Health Needs: _____

Client Goals for Health: _____

Allergies (food, medication, environmental)	
Medications	
Dietary Considerations	
Vital Signs	T _____ P _____ R _____ BP _____ O ₂ sats _____ Pain rating _____

HEALTH ASSESSMENT DATA	
Physiological Variable	
General Appearance/Mental State	Cardiovascular System
Respiratory System	Gastrointestinal System
Urinary System	Sensory Systems
Nervous System	Integumentary System
Musculoskeletal System	Reproductive System
Endocrine System	

HEALTH ASSESSMENT DATA	
Spiritual Variable (Environment)	Developmental Variable (Environment)
Sociological Variable (Environment)	Psychological Variable (Environment)
Determinants of health impacting client's health (Environment)	
Interdisciplinary Team Members	
Health Priorities	
Client Strengths	

Nursing Care Plan

CLIENT NAME:		
HEALTH PRIORITIES BASED ON ASSESSMENT DATA Summarize findings from assessing all concepts of nursing metaparadigm Summarize and prioritize findings to identify most significant actual/potential wellness/problems		
NURSING DIAGNOSIS Use assessment data to establish a nursing diagnosis that reveals actual/potential wellness/problems. (May use nursing concept summary statement.)		
PLANNING		
Client Goals: State goals in terms of client behaviour using SMART criteria: <ul style="list-style-type: none"> • Specific • Measurable • Attainable • Realistic • Time-based 	Expected Outcomes State, in client's terms, the expected behaviour if goals are met:	
INTERVENTIONS		
List Interventions Select nursing interventions to meet the goals set, and to change or maintain health status	Rationale for Interventions Provide rationale for selection of nursing interventions and use appropriate literature such as text, articles, and internet sites to support choices	
EVALUATION		
Achievement of Expected Outcomes Assess goal achievement and reasons, and set new plan as needed.	Client Responses and Findings Describe why goal was met or not met. Summarize the effectiveness of nursing interventions.	Further Nursing Actions Assess evidence that outcome was met. Readjust nursing care plan as necessary.
CLIENT NAME:		

CLIENT NAME:

HEALTH PRIORITIES BASED ON ASSESSMENT DATA

NURSING DIAGNOSIS

PLANNING

Expected Outcomes

CLIENT NAME:

INTERVENTIONS

List Interventions

Rationale for Interventions

EVALUATION

Achievement of Expected Outcomes

Client Responses and Findings

Further Nursing Actions

2. Reflective Practice

Self-reflection is a requirement for continuing competency of the practical nurse. The purpose of this assignment is to assist you to reflect on your nursing practice. Through reflective practice you will demonstrate self-reflection by recognizing your own learning, goals, strengths and areas for improvement.

You will submit reflections in each of the nursing practice courses. These submissions are a requirement of this course and must achieve a satisfactory rating to receive a **pass**. Use the following to guide your reflective journaling. Attached is a marking guide that will be used by your instructor to evaluate your submissions.

Reflective Journaling

Due Date: Submit on Dropbox by 4pm on the 1st day after your set of shifts

GUIDELINES

- The reflective journal will be reviewed by the instructor. Due dates for submission will be determined by your instructor.
- The journal may be handwritten but must be legible.
- Submission format may vary based on instructor preference or clinical group decision (i.e., may be done through online discussions, group discussion, with the use of concept maps or traditional journaling).
- The journal must be completed as assigned in order to receive a **pass** grade in the course.
- See **APPENDIX D** for marking guide.

REFLECTIVE PRACTICE CRITERIA

Description

Choose a significant situation or event that occurred this week in clinical practice.

- Describe this situation in detail, relating it to your own practice.
- What was going on? What happened?
- How did the client, family or staff respond? (Use only initials to maintain confidentiality.)
- What was your role in this situation?

Reflection

Reflect on the situation as it happened.

- What were your feelings and thoughts about the situation?
- What did you do? How did you feel about what you did? Why?

- What were the important elements of the event? What preceded the event and what followed it?

Analysis

Analyze the situation.

- What went well? What did you find difficult?
- Integrate what is known from nursing theory and related courses. Use your nursing textbooks or other professional resource to interpret this situation and expand your understanding of the event.
- Identify the course learning outcomes that apply to this situation. What have you learned?
- How does this experience compare to other situations in which you have been involved?

Evaluation

Evaluate the situation.

- What did you learn from this situation?
- What would you do differently in the future?
- What should you be aware of if this situation occurs again?

Your instructor will read the entries and write comments to help focus and guide you throughout your practice. The entries will remain confidential.

3. Student Evaluation

Due Date: As per instructor

Student Assessment/Evaluation

Assessment of your performance is based on satisfactory preparatory work and successful delivery of client care. Throughout these clinical practice courses, your instructor will provide you with both verbal feedback and written feedback (anecdotal notes) on your clinical performance. Feedback will be provided on a weekly basis. Feedback may be provided more frequently if required. These notes are used to support comments and performance ratings of your midterm and final evaluations.

Student concerns should be discussed directly with the instructor if the outcome is unsatisfactory. If necessary, concerns can be submitted in writing to the program supervisor, and a copy must be given to the instructor.

The clinical practice evaluation will be completed by your instructor. You will be given a written midterm and final evaluation. Each evaluation will be discussed with you during a meeting with your instructor. See **APPENDIX E** for Expectations of Students

Students must consistently meet minimal safe practice. Examples of minimal safe practice are as follows:

The student:

- Is punctual for all scheduled clinical activities (pre/post conference, report)
- Can discuss assigned client's pathophysiology and related symptoms in his/her own words
- Correctly selects a high-priority nursing diagnosis and discusses at least two interventions that are supported by evidence-based practice
- Demonstrates correct medication and intravenous administration including calculations and safe dosages; can communicate actions, side effects, and nursing implications
- Demonstrates beginning psychomotor skills appropriate to practice setting
- Maintains asepsis and standard precautions
- Reports to appropriate parties (RN, instructor, preceptor) regarding all client care and changes in client condition
- Documents in a timely manner and according to current nursing practice within the practice setting
- See **APPENDIX F** for marking guide.

CODE OF ETHICS

CLPNA Competencies

The following CLPNA competencies are learned during the Nursing Practice I course:

- A: Nursing Knowledge
- B: Nursing Process
- C: Safety
- D: Communication and Interpersonal Skills
- E: Nursing Practice
- F: Respiratory care
- I: Neurological/Neurovascular Nursing
- O: Gerontology Nursing
- P: Palliative Care
- T: Occupational Health and Safety
- U: Medication Administration
- W: Professionalism
- X: Licensed Practical Nurse Leadership Role

Refer to www.clpna.com for reference

REQUIRED TEXTS

Required Textbooks and Resources

Primary Texts

Anderson, M. A. (2013). *Nursing leadership, management, and professional practice for the LPN/LVN* (4th ed.). Philadelphia, PA: FA Davis.

Lipe, S.K., & Beasley, S. (2004). *Critical thinking in nursing: A cognitive skills workbook*. Philadelphia, PA: Lippincott Williams & Wilkins.

Nursing Practice 1: Continuing Care Clinical Guide (PNCC, 2012)

Potter, P.A & Perry, A.G. (2019). *Canadian fundamentals of nursing* (5th ed. Rev.). Ross-Kerr, J.C., & Wood, M.J. (Canadian Eds.). Toronto, ON: Elsevier.

Other Required Resources

Drug guide or online drug guide such as Medline Plus:

<http://www.nlm.nih.gov/medlineplus/druginformation.html>

Medical dictionary or online medical dictionary such as Medline Plus:

<http://www.nlm.nih.gov/medlineplus/mplusdictionary.html>

METI eDose. Online medication calculation program. <https://www.edose.net/>

Appendix A
CONTINUING CARE
Clinical Standard Practices

Clinical Standard Practices

Overview

It is your responsibility to adhere to the following standard practices for the Practical Nurse Program. Please familiarize yourself with them and refer to them throughout the program.

DRESS CODE STANDARDS

You are expected to adhere to the dress code standards for the clinical area as outlined in the Practical Nurse Program Handbook.

ATTENDANCE

You must report illness or reasons for inability to attend clinical practice to your instructor/preceptor prior to your assigned shift. You are expected to adhere to the attendance standards for the clinical area as outlined in the Practical Nurse Program Handbook.

DOCUMENTATION OF CLIENT CARE

Documentation must follow agency policies and instructor and unit expectations where you are practising.

ENSURING CLIENT SAFETY

If your actions result in an actual or potential violation of client safety, you may be removed from the clinical area and may fail the course. Your progress in the program will be outlined in a learning improvement plan. Examples of safety violations are included in the Practical Nurse Program Handbook.

LEARNING IMPROVEMENT PLAN

If you are experiencing difficulty meeting the identified course outcomes and expected behaviours at any time, a case conference involving you, your instructor, and a counsellor may be called. A learning improvement plan will be initiated as per the Practical Nurse Program Handbook.

A learning improvement plan includes:

- Identification of problem
- A specific action plan required if you are to overcome the problem
- A timeframe for the problem to be resolved and evaluated

REPORTING WHEN LEAVING THE UNIT

When leaving the unit for breaks or at the end of the shift, you must report your leaving to the buddy nurse (a staff member also assigned to care for the client) and your instructor in an instructor-supervised practicum.

WORKPLACE INJURY

If you are injured or exposed to a blood-borne pathogen on the premises of the college or at a clinical agency, it is your responsibility to inform your instructor/preceptor as soon as possible. The protocol of the agency where the injury occurs will be followed. As reporting forms are time sensitive, it is essential that the injury be reported as soon as possible. Your instructor or preceptor will have the necessary WCB and Blood-Borne Pathogen forms. You may also be required to complete agency-specific reporting forms.

Appendix B
CONTINUING CARE
Student Experience Guidelines for Instructor-Supervised Practice

Student Experience Guidelines for Instructor-Supervised Practice

Attendance

You are expected to make every effort to be present and on time for every clinical shift. Missed days may make it impossible for the instructor to complete an evaluation of your performance. If the instructor is unable to evaluate your performance due to poor attendance, you will not pass the course.

Preparation for Clinical Assignments

Client safety is the highest priority. You are expected to come prepared for each clinical practice experience. If you are unprepared, you will be removed from the clinical area and marked absent for that clinical shift. A learning improvement plan will be put in place outlining the expectations and importance of preparing for assignments, and to address implications to professionalism, legalities, and client safety.

You are required to conduct your research in the clinical area on your assigned client prior to start of shift. You are responsible for reviewing the nursing skills that you will be required to perform during client care.

For all Nursing Practice courses, client research must be prepared in writing and brought with you to the clinical area.

Assignments/Team Responsibilities

- Research your assigned clients.
- Using the nursing process and the nursing metaparadigm, provide holistic, competent nursing care to assigned clients.
- Inform the instructor of learning needs.
- Seek learning experiences and opportunities to practise nursing skills, within appropriate scope of practice.
- Ask the instructor to directly supervise any nursing skills.
- Modify nursing skills according to agency policies and procedures as required.
- Perform only those nursing skills that are within the student role of the Practical Nurse Program.
- Consult with the instructor when unsure of any aspects of client care.
- Report any significant changes in the client's condition to appropriate staff and your clinical instructor.
- Document pertinent client information according to unit policy and routine.

- Collaborate with members of the health-care team in providing client care.

Performance of Skills

You are expected to adhere to the skill performance standards for the clinical area as outlined in the Practical Nurse Program Handbook.

Documentation of Client Care

At the beginning of the clinical practice course, you may be required to submit a draft of your documentation to your clinical instructor to check before it is entered on the client's record. Documentation of all medications that you have administered is a requirement.

Pre- and Post-Conferences and Nursing Rounds

You are expected to attend all pre- and post-conferences and nursing rounds. A pre-conference is a meeting between the instructor and students at the start of the clinical shift. At this time, you will be able to address questions and concerns, and identify when the instructor will be available to supervise skills or provide assistance with client care. The instructor will check the research sheets, nursing care plans, and organizational plans. The instructor must ensure that you are prepared to provide safe client care.

A post-conference, or nursing rounds, is a meeting of the instructor and the students, usually at the end of the clinical shift. It provides an opportunity to reflect on your practice by reviewing the day's activities, asking questions, discussing concerns, dealing with feelings and accomplishments, discussing progress, identifying and sharing significant learning, reorganizing or clarifying the next day's plans, and/or attending in-service sessions.

Appendix C
CONTINUING CARE
Marking Guide for Nursing Care Plan Assignment

NURSING CARE PLAN: MARKING GUIDE

KEY CONTENT	MARKING GUIDE				
	POINTS:	5	3	1	0
NURSING ASSESSMENT					
• Entered assessment of client findings	Excellent	Satisfactory	Minimal	None	
• Entered assessment of environment findings	Excellent	Satisfactory	Minimal	None	
• Entered assessment of health findings	Excellent	Satisfactory	Minimal	None	
					/15
Comments:					
NURSING CARE PLAN					
Nursing Diagnosis					
• Wrote a nursing diagnosis statement that focused on a health behaviour and included client strength or health need, related factors, and evidence presented	Excellent	Satisfactory	Minimal	None	
• Wrote a nursing diagnosis statement that focused on an educational need and included client strength, related factors, and evidence presented	Excellent	Satisfactory	Minimal	None	
• Wrote a nursing diagnosis statement that focused on a potentially ineffective behaviour and included client strength, related factors, and evidence presented	Excellent	Satisfactory	Minimal	None	
					/15
Comments:					
GOALS/EXPECTED OUTCOMES					
• Wrote one goal/expected outcome for each diagnosis	Excellent	Satisfactory	Minimal	None	
• Wrote a goal/expected outcome that included measurable criteria by using the SMART criteria	Excellent	Satisfactory	Minimal	None	
					/10

KEY CONTENT**MARKING GUIDE**

	POINTS:	5	3	1	0
Comments:					
INTERVENTIONS					
• Included 3 nursing interventions per goal		Excellent	Satisfactory	Minimal	None
• Provided support for interventions with evidence from the literature		Excellent	Satisfactory	Minimal	None
					/10
Comments:					
EVALUATION					
• Determined if goals/expected outcomes were met or not met, with rationale		Excellent	Satisfactory	Minimal	None
• Described if nursing interventions were effective in meeting identified goals/expected outcomes, with rationale		Excellent	Satisfactory	Minimal	None
					/10
Comments:					
SUMMARY					
• Described the benefits of using the nursing process and the nursing concepts in assessment and nursing care planning		Excellent	Satisfactory	Minimal	None
					/5
Comments:					
	TOTAL				/65

Submit this marking guide with the assignment.

APA AND GRAMMAR: MARKING GUIDE

KEY CONTENT	MARKING GUIDE			
	POINTS:	1	0.5	0.25
TITLE PAGE				
<ul style="list-style-type: none"> Included: Title centered 2 double spaces below top of page (bolded); page numbers top right. Remaining items 1 double space below title: student name, college name, course and section number, assignment name and number, instructor name; date. 	Excellent	Satisfactory	Minimal	None
BODY OF PAPER				
<ul style="list-style-type: none"> Paper organized – page number; introduction, body and conclusion; appropriate margins, double-spaced throughout, indent 5 spaces or 1 tab for new paragraphs, Appropriate font – 12-pt. 	Excellent	Satisfactory	Minimal	None
REFERENCES				
<ul style="list-style-type: none"> Citations in body of paper follow APA format 	Excellent	Satisfactory	Minimal	None
<ul style="list-style-type: none"> References, on separate page, follow APA format 	Excellent	Satisfactory	Minimal	None
GRAMMAR AND SPELLING				
<ul style="list-style-type: none"> Grammar appropriate and words spelled correctly (< 5 errors) 	Excellent	Satisfactory	Minimal	None
	TOTAL			/5
Comments:				
GRAND TOTAL (ALL MARKING GUIDES)				/70

Students must achieve at least 60% on this assignment in order to receive a PASS grade.

Submit this marking guide with the assignment.

Appendix D
CONTINUING CARE
Marking Guide for Reflective Practice

Assignment 2: Reflective Practice Marking Guide

Student: _____

Date: _____

Instructor: _____

CRITERIA	SATISFACTORY PERFORMANCE	UNSATISFACTORY PERFORMANCE (REQUIRES FURTHER DEVELOPMENT, EXPLORATION)
Description <ul style="list-style-type: none"> • The event/situation is described, in detail, related to your practice 		
Reflection <ul style="list-style-type: none"> • Identified how you felt during the situation • Discussed actions taken • Reflected on the events leading up to and after the situation 		
Analysis <ul style="list-style-type: none"> • Identified positive and negative aspects • Supported analysis with nursing knowledge • Identified learning outcomes related to the situation/learning • Included comparison to other situations 		
Evaluation <ul style="list-style-type: none"> • Described what you learned from this situation • Discussed application to future practice 		
Presentation <ul style="list-style-type: none"> • Organized, legible • Spelling and grammar appropriate 		

Comments:

EXPECTATIONS OF STUDENTS

Knowledge

1. Consistently prepares for client care:
 - a. Client research
 - b. Care plan
 - c. Organizational plan
2. Actively involves the client in the plan of care to promote independence
3. Demonstrates a holistic view of diverse clients by incorporating spiritual, physiological, psychosocial, cultural, and developmental aspects to care
4. Applies knowledge of the nursing metaparadigm in the development of nursing care plans
5. Applies research and evidenced-based care in the practice setting

Nursing Process and Critical Thinking

1. Performs and documents assessments of the client
2. Prioritizes needs of the client
3. Formulates nursing diagnoses from the assessment data
4. Collaborates with client and family to identify SMART goals related to each nursing diagnosis
5. Performs nursing interventions and provides rationale for each nursing intervention professionally, safely, accurately, and in a timely manner
6. Evaluates client's progress towards established goals, and modifies care plan and nursing care appropriately
7. Questions and analyzes data to make sound decisions
8. Adapts to changes in health, client and/or environment

Professionalism

1. Maintains a professional appearance and behaviour
2. Consistently meets attendance, punctuality, and notification requirements
3. Maintains confidentiality
4. Takes accountability and responsibility for actions and decisions
5. Adheres to the following:
 - a. Scope of practice
 - b. Standards of Practice
 - c. CLPNA competencies
 - d. Code of Ethics

- e. Agency policy

Communication

1. Follows verbal and/or written direction
2. Reports pertinent data to appropriate persons following established lines of communication
3. Charts pertinent data sequentially, legibly, accurately, and completely; follows agency policy; uses correct medical terminology
4. Contributes to group discussions and team conferences in a positive manner
5. Utilizes therapeutic communication skills with clients at all stages of the life cycle
6. Accepts and utilizes constructive feedback
7. Takes action to resolve conflicts, using appropriate communication skills
8. Plans, implements, and evaluates client/family teaching based on client needs and learning abilities

Safety

1. Recognizes, reports, and manages situations in which the safety and well-being of client, self, coworkers and others are compromised
2. Verifies and clarifies orders, decisions or actions made by interdisciplinary team members
3. Seeks clarification and assistance as needed

Reflective Practice

1. Identifies and shares learning needs (instructor, preceptor, supervisor, peers)
2. Accesses learning resources applicable to learning needs
3. Implements actions to improve performance
4. Demonstrates reflective practice, verbally and/or in writing

Leadership

1. Demonstrates leadership abilities, including the ability to:
 - a. Problem-solve and take appropriate action
 - b. Delegate when appropriate
 - c. Advocate for the client and profession
 - d. Contribute to the interdisciplinary team
 - e. Influence positive change
2. Demonstrate the attributes of a leader, including
 - a. Competence
 - b. Integrity
 - c. Ethics
 - d. Honesty and respect for others

Appendix F
PN 160 NURSING PRACTICE I: CONTINUING CARE
Marking guide for Nursing Practice Student Evaluation

Nursing Practice Student Evaluation

Student: _____ Clinical Faculty: _____

Site/Facility: _____ From: _____ To: _____

Days Absent: _____ Older Adult Adult Pediatrics

Final Mark Pass Fail **Diversity:** Gender Ethnicity Chronicity

Performance Ratings:

<u>MEET</u>	<u>Meeting</u> With limited guidance is able to meet objective
<u>AR</u>	<u>At Risk:</u> Is inconsistent in meeting clinical objectives
<u>N/A</u>	<u>Not Yet Assessed</u> Criteria has not been assessed
<u>OP</u>	<u>Outstanding Performance:</u> Consistently, skillfully, and with early and progressive independence is able to meet all objectives
<u>SAT</u>	<u>Satisfactory Performance:</u> With limited guidance is able to meet all clinical objectives

related to each nursing diagnosis									
<ul style="list-style-type: none"> Performs nursing interventions and provides rationale for each nursing intervention professionally, safely, accurately, and in a timely manner 									
<ul style="list-style-type: none"> Evaluates client's progress towards established goals, and modifies care plan and nursing care appropriately 									
<ul style="list-style-type: none"> Questions and analyzes data to make sound decisions 									
<ul style="list-style-type: none"> Adapts to changes in health, client and/or environment 									

STUDENT MIDTERM: STATE 1 GOAL TO IMPROVE PRACTICE IN THIS DOMAIN FOR THE REMAINDER OF CLINICAL

INSTRUCTOR COMMENTS MIDTERM:

STUDENT FINAL: REFLECT ON YOUR PRACTICE. *PROVIDE 2-3 EXAMPLES OF HOW YOU MET THIS DOMAIN*

INSTRUCTOR COMMENTS FINAL:

and completely; per agency policy; uses correct medical terminology									
<ul style="list-style-type: none"> • Contributes to group discussions and team conferences in a positive manner 									
<ul style="list-style-type: none"> • Utilizes therapeutic communication skills with clients at all stages of the life cycle 									
<ul style="list-style-type: none"> • Accepts and utilizes constructive feedback 									
<ul style="list-style-type: none"> • Takes action to resolve conflicts, using appropriate communication skills 									
<ul style="list-style-type: none"> • Plans, implements, and evaluates client/family teaching based on client needs and learning abilities 									

STUDENT MIDTERM: STATE 1 GOAL TO IMPROVE PRACTICE IN THIS DOMAIN FOR THE REMAINDER OF CLINICAL

INSTRUCTOR COMMENTS MIDTERM:

STUDENT FINAL: REFLECT ON YOUR PRACTICE. *PROVIDE 2-3 EXAMPLES OF HOW YOU MET THIS DOMAIN*

INSTRUCTOR COMMENTS FINAL:

• Accesses learning resources applicable to learning needs									
• Implements actions to improve performance									
• Demonstrates reflective practice, verbally and/or in writing									

STUDENT MIDTERM: STATE 1 GOAL TO IMPROVE PRACTICE IN THIS DOMAIN FOR THE REMAINDER OF CLINICAL

INSTRUCTOR COMMENTS MIDTERM:

STUDENT FINAL: REFLECT ON YOUR PRACTICE. *PROVIDE 2-3 EXAMPLES OF HOW YOU MET THIS DOMAIN*

INSTRUCTOR COMMENTS FINAL:

<u>LEADERSHIP</u>	MIDTERM: STUDENT			MIDTERM: INSTRUCTOR			FINAL: INSTRUCTOR	
	MEET	AT RISK	NOT YET ASSESSED	MEET	AT RISK	NOT YET	PASS	FAIL
<u>LEADERSHIP</u>								

STUDENT MIDTERM: STATE 1 GOAL TO IMPROVE PRACTICE IN THIS DOMAIN FOR THE REMAINDER OF CLINICAL

INSTRUCTOR COMMENTS MIDTERM:

STUDENT FINAL: REFLECT ON YOUR PRACTICE. *PROVIDE 2-3 EXAMPLES OF HOW YOU MET THIS DOMAIN*

INSTRUCTOR COMMENTS FINAL:

INSTRUCTOR : Midterm Evaluation

Date:

INSTRUCTOR FEEDBACK:

Strengths:

Areas Requiring Improvement:



-

SIGNATURES:

Instructor:

Student:

Print Name

Print Name

Signature

Signature

INSTRUCTOR: Final Evaluation

Date:

INSTRUCTOR SUMMARY AND RECOMMENDATIONS

Strengths:

Areas Requiring Improvement:



SIGNATURES:

Instructor:

Student:

Print Name

Print Name

Signature

Signature