Seattle University

College of Nursing

NURS 335

Promoting Wellness for Older Adults
Clinical Syllabi

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Faculty

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Course Hours:	**Tues, Wed, or Thurs, 6:00 am to noon or 7:00 am to 1:00 pm** (depending on location, see clinical faculty)
Prerequisites:	NURS 332, 333
Co-requisites:	NURS 334
Placement:	Quarter 3 of Nursing Sequence
Faculty:	Karen Feldt, PhD, ARNP, GNP Contact Information e-mail feldtk@seattleu.edu

Title: NURS 335 Promoting Wellness for Older Adults - Clinical

Course Description: Application of nursing process will focus on common and select biopsychosocial health concerns for older adults. Emphasis on health promotion, risk assessment, and prevention of illness and injury. Clinical experiences will occur in diverse settings appropriate to the older adult population.

Course Objectives: Upon completion of this course, the learner will:

1. Apply knowledge from liberal arts, nursing science and related disciplines for health promotion and risk reduction in the care of older adults.

2. Apply the process of assessment, diagnosis, outcome identification, planning, intervention and evaluation for health promotion and risk reduction in the care of older adults.

3. Demonstrate critical thinking attitudes, skills and abilities in clinical decision-making and in evaluating nursing practice with older clients.

4. Integrate technological and relationship-centered nursing interventions to promote the health of older adults in diverse community settings.

5. Use communication and collaboration skills to develop partnerships with older individuals and their social systems (families, community, and healthcare resources) to promote healthy aging.

6. Demonstrate commitment to self-evaluation, life-long learning, professional behaviors, service, diversity, and social justice in the care of families.

Required Texts:

Seattle University College of Nursing. (2009). *NURS 334 Promoting Wellness for Older Adults syllabus.* Seattle: Author.

Meiner, S.E. & Lueckenotte. (2006). *Gerontologic Nursing* (3rd ed.). St. Louis: Mosby.

Required Websites

ANGEL website for course forms and materials.

Lyons SS. (2004). Fall prevention for older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; Feb. 60 p. [104 references] can be found at:
http://www.guideline.gov/summary/summary.aspx?doc_id=4833&nbr=003480&string=falls

Strongly Recommended websites:

The Hartford Institute for Geriatric Nursing (HIGN) at New York University's College of Nursing, and the *American Journal of Nursing*, for a project called How to *Try This*.
http://www.nursingcenter.com/library/static.asp?pageid=730390

At this website you can view videos on how to do the following assessments
SPICES – an overall assessment tool

Geriatric Depression Scale
Braden Scale (assessment of skin)
Heinrich II fall risk scale
Mini-Cog
Recognition of Dementia
Delirium
Assessing Nutrition in Older Adults
Preventing Aspiration in Older Adults with Aphasia
Avoiding Restraints

Previously Required:

Deglin, J.H. & Vallerand, A.H. (2007). *Davis's Drug Guide for Nurses* (10th ed.) Philadelphia, PA: F.A. Davis. May need to supplement this book with other resource information on Medications: rxlist.com, drugs.com (Wikipedia is not an acceptable site for medication information)

Huether, S., & McCance, K. (2004). *Understanding Pathophysiology Third Edition.* St. Louis: Mosby

Ackley, B., & Ladwig, G. (2006). *Nursing Diagnosis Handbook A Guide to Planning and Care Seventh Edition.* St. Louis: Mosby Elsevier

Allocation of Clinical Hours
3 credit clinical course = 60 hours (2:1 ratio for undergraduate clinicals)

Final Evaluation is not counted in course hours

Clinical Lab Workshop Intensives	6 hours (two 3 three hour lab days: practicing assessment tools, communication, orientation to facility)
Facility setting	48 hours (8 six hour days or 7 seven hour days during the quarter)
AL or independent setting	6 hours (6 hours spread through the quarter: will need this to identify a resident to complete the project on falls, see below)

Clinical experience in the facility setting; (Students will complete eight 6 hour days) 6 hrs per week x 8 weeks = 48 hr; faculty have an option to do this as 7 seven hour days). Students will provide basic care to older clients, including basic hygiene, ambulation, and nutrition. Emphasis will be placed on targeted assessments relevant to older adults including evaluating sensory changes, functional status, cognitive and mood changes, fall risk, nutrition status, environmental hazards, and pain. Students will prepare and administer medications. Other skills will include dressing changes, glucometry readings, and other skills based on availability of opportunities and faculty discretion.

Clinical experience in the AL or independent setting: (6 hours). Students will be assigned older adults living in an assisted living level or independent level in communities linked to long term care facility in senior housing: (Covenant Shores, Elderhealth, Sara Faerland, Mt. St. Vincents, Horizon House, Mission Healthcare assisted living, Covenant Shores independent or assisted living, etc). Each student will visit one older person over the quarter for purpose of promoting health in well elders. The Fall Prevention project can be based on this resident. Students will practice interviewing, communicating, and collaborating with clients/ families. Assignments will include targeted assessments relevant to older adults including evaluating sensory changes, functional status, cognitive and mood changes, fall risk, nutrition status, environmental hazards, and pain.

Targeted assessments will be completed for elders in both settings, including:

Sensory Evaluation,
Activities of Daily Living, and Instrumental Activities of Daily Living
Nutritional Assessment, Oral Health Screening,
Fall Risk, Gait and Balance
Environmental/Safety Assessment, Skin/Wound Assessment,
Mood Assessment
Cognitive Assessment,
Pain Assessment

Course Schedule with assignments

Week	Class Topics	Clinical Assignments
Week 1 **Tues, Wed** **Or Thurs**	**Orientation 335 at CPL**	**Complete Student Profile Form and hand in to your instructor**
Week 2 **Tues, Wed** **Or Thurs**	**Gerontological Assessment** **Instruments used in comprehensive assessment** **Communicating with Older Adults**	**Get oriented to your clinical facility.** **Complete orientation form.** **Print out your forms for your clinical site:**
Week 3 **Tues, Wed** **Or Thurs**	**First week of Clinical** **Lecture topics: Dementia, behavior issues**	**Get acquainted with your assigned client.** **Complete Prep sheet and medication sheet**
Week 4 **Tues, Wed** **Or Thurs**	**Second week of Clinical** **Theory topics: Functional assessment** **Pharmacology issues**	**SOAP Note Due** **First Comprehensive Geriatric Assessment due.**
Week 5 **Tues, Wed, Or Thur**	**Third week of clinical** **Theory topics: Nutritional health, hydration**	**Prep sheet and medications for weekly client** **Identify an older adult for Preventing Falls project**
Week 6 **Tues,Wed** **Or Thurs**	**Fourth week of clinical** **Theory topics: Continence, Wound and skin**	**SOAP due** **Prep sheet and medications chart available for faculty** **Second Comprehensive Geriatric Assessment due**
Week 7 **Tues, Wed** **Or Thurs**	**Fifth week of Clinical** **Theory topics: Safety Evaluation, Falls**	**SOAP due** **Prep sheet and medications chart available for faculty**
Week 8 **Tues, Wed** **Or Thurs**	**Sixth Week of Clinical** **Theory Topics: Psychosocial issues, cultural issues, Sleep, loneliness, depression, caregiving**	**SOAP due** **Prep sheet and medications chart available for faculty**
Week 9 **Tues, Wed** **Or Thurs**	**Seventh Week of Clinical** **Theory topics: Elder abuse, Dying bereavement**	**SOAP due (with prep sheet and medications)** **Preventing Falls Paper Due**
Week 10 **Tues, Wed** **Or Thurs**	**Eighth Week of Clinical** **Theory Topics: Socioeconomic issues**	**Share your Falls prevention nursing care plan with facility staff**
Week 10 or 11	**Final clinical evaluations**	**Scheduled with your clinical faculty** **Complete Clinical performance evaluation**

Strategies for teaching and learning: Student assignments
Description of Assignments to be evaluated

Clinical Labs prior to clinical setting.

- ***Learning/practicing use of geriatric assessment instruments. Attendance mandatory*** Professionalism during clinical lab experience is expected and will be evaluated in the professionalism objective criterion of the course.
- ***Orientation to clinical site; Attendance is mandatory this session will occur the first week of classes***

Prep sheets and Medication Sheets for NH client, 10**% of course grade**

Students will assess their client, complete their LTC prep sheet (see Angel website) and a chart on all of the medications the patients receives during your clinical time frame (See Angel website for form). You do not need to complete medication information on medications the resident does not receive on your shift. **These must be available for the faculty to review each week during your clinical time** and are graded on an S/N basis. Students will cite references in APA format for medication chart. If medication information is not found in the student's medication book, students ARE REQUIRED to find out information about that medication from other sources, (the SU library, online sites such as rxlist.com, drugs.com, etc.) and cite them appropriately. Incomplete information or lack of understanding of medications results in an unsatisfactory grade for this clinical experience.

SOAP notes, **10% of course grade**. (Due clinical weeks of 2/10, 2/17 2/24, 3/3) or at the time assigned by your clinical faculty member) Based on the data you gather in your history and physical assessment, as well as data gathered using the special geriatric assessments (described below), identify one nursing diagnosis for your assigned SOAP note and care plan notes. Since most long term care residents do not have acute medical problems, the focus of most care plans should be health promotion and prevention of complications related to chronic health conditions, sensory, cognitive, and mobility impairments, and the like. Students will select an important nursing issue for their client, conduct an assessment, identify the nursing diagnosis and write a SOAP note with a care plan for that problem. Nursing diagnoses for many geriatric medical problems are noted in your text book. Students will cite references in APA format for SOAP note plan and for medication chart. A sample of a SOAP note is posted on ANGEL.

Comprehensive geriatric assessment write-ups (History and physical, assessment tools, nursing care plan) are required (10% each) or 20% of course grade

Students use the standard nursing assessment format as well as some of the assessment tools from the packet posted on the Angel website to complete geriatric assessment of their assigned client. ***Geriatric assessment due on Week 4: (***must include: prep sheets, med sheets, history, physical exam findings, sensory assessment, functional assessment, fall risk assessment, Braden skin assessment, pain assessment and nutritional assessment (See assessment tool packet posted on Angel).

Geriatric assessment due on Week 6: must include: prep sheets, med sheets history, physical exam findings, functional assessment, Braden skin assessment, pain assessment, cognitive assessment, and depression assessment. (for this second client you may want to include other tools if appropriate

to their clinical status) Students identify one Nursing Diagnoses from this assessment that should be addressed for this client and develop a plan of care (See nursing care plan format posted on Angel).

Preventing Falls Paper: 20% of course grade
Nursing Approaches to Prevent Falls in Older Adults: Paper will be worth 100 points and will be graded using criteria guidelines.

Students will conduct a complete geriatric assessment of an older adult in assisted living or nursing home setting who has sustained a fall within the past year.

Students will write a paper that uses Lyons, S. (2004). Fall Prevention in Older Adults guidelines (see websites above). Paper will be written in APA format.

- describes complete assessment (history, physical, assessment tools related to resident problems
- identifies all of the risk factors for falls (see article)
- makes nursing recommendations to reduce risk of falls (nursing care plan) that includes interventions to address environmental hazards (see listing in Lyons article, including lighting, footwear, etc), nursing interventions that address physiological problems related to this resident's falls (incontinence, recommendation exercise or activity, strategies to reduce or manage side effects of medications that contribute to falls), and nursing interventions that address psychological problems (ie, impulsivity or poor judgment related to dementia, cognitive impairment)
- Students will cite at least two research based articles and one text to support their interventions.

Faculty observation of student clinical experience (40% of course grade)
Evaluation is ongoing in a clinical course. Faculty collect data from a variety of sources to get the fullest picture of the student's knowledge and skills. Examples of data sources can include (not an exhaustive list):

- direct observation of clinical performance
- verbal discussion of client care with student
- written work and observed level of student preparation and understanding of the clients medications, diagnoses and needs
- evaluation of professional behavior by facility staff
- feedback by clients and their families
- conference participation
- interaction with faculty and peers

It is incumbent upon the student to clearly ***demonstrate*** to the faculty the knowledge and skills required to pass the course.

Evaluation Methods

Comprehensive geriatric assessment write-ups	20%
SOAP notes	10%
Medication charts, prep sheets	10%
Preventing Falls Paper:	20%
Faculty observation of student clinical experience	40%
Total	100%

Final grade distribution is as follows (minimum pass grade is C or 2.0)

College of Nursing Scale		University Scale	
94-100	A	4.0	Superior
90-93	A-	3.7	
87-89	B+	3.3	
83-86	B	3.0	Good
80-82	B-	2.7	
76-79	C+	2.3	
* 73-75	C	2.0	Adequate
70-72	C-	1.7	
66-69	D+	1.3	
63-65	D	1.0	Poor
60-62	D-	0.7	
Below 60	F	0.0	Failing

* Minimum passing grade for nursing courses

General rules

The following policies are meant to provide *clarity and consistency* in terms of course expectations and consequences. Of particular note in 335:

- The clinical labs and orientation during the first two weeks are carefully designed to help a student succeed in his/her clinical experience. Therefore, student attendance, preparation, and participation are mandatory during the initial two-week workshop. Missing parts of the workshop, whether due to an excused or unexcused absence, or unsatisfactory preparation and participation may mean a student cannot progress into the clinical experiences in this course.

Faculty and Students, Please Read: Safety and Clinical Focus in 334/335 Clinicals

Students may only practice the skills they have been validated on in the 308/326 validation labs. For example, students may not give medications until the 326 medication administration labs are successfully completed. Students may only perform clinical procedures after they have performed them successfully in 326 (e.g., catheterization; dressing changes).

The primary emphases in this course are: practice of assessment skills, practice in use of family and health promotion concepts, orientation to clinical community settings, practice of communication and collaboration skills, and practice of basic nursing care skills (after lab validation).

This course is focused on wellness concepts. ***This is not intended to be a medical-surgical or acute care clinical.***

Student Responsibilities in Long Term Care

The primary emphases in this course are practice of: interview and assessment skills, use of family and health promotion concepts, communication and collaboration skills, medication administration, and basic nursing direct care skills (after validation in lab). This course is focused on wellness concepts. Since long term care facilities are residences, it is not expected that other nursing skills

will be available for your practice. Should opportunities present themselves, you can practice other skills according to instructor availability and the guidelines below:

Students may do *independently:* (* some faculty require initial evaluation by them)
Review charts
Client assessments, including vital signs and weights
Client interviews
Hygiene: bed bath, back rub, mouth care, hair, nails
Bed making
TED hose, cough and deep breathing, incentive spirometer
Environmental assessment & interventions
Transfer clients* (if a lift is required, you must practice with staff first)
Apply and assess effectiveness of assistive devices, apply splints
Toilet clients*
Ambulate*, position, range of motion
Feeding (staff must report swallowing ability)
Collect specimens

Students must perform with instructor:
Medication administration
Document care in client chart

Of low priority:
Tube feedings
Dressing changes
Catheterization
Suture or staple removal
Blood glucose checks
Intravenous assessment and monitoring

Students may NOT:
Take physician orders
Administer IV medications
Witness consents or legal documents
Draw or administer blood or blood products
Change IV pump settings or syringes
Participate in show of force or restraint of client
Participate in spinal immobilization, change of position, or cervical collar for unstable spine

All exiting behaviors of previously required courses, including

Entering Behaviors	• Basic understanding of systems • Familiarity with principles of health promotion, health protection and disease prevention • Basic understanding of pharmacology and pathophysiology • Ability to carry out individual and family health assessment, including evaluation of structure and function, strengths, health promotion needs, and risk factors. • Able to construct genogram and ecomap. • As a direct care provider, complete a focused assessment Recognize

	normal and abnormal physical assessments • Ability to plan and carry out developmentally and culturally appropriate health teaching to family members. • Ability to plan and carry out appropriate nursing interventions of teaching and/or referral based on above assessments and screenings. • Ability to perform basic nursing skills for physical care such as bathing, body mechanics, vital signs, and introduction to aseptic dressing changes, tube feeding, NG tube insertion and bladder catheterization • Document care in a variety of settings using appropriate medical and nursing terminology. • Appreciate the unique, complementary, and sometimes overlapping roles of various disciplines involved in family and individual health care. • Develop a professional relationship with clients and health care professionals • Seek supervision appropriately for clarification and/or validation

If you do not meet the expectations for entering the course as listed above, see course coordinator.

Exiting Behaviors	• Ability to plan and carry out appropriate nursing interventions of teaching and/or referral based on assessments and screenings of older adults. • Able to use communication and collaboration skills to develop partnerships with older adults and their social systems. • Appreciate the unique, complementary, and sometimes overlapping roles of various disciplines involved in care of older adults. • As a direct care provider, complete a focused assessment and provide basic nursing care for older adults in health care settings. • Safely prepare and administer oral medications with direct supervision of an RN. • Able to document care in a variety of settings using appropriate medical and nursing terminology.

COMPETENCIES

The following tables describe for you how this course is planned to address the competencies set forth in the SUCON curriculum, the competencies described by the Association of American Colleges of Nursing (AACN), and what we view as the skills and knowledge you should have before and after this course. Similar tables will be found in the syllabi of all your clinical nursing courses. The tables in each syllabus differ because they are written to be specific to each course. You should always read these tables to get an idea of what you are going to get from the course.

BSN 2000 Competencies

Critical Thinking	Students will utilize critical thinking skills in the classroom, in seminar and in clinical settings as they practice interviewing, assessment and intervention skills for health promotion and disease prevention, and utilize

	case studies to apply learning.
Relationships/ Communication	Students will practice communication skills with elders, and with peers, faculty and other health care providers in the clinical settings. They will establish therapeutic relationships with adults and families and practice teaching skills with individuals and families.
Provider Skills	Basic provider skills will be applied to the practice setting. These will include assessments with elders, bed making, bathing, mobility and transfers, aseptic techniques and oral medications.
Care Management	Not addressed in NURS 334-335
Community	Students in the community will learn about safety issues, assessment issues, confidentiality, and therapeutic relationships (role of the nurse in the community).

AACN Essential Knowledge

Health Promotion	Principles of health promotion will be taught as well as specific assessment and intervention measures for elders. These will be taught in theory classes and implemented in related clinical situations. Students will be doing direct health teaching.
Risk Reduction, Disease Prevention	Principles of risk reduction and disease prevention through screening, teaching and immunization with elders. Applied in inpatient or long-term care settings and community centers.
Illness/Disease Management	Identification of common health problems across the lifespan. Basic illness management incorporated with health promotion and disease prevention in long-term care settings.
Information/ Technology	Students will utilize computers as a learning tool by accessing the internet website for this class, the SU library website for health sciences search engines, and websites for various other health related organizations.
Ethics	Ethics will be integrated in theory classes, clinical conferences and clinical settings. Issues of privacy, confidentiality, client choice, respect and honesty will be addressed.
Diversity	Socio-cultural issues that relate to family and health promotion will be addressed in theory classes and through case studies that include diverse situations with elders. The clinical settings provide students the opportunity to provide care to people from a variety of cultural and ethnic backgrounds.
Global Health Care	Not addressed in NURS 334 and NURS 335
Systems and Policy	Systems theory will be reviewed in class and utilized throughout the course as an approach to families and health care settings.

AACN Role Development

Provider of Care	Students will have the opportunity to learn and practice a variety of basic provider skills, including medication administration, bathing and bed-making, communication skills (interviewing and assessment), mobilization/ transfer skills, and aseptic technique.
Design, Manage, Coordinate Care	Not addressed in NURS 334 and 335

Member of Profession	Students will learn about, discuss and experience the role of the nurse with health promotion in elders. They will have direct clinical experiences with clients, nurses, and other members of the health care team in a hospital setting and a nursing home or long term care setting.

APPENDIX of Forms

There are several forms required for this course that are not attached to this syllabus but **are REQUIRED** for this course. They are all posted on the Angel website and include:

1. **Preparation Sheet**: Complete a preparation sheet for each individual resident with whom you work. This work does not need to be handed in, but will be necessary for you to use when your instructor quizzes you about your patient care needs, diagnoses, and nursing plan
2. **Medication Chart**: Complete a medication chart to include all medications that the student will be administering to their resident. This work does not need to be handed in, but will be necessary for you to use when your instructor quizzes you about your patient care needs
3. **Clinical Health History and Assessment:** Complete a health history and psychosocial assessment, physical exam, and other geriatric assessment instruments appropriate for the individual resident. Since a major emphasis in this rotation is to practice physical assessment skills, you will complete a head-to-toe assessment on each resident every day you work with him/her, even though only two of these assessments are turned in for grading. All residents should be assessed for pain. Consult with faculty for any exceptions.
4. **Focused Geriatric Assessments**: You will complete two comprehensive geriatric assessments which will include several tools. Due dates for these assessments are shown on the weekly clinical schedule. Your instructor may modify these dates according to availability of residents with whom you can complete the assessments. Tools that are posted on the ANGEL website include:

    - **Instrumental Activities of Daily Living:** This assessment tool is used for community based residents.
    - **Katz Index of Independence in Activities of Daily Living:** Your assessment is based on your knowledge and observation of the resident and his ability to perform each task. Indicate the level that reflects your assessment of your resident's abilities. It may be appropriate to add a specific description of what the resident can and cannot do.
    - **Sensory Assessment:** This tool examines vision and hearing needs and issues
    - **Pain Assessment:** A pain assessment should be done for each resident each day. For residents without dementia, use the Verbal Descriptor scale. For patients with dementia, use the Checklist of Nonverbal Pain Indicators.
    - **Nutritional Assessment,** the DETERMINE form will be available for assessing your community based client.
    - **Oral Health Assessment:** This tool examines oral care needs and issues
    - **Fall Risk Assessment:** Check the items that apply to your resident, and total the score. A score of ≥ 15 indicates that fall precautions should be implemented. Also available are Tinetti's assessment of gait and balance.
    - **Environmental/Safety Assessment:** This tool is to be used with your community or nursing home based clients to identify environmental risks.

- **Braden Risk for Skin Breakdown Assessment:** Assess each category for your resident and total the numeric score. A score of ≥ 16 indicates a risk for skin breakdown.
- **Folstein Mini Mental State Examination (MMSE):** This screening tool for cognitive impairment is appropriate for all residents in long term care facilities, but may not be possible for those who are severely cognitively impaired. Your instructor or the nursing staff can assist you to identify a resident with whom to complete this assessment if your resident is not able to do so.
- **(Yesavage) Geriatric Depression Scale Short Form:** As with the MMSE, complete this instrument only with cognitively intact or mild to moderately impaired residents, *not* with severely impaired residents. Introduce the questions by saying that the items ask about mood and feelings. The person does not need to answer every question if it makes him uncomfortable. Your instructor or the nursing staff can assist you to identify a resident with whom to complete this assessment if your resident is not able to do so.

5. **Clinical Performance Evaluation**: Both students and faculty use the following form to evaluate student clinical performance. Faculty score each course objective on a 1-4 scale. These grades are averaged to obtain the grade for this rotation. Faculty convert this mean to a percentage grade using the shared scale identified under the evaluation section of this syllabus. Students who score themselves as superior on this clinical performance must identify ***specific clinical examples*** that demonstrate how they **exceeded** the expectations of this course.

Seattle University

NURS 335: Promoting Wellness in Families

Clinical Performance Evaluation

Student: _____ Quarter _____

Directions To Students and Faculty:

1) Review the behaviors listed under each objective that indicate accomplishment of the objective. Analyze the degree to which each objective was accomplished throughout the rotation.

2) Rate each objective using the evaluation scale ("superior," etc.). Note: In order to pass clinical, students must demonstrate adequate performance on each critical behavior, indicated with an asterisk (*), and each objective. Students, who do not pass a clinical rotation in 335, do not pass the course.

3) Students and faculty each complete the entire form, including circling the evaluation scale, prior to the evaluation meeting.

4) Students photocopy their completed form and give the original to the faculty at the designated time prior to the clinical evaluation. Students who do not submit their self-evaluation forms to the faculty at the designated time will reschedule the evaluation and should include this behavior in rating objectives 4 and 6.

5) Student and faculty forms are stapled and given to the faculty for the second rotation. When the second rotation is evaluated, the student is given a copy of the faculty's evaluations and stapled forms are placed in the student file.

6) A copy of the clinical evaluation should be placed in the portfolio under Provider Skills

Evaluation Scale for Objectives
The evaluation scale is based on the SU grading system. Each objective is evaluated as: Superior, Good, Adequate, or Poor.

Superior: Consistently **exceeds** expectations. Functions above the expectations of a student at this level. Meets objective **consistently** and with **reasonable guidance**:

*Good***:** Consistently **meets** expectations in meeting objective. Student functions well for a student at this level. Student usually meets objective with occasional direction. Student consistently demonstrates professional conduct.

Adequate: By end of clinical experience is able to **adequately meet objective**. Student functions at the expectations of a student at this level. Consistently demonstrates professional conduct.

Poor: Not passing. Clinical performance in this area is **inadequate**. Indicates lack of skill, **unsafe** nursing practice, inadequate depth of knowledge, or inadequate application of nursing principles. Student functions below the expectations of a student at this level. Student inconsistently demonstrates professional behavior.

Grading
Faculty will identify the grade earned in each of the two primary components of NURS 335 (community and facility clinical). The two grades will be averaged to yield the final NURS 335 grade. Consistent with the SU grading system, the scale grade is converted to a letter grade.

Clinical Objective 1: Integrate knowledge from liberal arts, related disciplines and nursing science to promote well-being for older adults

Exemplar Behaviors Related to Objective:

- Health Promotion: incorporates an individual's health beliefs into plan of care; identifies factors that strengthen and inhibit the health status of individuals and families; individualizes strategies.*
- Family System: considers the family as a system and its implications for health promotion.
- Development: understands the developmental stage of the individual and incorporates this into health promotion and illness management.
- Teaching/learning: identifies the learning needs of individuals and family. Plans and implements teaching using a plan that accounts for individual factors that influence and inhibit learning.
- Pathophysiological/ psychobiological processes: uses applicable theories as a basis for understanding altered health states of individuals.
- Pharmacology: states the rationale for the use of specific medications in the prevention and treatment of health alterations; demonstrates application of pharmacotherapeutics to the nursing process. *

Evaluation (Circle):	**Comments:**
Superior Good Adequate Not Passing	

Clinical Objective 2: Applies the process of assessing, diagnosing, identifying outcomes, planning, intervening and evaluating to promote health, prevent illness and provide basic care for individuals and families.

Exemplar Behaviors Related to Objective:

- Systematically collects pertinent assessment data that relates to the individual, holistic needs of clients from a variety of sources including the individual, the family, support systems, and health care providers.
- Identifies accurate, priority nursing diagnoses that are derived from the assessment data and are consistent with NANDA terminology.
- Develops outcomes for the specified nursing diagnosis that are realistic, measurable, attainable, time specific and culturally appropriate to the client/family.
- Provides interventions that are individualized, pertinent to the nursing diagnosis and outcomes and based on theoretical, empirical or analytical rationales.
- Involves individual and family support systems in the planning and implementation of care.
- Evaluates the status of individuals and their families in relation to expected outcomes and revises the plan of care accordingly.
- Utilizes recognized scientific resources to develop a plan of care.

Evaluation (Circle):	**Comments:**
Superior Good Adequate Not Passing	

Clinical Objective 3: Demonstrates critical thinking attitudes, skills and abilities in clinical decision making and in evaluating nursing

practice.
Exemplar Behaviors Related to Objective: • *Utilizes critical thinking skills throughout the nursing process. • Demonstrates the following critical thinking criteria and attitudes: accuracy, preciseness, relevance, depth, breadth, logic, clarity, intellectual humility, value for reason, empathy, perseverance, integrity/fairness, courage. • *Demonstrates the ability to use theoretical rationales to make sound clinical decisions based upon individual and family differences, needs and responses. • Demonstrates an attitude of inquiry.

Evaluation (Circle):	*Comments:*
Superior Good Adequate Not Passing	

Clinical Objective 4: Integrates technological and relationship-centered nursing interventions in providing health promotion and direct care to older adults in a variety of health care and community settings.
Exemplar Behaviors Related to Objective: • *Demonstrates preparedness for performing strategies/interventions/care. • Individualizes care. • Incorporates client teaching into practice. • *Demonstrates competence in the performance of nursing interventions/care. • *Demonstrates knowledge of medication administration including route, dose, actions, precautions, side effects, expected client's response, and nursing implications. • Completes interventions/care in an organized, timely manner. • *Establishes a safe environment for the client. • Provides a therapeutic environment for the client, providing clear boundaries and respecting interpersonal space. • Protects the client's rights to privacy and confidentiality. • Exhibits professional behavior: appearance, attendance, punctuality

Evaluation (Circle):	**Comments:**
Superior Good Adequate Not Passing	

Clinical Objective 5 Utilizes communication and collaboration skills to develop teams and partnerships with individuals, families, community members, and other health care providers to facilitate healthy communities.	
Exemplar Behaviors Related to Objective: • Utilizes active listening skills. • Identifies influencing factors and utilizes effective interpersonal communication with individuals and families. • Demonstrates professional communication with peers, instructor, and members of health care team. • Collaborates with health care team in planning care for individuals and their families. • *Communicates promptly and appropriately regarding the individual's changing health status, adverse reactions to medications or therapies, or potential risks for injury to self or others. • Accurately and legibly documents nursing assessments and care on individual's records in a timely manner, using correct spelling, punctuation and medical terminology.	
Evaluation (Circle): Superior Good Adequate Not Passing	**Comments:**

Clinical Objective 6: Demonstrates commitment to self-evaluation, life long learning, service, diversity, and social justice.	
Exemplar Behaviors Related to Objective: • Identifies own skill and knowledge limitations and seeks assistance and/or guidance appropriately. • Identifies own strengths and learning needs. • *Demonstrates honesty and accountability in accordance with principles of ethical conduct as described in the COLLEGE OF NURSING Handbook. • Demonstrates respect for the client's right to exercise choice in defining health and health care regardless of own personal beliefs • Recognizes the ethical issues • Conveys respect for the ideas, values and beliefs of clients, families, peers, and members of the health care team.related to the health care of clients/families from diverse backgrounds.	
Evaluation (Circle): Superior Good Adequate Not Passing	**Comments:**

Student Summary:

1. Identify by number the objective that you accomplished best. Give an example that describes how you met it in an exceptional way.

2. Identify by number the objective you feel was the greatest challenge. Give an example that describes that challenge.

3. Identify a specific goal you want to work on during your next clinical experience.

Faculty Summary:

	Strengths	Areas for Growth
Skilled facility and/or Assisted living Elders		

Clinical Grade	Letter Grade	Number Grade
Faculty Observation		
Nurs 335 Grade Earned:		

Faculty _____ Date_____ Faculty _____Date____

Student _____ Date _____Student_____ Date _____