NURSING 099 COURSE SYLLABUS
NURSING SKILLS AND SAFETY SCREEN

KEYANO COLLEGE

March 3, 2014 – April 17, 2014

Lab Tutor:

Melissa Brown RN, BN
# NURSING 291
## Course Outline

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NURSING 099
NURSING SKILLS AND SAFETY SCREEN
COURSE OUTLINE

CALENDAR STATEMENT

NURSE 099 Nursing Skills and Safety Screen* 5 credits

This course is mandatory for students who have failed a clinical course or the student who has left the program and wishes to return. In the lab setting, the student will simulate the nursing care of clients experiencing acute and complex variances in health in ambiguous, rapidly changing situations. Objective data will be collected through the observed structured nursing care for simulated patients utilizing selected levelled clinical scenarios. This data will be supplemented with examples of writing (learning goals, nursing care plan, patient research, charting and self-evaluation). Developed checklists for the skills chosen will be utilized to evaluate the skills component of this screen. In addition, the student will be required to write and pass a Medication Administration Safety Screen (MASS) prior to the lab skills evaluation. The student will not register in any courses until successfully completing the Nursing Skills and Safety Screen course.

COURSE HOURS

SEMINAR: 21  LAB: 42

COURSE DESCRIPTION

This mandatory course will be available to students who have failed a clinical course or students who have taken a year off and are making application to re-enter the program. The course will consist of both seminar and lab time under the supervision of an instructor. The overall objectives of this course are to champion client safety, promote student safety, and assist the student to be successful within the program. In the lab setting, the student will simulate the nursing care of clients experiencing acute and complex variances in health in ambiguous, rapidly changing situations, by consistently demonstrating competence with: required skills indicated in the integrated lab map; reflective practice; nursing process; communication skills; teaching skills; self-direction; and critical thinking. The student will be assessed on knowledge covered in all previously successfully completed courses. This course is a pass/fail course. The student will be given two chances to successfully complete the Nursing Skills and Safety Screen course. If unsuccessful in both attempts, the student will be required to withdraw from the program.
TUTOR INFORMATION

Melissa Brown, BN, RN
Phone (Office) 780-791-8921
e-mail: melissa.brown@keyano.ca

Tutor will be available for student consultation in office from Monday to Friday. Please contact your tutor or nursing office administration (780-791-4889) to arrange a time.

COURSE OBJECTIVES

LEVELS OF INDEPENDENCE

In evaluating objectives, the following levels of independence will be used:

With assistance: The student requires direction and information.
With minimal assistance: The student requires occasional direction and information.
With guidance: The student requires clarification, prompting and confirmation.
With minimal guidance: The student requires occasional clarification, prompting and confirmation.
Independently: The student works mostly on his or her own and seeks information, clarification and consultation as appropriate.

Direction: Clinical tutor tells student what to do, about what steps to take.
Information: Clinical tutor tells student specifics about a concept or topic.
Clarification: Clinical tutor, through questioning and feedback, assists the student to state their information in a different and clearer way, often with more details. The student asks questions to increase their understanding; questions asked demonstrate a sound knowledge base.
Prompting: Clinical tutor provides student with a cue that answer is incomplete or incorrect and how to resolve the lack of information. A prompt is broader than a hint. Prompting is generally used to add breadth or depth.
Confirmation: Clinical tutor provides positive feedback for correct information and direction provided by the student.
Consultation: The student provides clinical tutor with information and/or direction and asks specific questions about the information or direction which the tutor confirms.
Occasional: The clinical tutor provides input every now and then.
OBJECTIVES

In addition to maintaining competency with previous course objectives, upon completion of Nursing 099, the nursing student will be able to demonstrate the ability to achieve all of the following goals with minimal guidance from the lab tutor:

1. The student will demonstrate the ability to access, correctly interpret and apply written information from chart and policy/procedures to simulated patient scenarios.
2. The student will verbalize rationale for written medical and nursing information (example: Dr’s orders, policy and procedure manuals) as applied to a simulated patient scenario.
3. The student will verbalize understanding and rationale of physical assessments.
4. Using simulated patient scenarios, the student will demonstrate the ability to identify and verbalize abnormal assessment findings.
5. Using simulated patient scenarios, the student will demonstrate the ability to identify and apply nursing interventions to address abnormal assessment findings and verbalize rationale to support selected interventions.
6. Using simulated patient scenarios, the student will demonstrate the ability to evaluate the effectiveness of nursing interventions and verbalize rationale to support selected interventions.
7. Using simulated patient scenarios, the student will demonstrate the ability to complete accurate, comprehensive charting (written documentation).
8. Using simulated patient scenarios, the student will verbalize understanding and rationale for medication orders and demonstrate the ability to perform safe medication administration skills.
9. Using simulated patient scenarios, the student will demonstrate competence and understanding of selected psychomotor skills relevant to current placement in the program (i.e. medication administration, insulin administration, dressing changes, care of an IV line, IM/SC injections and blood product administration).

NURSING PROGRAM POLICIES

Please refer to University of Alberta Collaborative Baccalaureate Nursing Program: Keyano College Student Handbook (2013-2014) for specific BScN Program policies or refer to the Keyano College Practical Nurse Handbook (2013-2014) for specific Practical Nursing Program policies.

Please see Keyano College Credit Calendar 2013-2014 for an overview of the Student Rights, Responsibilities, Student Misconduct and Discipline, and the Student Appeal Process.

University of Alberta Collaborative Baccalaureate students are expected to be familiar with the CARNA Nursing Practice Standards and the Canadian Code of Ethics for Registered Nurses. Practical Nurse Collaborative Curriculum students are expected to be familiar with the Practical Nurses of Alberta Standards of Practice and Code of Ethics for Practical Nurses.
SPECIALIZED SUPPORTS & DUTY TO ACCOMMODATE

DISABILITY SUPPORT SERVICES: LEARNER ASSISTANCE PROGRAM

If you have a documented disability or you think that you would benefit from some assistance from a Disabilities Counselor, please call or visit the Disability Supports Office 780-792-5608 to book an appointment (across from the library). Services and accommodations are intended to assist you in your program of study, while maintaining the academic standards of Keyano College. We can be of assistance to you in disclosing your disability to your tutor, providing accommodations, and supporting your overall success at Keyano College.

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

SAFETY SCREEN EXPECTATIONS

1. **Student will:**

   1.1 Formulate a learning plan and give to their tutor within **one week** of the onset of this safety screen course (**Appendix A**).
   1.2 Come to each practice lab prepared (having completed required readings, viewed required audiovisual resources, and with specific questions for the lab supervisor).
   1.3 Seek resources that will support their learning.
   1.4 Complete patient research, nursing care plan and medication research for each of the simulated patients they are assigned for in the lab and to care for in the safety screen simulation. To be handed in to the tutor at the beginning of lab or simulation.
   1.5 Ask questions which contribute to their ability to assess, critique and appraise what they do and do not know or understand.
   1.6 Explore and discuss the underlying rationale for nursing care provided during the safety screen.
   1.7 Applying research-based evidence to the development of their nursing practice.
   1.8 Prepare a final self-evaluation (completion of the learning plan) including critical reflection following the safety screen simulation (**Appendix A**).

2. **The lab tutor will:**

   2.1 Provide a schedule negotiated with the student.
   2.2 Inform student of supervised practice labs (which will allow the student to demonstrate
the skill(s) and receive tutor feedback for skill refinement prior to the Objective Structure Clinical Evaluation (OSCE) test).

2.3 Administer the safety screen simulation and skills OSCE.
2.4 Provide ongoing feedback to the student.
2.5 Administer the Medication MASS.

**SAFETY SCREEN CONTENT**

Safety Screen Content will vary and may include all or some of the following:

1. Specific medicine and/or surgical scenarios that provide opportunities to integrate previously learned concepts from anatomy, physiology, and pathophysiology in developing a plan of care.
2. Concept mapping when needed.
3. Development of a comprehensive plan of care using the nursing process (including rationale for nursing interventions).
4. Organization and time management for up to 2 patients (lab simulation) appropriate to student learning level.
5. Complete shift assessments, e.g. head to toe assessments and focused assessments on system(s) as warranted by the simulated patient’s conditions.
6. OSCE testing based on simulated clients. Note: OSCE’S must be successfully passed before proceeding to a clinical course.

**LABS**

Lab time will be offered throughout the course according to the course timetable. It is the expectation that the knowledge and skills obtained from previous labs will be incorporated into practice time. Students must identify their own learning needs associated with their learning goals to identify which skills or concepts should be reviewed in the allotted lab time and are responsible for reviewing the required resources prior to the commencement of lab. Students must e-mail the tutor at least one day prior to lab time with request to review the desired concept or skill to ensure appropriate equipment is available.

Patient scenarios will be supplied on a weekly basis for further review of concepts and skills. Students must provide and hand in patient research corresponding to the supplied scenario at the commencement of the specified lab. Please see timetable for dates and times.

In the lab setting it is expected students will simulate the nursing care of clients experiencing acute and complex variances in health in ambiguous, rapidly changing situations, by consistently demonstrating competence with:

- Required skills indicated in previous completed courses in the University of Alberta Collaborative Baccalaureate Nursing Program, Keyano College, or Practical Nurse Collaborative Curriculum Program, Keyano College.
- Reflective practice
- Nursing process
• Communication skills
• Teaching skills
• Self-direction
• Critical thinking

It is the expectation that students bring their previously obtained lab kits to each lab and utilize these supplies during lab time. Supplies will only be provided for the safety screen simulation and skills demonstration OSCE.

SEMINARS

Please see the timetable regarding seminar times. Content of these seminars will vary and may include, but not limited to:
• Patient scenario assignment
• Patient research
• Concept review
• MASS exam review/administration
• Consultation with the tutor

<table>
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<tr>
<th>METHOD OF EVALUATION</th>
<th>DATES (See Timetable for Time and Location)</th>
<th>PERCENTAGE OF FINAL GRADE</th>
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<tbody>
<tr>
<td>Medication Administration Safety Screen (MASS)</td>
<td>March 24, 2014</td>
<td>PASS/FAIL</td>
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<td>Skill Demonstration OSCE</td>
<td>April 3-4, 2014</td>
<td>PASS/FAIL</td>
</tr>
<tr>
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<td>April 14-15, 2014</td>
<td>PASS/FAIL</td>
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OVERVIEW OF COURSE EVALUATION

In order to pass Nursing 099, students must demonstrate safe, knowledgeable, ethical nursing practice, professional behavior, and complete the specified learning experiences and evaluation requirements. Students must receive a passing evaluation for each component of Nursing 099 in order to pass the course.
MEDICATION ADMINISTRATION SAFETY SCREEN (MASS)

The medication administration safety screen exam (MASS) will be held prior to the safety screen simulation and skills OSCE. Refer to course timetable for date and location. Any required changes in time/room number will be posted on white board in nursing office.

The exam will include course appropriate level application of dosage calculations, medication preparation and administration protocols. This exam will include calculations, according to program and year requirements such as administering oral, subcutaneous and intra-muscular medications, as well as determining IV flow rates and conversions. This examination will provide an opportunity for students to demonstrate proficiency in calculating accurate medication dosage. Students may use a basic calculator in the exam. The pass mark is set at (A) 90%.

Students who are unsuccessful in this exam will be given the opportunity to write one (1) supplemental exam which must be completed within one week. Should it be necessary, the student and the tutor will schedule the MASS re-write in the Skill Centre at a mutually agreed time within a minimum of one (1) day and a maximum of one (1) week.

Students who are unsuccessful in the supplemental exam will be required to withdraw from Nursing 099.

SAFETY SCREEN SKILLS DEMONSTRATION AND SIMULATION OSCE

SKILLS DEMONSTRATION OSCE

The student is responsible for demonstrating they are current with all nursing skills covered in previous labs. To facilitate student accountability, the tutor will place all level appropriate skills in a hat and have the student draw out two to complete OSCEs on. OSCEs will be evaluated according to previous course OSCE evaluation tools. Please refer to the specific year Safety Screen Student Handout for OSCE evaluation tools. These handouts will be provided to students at the beginning of the course. 80% on both OSCEs must be obtained to receive a passing mark.

SIMULATION OSCE

Objective data will be collected through the observed structured nursing care for simulated patients utilizing selected, leveled clinical scenarios. This data will be supplemented with examples of writing (learning goals, nursing care plan, patient research, charting and self-evaluation). Refer to the specific year Safety Screen Student Handout for description of the patient scenario (s). 80% must be obtained to receive a passing mark (refer to Appendix C for evaluation tool).

See Appendix B for further information regarding observed structured clinical evaluations.
REQUIRED TEXTS

All required texts, labs, knowledge and experience from previous nursing courses are expected to be utilized in this course.
Appendix A – Learning Plan

Developing a Learning Plan

The learning plan including steps #1-3 is expected to be handed in within one week of the onset of the course. After the safety screen simulation OSCE students are expected to hand in the completed learning plan.

1. Reflect on and assess your nursing practice

Conduct a self-assessment of your learning needs based on your program year.

- What are your strengths?
- What are the areas that require improvement?
- Do you consistently apply the CARNA Nursing Practice Standards and CNA Code of Ethics or Practical Nurses of Alberta Standards of Practice and Code of Ethics for Practical Nurses to your everyday practice?
- How do you maintain your knowledge, skills and competence to provide safe, competent and ethical nursing care?
- What personal and professional attributes help to ensure that you establish and maintain a therapeutic nurse-client professional standard of practice?
- How can you participate effectively in health team discussions and share information about client assessments to contribute to the direction of the plan of care? What barriers exist and how can you overcome them?
- How do you demonstrate responsibility and accountability for your nursing practice?
- Do you report and complete thorough and accurate documentation of client care and its ongoing evaluation in a clear, concise and timely manner?
- Would your documentation stand up to legal scrutiny?

2. Set your nursing practice learning goals and outcomes

Your self-assessment should guide you in developing your personal learning plan. Ensure the goals are SMART.

- What do I want to achieve with my learning plan?
- What areas would I like to focus on for professional development?
- What strengths would I like to develop further to enhance my practice?
3. Develop a plan to meet your goals and outcomes

The learning plan outlines specific learning activities.

- Examples of study/learning may include:
  - Literature review: scholarly journals, scholarly books, electronic databases, internet search or secondary sources such as films, audio and/or video tapes.
  - In-service education presentations
  - Self-directed study
  - Consultation with tutor, peers, etc.

*We all enhance our knowledge in various ways, so don’t hesitate to list other examples if they contributed to your ongoing professional development.*

4. Implement the learning/action plan

A wide variety of resources, including your tutor, can be used to accomplish your plan. Be creative and innovative.

5. Evaluate the influences of your learning plan on your nursing practice in this course

- Did I meet my learning goals/objectives?
- How did I meet my learning goals and objectives?
- Was the outcome valuable to me? Why or why not?
- How have I been able to maintain and/or enhance my practice?

6. If the goals of your learning plan have not been met, reflect on why

- What circumstances influenced the implementation of my learning plan?
- Was my learning plan realistic and doable?
- Are there alternative ways that I could meet my learning goals?
- Do I need to re-assess my learning needs and revise my goals?

Self-assessment is a self-reflection and self-evaluation of your nursing practice based on the CNA Code of Ethics, CARNA Standards of Nursing Practice, Practical Nurses of Alberta Standards of Practice and Code of Ethics for Practical Nurses. This self-assessment gives you the opportunity to:

- Identify the strengths and competencies that you choose to enhance further;
✓ Develop goals for your self-assessment; and
✓ Implement a learning plan to assist you in meeting your competency goals.

**Critical Self Reflection**

Identifying critical incidents as a student in nursing education facilitates the integration of theory and practice and can assist the student to foster reflective practice, along with personal and professional development. Tutors will evaluate how students have shown reflective practice by asking questions throughout the course.

Students are highly encouraged to critically reflect on their nursing practice throughout the course and must include critical reflection in the completion and evaluation of the learning plan.

**Recommended guidelines for Critical Self-Reflection:**

- **Describe in detail a significant experience that you had during the course. Include thoughts, feelings, and perceptions.**
- **Reflect on the experience. Describe why this experience was important to you, and what factors (assessment, previously learned experiences, values, beliefs, stereotypes or biases) influenced yours/someone’s else’s decisions/actions/feelings.**
- **Evaluate your strengths and areas needing improvement in this situation. What were the strengths and areas for improvement for the other health care professionals involved? Explain why you think these were areas of strength or areas needing development. How would the client/family is ultimately affected?**
- **Describe your significant learning. How does this impact your nursing practice? Describe what you would do differently/investigate/maintain if a similar incident should occur in the future. Describe what you would teach someone else (i.e. peer) about this incident in order to improve nursing practice.**
- **Critical self-reflection should include evidence from the literature.**
<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Date:</th>
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<tr>
<td><strong>Strengths</strong></td>
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<tr>
<td><strong>Learning Needs</strong></td>
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<td><strong>Learning Goals and Objectives</strong></td>
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<tr>
<td><strong>Learning Plan</strong></td>
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Appendix B – OSCE (Objective Structured Clinical Evaluation)

**Purpose of an OSCE**

An OSCE is an objective method of assessing a student’s clinical skills where the areas tested and the evaluation criteria are determined in advance from course content and objectives. The OSCE is purported to have the potential for testing a wide range of knowledge and skills, and can be utilized to evaluate a large number of students in one examination period.

**Description of an OSCE**

During an OSCE, students may rotate around a series of timed stations or they may randomly draw particular skill(s) to perform. For example students may be asked to take a focused history or perform some aspect of physical examination. Further, students may be asked to answer short questions, to interpret client data or to record findings. In accordance with their level of performance, students will be rated and scored against set criteria.

**Guidelines for an OSCE**

Students must successfully complete their OSCE in order to pass Nursing 099. The pass mark for the OSCE is 80%. If students are unsuccessful at the time of their initial evaluation, they may have one opportunity to repeat the OSCE.

An OSCE is considered to be similar to an exam-testing situation. Therefore, the same policies apply with respect to sharing information about the content of the OSCE.
Appendix C – Safety Screen Evaluation Tool

Nursing 099 Safety Screen Evaluation Tool

Student Name:
Date:

<table>
<thead>
<tr>
<th>Communication &amp; Respect: /15</th>
<th>Complete</th>
<th>Incomplete</th>
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<tbody>
<tr>
<td>• meets with N498 tutor as agreed, sets schedules with tutor, arrives on time for MASS and OSCE, utilizes lab staff as resource;</td>
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<td>• notifies tutor if late or absent;</td>
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<td>• appropriately establishes a nurse-client relationship (i.e. introduces self, uses appropriate language, demonstrates caring, expresses self clearly and respectful manner) respectful of professional boundaries;</td>
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<tr>
<td>• speaks directly to client as applicable &amp; consistently informs client of actions prior to initiation of actions;</td>
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<tr>
<td>• gathers physical, emotional and psychological information from client as required;</td>
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<td>• displays appropriate &amp; positive verbal and non-verbal communication;</td>
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<td>• verbalizes knowledge and understanding of client condition by explaining client condition and drawing conclusions based on appropriate knowledge base (physiology, anatomy, pharmacology, nursing theory, nursing ethics, professional practice) as required</td>
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<tr>
<td>• Assesses clients understanding, identifies areas to incorporate appropriate client teaching and follows through by teaching client</td>
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<tr>
<td>• Maintains client confidentiality</td>
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<td>• Verbalizes findings to tutor, verbalizes variations in health</td>
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<tr>
<th>Professional Practice: /15</th>
<th>Complete</th>
<th>Incomplete</th>
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<tbody>
<tr>
<td>Safety</td>
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</tr>
<tr>
<td>1. Asepsis and Infection Control</td>
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<tr>
<td>• washes hands</td>
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<tr>
<td>• maintains and promotes infection control practices (i.e. uses disposable gloves appropriately, washes hands as required)</td>
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<tr>
<td>• uses appropriate aseptic techniques when appropriate throughout interaction with client</td>
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<tr>
<td>2. Patient Safety</td>
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<tr>
<td>• side rails up if required</td>
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<tr>
<td>• considers client’s situation and ensure all aspects of safety are addressed including risk of falls when appropriate</td>
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</table>
• checks wrist band
• checks for allergies on chart & verbalizes client allergies to instructor

3. **Personal Safety & Body Mechanics**
• applies principles of proper body mechanics when lifting, reaching, pulling, bending or transferring
• Appears to understand concepts related to maintaining professional boundaries

**Nursing Process:**

**Client Systematic Physical Assessment   /20**

• consistently uses appropriate technique for physical assessment (i.e. IPPA)
• positions client appropriately and drapes, inquires about client’s comfort (organizes to limit the number of times client must move or be re-positioned)
• assesses integumentary (skin condition and appearance) with each system and verbalizes findings
• systematically and comprehensively assesses each system
  - **Neurovascular**
    - Mental status
    - Orientation
    - Vital Signs including pain assessment
    - GCS
    - head and neck inspection
  - **Cardiovascular**
    - inspect for JVP or pulsations
    - palpate pulses and compares side to side, assess skin temperature on periphery, checks nail bed for cyanosis
    - auscultate (5 cardiac landmarks)
    - examines intravenous and site
    - assesses fluid balance, skin turgor, edema
    - asks appropriate questions
  - **Respiratory**
    - inspect shape (removes clothing to inspect), symmetry of movement, use of accessory muscles
    - palpate to assess symmetry of movement and tracheal position
    - percuss sample of all lobes
    - auscultate side to side comparison, anterior and posterior, noting intensity and quality of breath sounds, identifies adventitious sounds
- inquires about cough, mucus production, SOB
- examines equipment, O2, chest tubes, etc
  - GI
    - inspects for shape, scars, masses
    - auscultate bowel sounds, each quadrant
    - palpate abdomen noting feel (soft, hard, etc)
    - percuss abdomen
    - asks about bowel habits, dietary considerations, digestion, passing flatus
    - assesses equipment, NG suction, feeding tubes
  - GU
    - inspects gentalia
    - assesses urine output, quality, amount, clarity, smell
    - inspect and assess equipment
  - Musculoskeletal
    - inspects symmetry, compares side to side
    - assesses range of movement (active and passive)
    - Tests strength
  - Psychosocial
    - inquires about coping, support systems
  - Safety
    - side rails
    - considers client’s situation and ensure all aspects of safety are addressed

**Client Evaluation /10**
- based on the findings from the assigned client, appropriately chooses the focus system and completes in-depth assessment of focus system, verbalizing rationale for choice to tutor
- throughout systems assessment is able to distinguish between normal and abnormal findings, verbalizing appropriately
- accurately interprets findings develops appropriate interventions based on findings
- reports abnormal findings to charge nurse as needed

**Interventions /10**
- identifies appropriate interventions and discusses rationales with sufficient depth drawing from previous knowledge areas (physiology, anatomy, pharmacology, nursing theory, nursing ethics, professional practice guidelines)
- identifies impact of care on client and addresses outcome
- gives detailed explanation to client when appropriate
- selects Appropriate equipment
- completes intervention systematically
- uses appropriate aseptic and/or clean technique when appropriate
- interprets client’s response to interventions and addresses response using communication techniques

**Assessment of Intervention /5**
- Ongoing evaluation of interventions demonstrated
- Adjustments made as needed

**Documentation /5**
- Systematically and comprehensively records assessment findings
- Documents in a concise and legible manner
- Utilizes appropriate documentation principles at an expected level of learning
- Documentation is grammatically accurate with no abbreviations utilized

**Critical Thinking /10**
- Accurately identifies client care assessment priorities based on the client’s current condition and care needs
- Accurately interprets available evidence and provides a well developed, logical explanation that clearly articulates and draws from previous learning
- identifies gaps in learning and/or understanding
- explains key concepts with supporting rationale
- verbally reflects on content
- raises significant points, asks questions
- makes reasonable inferences and conclusions, explores alternate strategies to address questions or issues

**Self Direction: /10**
- Develops SMART learning goals
- Identifies own strengths and areas for development
- Responds to fair evaluation comments from tutor
- Demonstrates a understanding of tutor directed and self directed learning
- Completes tasks as required

**Comments**
<table>
<thead>
<tr>
<th>Total Score:</th>
<th>/100</th>
</tr>
</thead>
</table>

**PASS / FAIL**

*Student must receive 80% in order to obtain a passing mark.*

<table>
<thead>
<tr>
<th>Tutor Signature:</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>The above evaluation findings have been reviewed with me. I have received a copy of this evaluation.</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Signature:</td>
<td>Date</td>
</tr>
</tbody>
</table>

