**A bird with wings and a sword

Description automatically generated**

**DEPARTMENT OF HEALTH**

**DIPLOMA OF GENERAL NURSING**

**FUNDEMENTALS OF NURSING**

**NUR 113**

**TEACHING & LEARNING RESOURCES**

**Introduction**

These resources have been put together to help teachers in nursing schools prepare for the implementation of the new curriculum in 2024.

This folder contains details of the subject purpose, its aim, objectives, a week by week plan and assessment details.

Because the revised program for nurses has been developed with an increased expectation of students learning independently, two document have been developed to assist this process. The first document is a resource for teachers and the second a learning guide for students. Both documents are based on the activities that students will be expected to complete during the semester. Teachers will need to review the teachers resource guide which outlines the lectures and student activities and resources needed for each teaching session. Each school is able to adapt these to fit their own institutional needs.

**It is recommended that teachers each complete the learning guide before asking the students to do this. This will provide teachers with the knowledge they need to successfully deliver the course. All the readings are highlighted. Teachers should read and review the identified chapters and then guide the students to the key areas that they should concentrate on.**

Each student should be given a learning guide at the start of the semester and time spent in tutorials providing students with the confidence and resources needed to successfully complete each learning activity.

The recommended text books are all open access and freely available on line for adaptation and adoption.

# SUBJECT GUIDE

|  |  |
| --- | --- |
| SUBJECT NAME: | Fundamentals of Nursing 1 |
| SUBJECT CODE: | NUR111 |
| TOTAL CREDIT POINTS: | 10 |
| PNGQF: | 5 |
| PREREQUISITES: | Nil |
| COREQUISITES: | Nil |

## SUBJECT AIM

This subject will introduce students to the essential elements of safe nursing care within the context of Papua New Guinea. Using a person-centred approach, students will develop an understanding of effective interpersonal and professional modes of communication, counselling skills, therapeutic relationships and the importance of being culturally aware. There is a focus on the development of core clinical nursing skills based on current best practice and students will develop beginning critical thinking skills in relation to infection control, risk assessment and risk management, physical assessment, assisting with personal and hygiene needs, safe patient movement and promoting patient’s well-being.

## SUBJECT DESCRIPTION

This subject will introduce students to the history of nursing and the influence of major nurse theorists in shaping the nursing profession. The development of nursing in PNG will be highlighted. The growth of nursing professionalism supported by standards for practice, codes of ethics and regulation will be discussed. Students will explore the essential elements of safe nursing practice including the Nursing Process, while developing basic clinical nursing skills and acquiring critical thinking skills in relation to infection control, risk assessment, physical assessment, assisting with personal hygiene care, patient safety, promoting patients’ well-being. Using a person-centred care approach, students will develop an understanding of effective interpersonal and professional modes of communication, therapeutic relationships and the concept of cultural safety. The roles of other team members within the context of professional nursing practice in PNG will be considered.

## SUBJECT DELIVERY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Teacher Directed Hours  70 | | Learner Directed Hours | Total Theory Hours | Work Experience Hours | Total Credit Points  10 | |
| Lectures | Tutorials |  |  |  | Theory | Work Experience |
|  |  | 30 | 100 | 0 | 100 | 0 |

## LEARNING OUTCOMES

Upon completion of this subject the student will be able to:

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| --- | --- | --- |
| Subject Learning Outcomes | Focus Competency Units and Elements | Focus Course Learning Outcomes |
| 1. Describe the history of nursing and the growth in nursing professionalism in PNG and Global context | 4.1, 4.2, | 10, 11 |
| 2. Explain nursing theory and at a basic level and apply this understanding to the development of the Nursing Process; | 2.1, 2.2 | 9 |
| 3. Describe what is meant by person-centred care and its relevance to the PNG context; | 10.1, 10.2, 11.1, 12.1 | 1 |
| 4. Apply beginning knowledge of scientific concepts to care practices; | 10.1 | 1 |
| 5. Demonstrate an application of effective, culturally safe and therapeutic communication (verbal, nonverbal and written) with patients and other healthcare professionals; | 2.1, 6.1, 10.1, | 5, 6, 9, |
| 6. Demonstrate the skills needed to deliver safe and effective nursing care within the constraints of level of knowledge, available resources and the boundaries of selected legal and ethical considerations; | 1.1, 1.2, 1.3, 2.4, 3.1, 3.3 | 1, 4,7 |
| 7. Apply knowledge of infection control standards to nursing care; | 8.1 | 1 |
| 8. Demonstrates mastery of basic life support; | 8.1 | 7 |
| 9. Review the evidence for nursing interventions and show beginning skills in the application of clinical judgement. | 10.1, 10.2, 11.1, 11.2, 12.1 | 10 |

## TOPIC OUTLINE

### Topic 1

**HISTORICAL DEVELOPMENT OF NURSING:** The history of nursing in PNG. International nursing beginnings. The influence of Florence Nightingale, Martha Rodgers, Patricia Benner and other nursing theorists.

### Topic 2

**NURSING PROFESSIONALISM:** Requirements of a profession highlighting basic ethical and legal responsibilities. Introduction to the code of ethics and professional regulation highlighting, patient’s rights, providing information and consent, confidentiality, invasion of privacy and negligence. PNG Nursing Council mandated roles and responsibilities.

**Topic 3**

**THE NURSING PROCESS:** The elements of the nursing process: assessment, planning, implementation and evaluation. The relationship between the nursing process and assessing alterations in health status. The process of assessment. Collecting unitive and objective data.

**Topic 4**

**CLINICAL REASONING AND THE APPLICATION OF CLINICAL JUDGEMENT:** Clinical reasoning: frameworks for making clinical decisions, applying clinical reasoning skills to case studies. Developing a framework for thinking like a nurse.Applying the Nursing Process.

**Topic 5**

**COMMUNICATION AND DOCUMENTATION:** Definition of communication, factors that influence effective communication, barriers to communication, definition and characteristics of the therapeutic relationship. Basic principles of nursing reports and documentation. Legal and ethical responsibilities.

**Topic 6**

**RISK AND SAFETY:**  Current issues in patient safety, evidence for need, applying the evidence: Hand hygiene**. I**nfection control (standard precautions). Hospital and environmental safety. Safe patient moving, body mechanics and safe moving techniques. Self-care and reflective practice. Exploring and applying patient safety competencies.

**Topic 7**

**CLINICAL SKILL DEVELOPMENT:** The following clinical skills will be practiced in this unit:

|  |  |  |  |
| --- | --- | --- | --- |
| Personal Care: Assisted ambulation Hygiene: bed making Hygiene:  shower/bath Hygiene: bed bath | Clinical Communication and Documentation  Recording vital signs  Recording fluid input and output  Using and maintaining patient records | Clinical Assessment and Monitoring:  Vital signs: TPR BP Sp02  Physical assessment: weight height, BMI, | Clinical Interventions and Management:  First Aid (Mastery at a novice level) |
| Hygiene: oral care Skin integrity: assessment | Negotiating care with patient/family | Using a stethoscope Beginning nursing assessment |  |
| Privacy and Dignity:  Respectful care  Confidentiality | Promoting Self -management:  Health education and health promotion Applying evidence | Risk and Safety:  Hand hygiene Basic  Infection control  Beginning manual  handling |  |

## TEACHING GUIDE

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| **Learning Outcomes** | **Topic** | **Content** | **Time Frame** | **Teaching Methods** | **Assessment Tasks** | **Teaching Resources** |
| 1 | Historical development of nursing | History of Nursing in PNG  International nursing beginning  Influence of Nightingale & other nursing theorists.  Concepts of health and Nursing | 7 hours (5 hours teacher directed, 2 hours student directed) | * Lecture discussion * PowerPoint presentation * Brain storming * Individual activities * Group activities * Peer teaching/feedback * Student’s reflection * Role play |  | Recommended textbook  Laptop & projector  Student handbook  Butcher papers, markers  White board  Lecture notes |
| 1 | Nursing professionalism | Requirements of a profession  Basic ethical and legal responsibilities in nursing  Introduction to code of ethics competency standards, professional conducts & professional regulation, highlighting, patient’s rights, providing information and consent, confidentiality invasion of privacy and negligence |  | * Lecture discussion * Group activities * Peer teaching/feedbacks * Case scenario * PowerPoint presentation * Role play |  | National Health Plan  Nursing competency standards  Nursing Code of Ethics  Patient rights |
| 2, 3, 4 | Nursing process | Elements of nursing process: (A, D, P, I, E)  Relationship between nursing process and assessing alterations in health status |  | * Clinical case scenario * Lecture discussion * PP presentation * Group activities & individual activities |  | Recommended textbook  Laptop & projector Butchers papers  Markers  Whiteboard |
| 5 | Communication and documentation | Definition of communication, factors that influence effective communication, barriers in communication, definition and characteristics of the therapeutic relationship.  Basic principles of nursing report and documentation  Legal and ethical responsibilities  Assisting students to read academic texts.  Introduction to referencing requirements for assessment 1.  Distinguishing between in-text referencing and creating a reference list. |  | * Lecture discussion * Student group activities * PP presentation * Role play * Peer teaching/feedback |  | Laptop & projector  Butcher papers Markers  White board  Lecture notes |
| 6, 7 | Risk and safety | Current issues in patient’s safety, evidence for need, applying the evidence: Hand hygiene  Infection control (standard precautions)  Hospital and environment safety  Safe patient moving, body mechanics, and safe moving techniques.  Self-care and reflective practices.  Exploring and applying patient’s safety competencies |  | * Role play * Group activities * Demonstration & simulation * Lecture discussion * Video * Peer assessment/evaluation |  | Laptop  Butcher papers  Markers  White board  Lecture notes  Recommended textbook |
| 8 | Basic first aid | Aims, principles and practice of first aid  Bandages, slings  Haemorrhage and shock, causes, signs and symptoms& management  Fractures and soft tissue injuries and management of symptoms  Burns: types, causes and management  Poison: types, snake bites, signs and symptoms, management  Emergencies causing lack of O2 – procedure for EAR, CPR determine by principle of BLS  Handling and transporting causalities in emergencies  Fire safety measures  Altered level of consciousness |  | * Lecture discussion * Role play * Demonstration * Simulation * Video * Peer teaching * Peer assessment |  | Guest lecturer  Mannequins  Bandages, slings, stretchers  First aid textbook  Lecture notes |
| 9 | Clinical skill development | Personal care   * + Assisted ambulation   + Hygiene – bed making, shower/bath, oral care   Skin integrity   * + Assessment   + Pressure area care   Clinical communication and documentation   * + Recording vital signs   + Recording fluid input and output   + Using and maintaining PTI record   + Negotiating care with patient/family   Clinical assessment and monitoring   * + Vital signs: TPR, BIP, SPO2   + Physical assessment: weight, height, BMI, BSL   + Using a stethoscope beginning nursing assessment   Clinical intervention   * + Basic life support |  | * Lecture discussion * Demonstration * Simulation * Video * Role play * Peer assessment * Peer feedback * Group activities * Peer teaching |  | Skill logbook  Assessment criteria  Mannequins  Thermometer/ Sphygmomanometer  Pulse oximeter  Foot scale  Height board  Tape measures  Stethoscope  Soap/towel/basins  Bucket/mop/brush  Broom  Cleaning detergents  BMI chart  Body oil, powder  Toothbrush, Toothpaste  Hair comb, hairbrush Macintosh  Bed linens mattress Pillows |

## ASSESSMENT

Student assessment in this subject is an integral part of the overall teaching and learning experience. It ranges from informal formative assessment to formal formative and summative assessment. There is continuous informal assessment given prior to formal assessments. The pass mark for this subject is 60%. The table below describes the assessment tasks.

To pass this subject each student must:

* Attend all classroom learning sessions
* Complete all assessments
* Achieve 60% or above in all formative assessments and 60% or above in the summative assessments

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| --- | --- | --- | --- | --- | --- | --- |
| Assessment | Description Tasks of Assessment Task | Percentage | Subject | Course Learning Outcome | Relationship to PNG Competency | Due Date |
| 1 | **Skill Evaluation**  Handwashing technique and First Aid. **Task:** Students will be assessed on hygienic handwashing and Basic First Aid. Detailed criteria will be provided and discussed in class. | 30% | 3,6, 7 | 5, 6, 7 | 1.5, 4.1, 8.1 |  |
| 2 | **Written Assessment**  **Essay** Applying person-centred care and the Nursing Process to a case study. **Task:** Written Assessment: Nursing Documentation.Applying the Nursing Process to a case-study. **Task:** students will be given a case study and, using a provided template, asked to write a nursing report about the case. | 30% | 1, 2, 4, | 1, 2, 6, 8 | 10.1, 10.2, 11.1, 11.2, 11.3,12.1, 13.1 |  |
| 3. | **Objective Structured Clinical Assessment** (**Practical Examination)**  **Task:** Students will be evaluated as they participate in a simulated clinical scenario. Students will be expected to demonstrate the desired knowledge, attitudes and skills introduced in this unit and appropriate to their stage of learning. The scenario will involve the student in communicating with a simulated patient and providing a safe environment for the patient based on legal and ethical considerations. Students will also be required to undertake a temperature reading and recording and evaluate the result and provide any necessary follow-up care.    Students that fail the OSCA may be offered an additional assessment. | 40% | 1, 2, 3, 4, 5, 6, 8 | 1, 2, 3, 4, 5, 6, 7,8 | 10.1, 10.2, 11.1, 11.2, 11.3,12.1, 13.1 |  |

**Learning and teaching approaches**

* Student centred learning approaches scaffolded via:
* Educator guided classroom learning and discussion
* Student facilitated classroom group learning
* Scenario based problem solving activities
* Clinical skills development and practice in clinical laboratories (Demo Lab)
* Self-directed learning activities
* Student led classroom group feedback
* Reflective practice
* Group Quiz
* Clinical laboratory sessions will focus on the integration of key concepts and skills.
* In these sessions, students will be introduced to the processes of clinical judgement and patient centred care and in that context learn to apply a range of nursing skills, including assessment and interventions and simulation activities.
* Simulation activities are practical learning experiences designed to give students exposure to a variety of scenarios that may be encountered in practice.
* Students learn and practice clinical and interpersonal skills with case scenarios in the laboratories.
* These practice scenarios incorporate the development of professional communication skills including the professional and therapeutic communication skills required for nursing practice.

**Texts**

Ernstmeyer K., Christman D. Nursing Fundamentals, (2023). Open Resources for Nursing (Open RN). Chppewa Valley Technical College, Wisconsin, USA. Available: <https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_(OpenRN)>

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Ernstmeyer K., Christman D. Nursing Skills, (2023). Open Resources for Nursing (Open RN). Chppewa Valley Technical College, Wisconsin, USA. Available: <https://med.libretexts.org/Bookshelves/Nursing/Nursing_Skills_(OpenRN)>

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Brown, D., Buckley, T. Aitken, R. & Edwards, H. (eds), 2024, *Lewis’s Medical-Surgical Nursing 6e,* Elsevier Australia, Chatswood, Australia.

**Assessment Task One**

Students will need to understand and apply the principles of safe hand hygiene to an assessment of them safely performing the skill of hand hygiene. They will have the opportunity to practice in class and then with a learning partner (fellow student). They then need to perform the task and be assessed and get feedback from another student.

They will then grade each other as competent or not competent in this skill. This skill will be reassessed during the practical exam at the end of the semester (the OSCA) and also again on clinical practice.

Hand hygiene will be peer assessed using the criteria provided below.

## Hand hygiene

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| **Criteria: C – Competent, NYC – Not Yet Competent** (Educator must comment why grade was NYC) |

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| --- | --- | --- | --- | --- |
| **Criteria for skills performance** | **Self Practice** | **Observed Practice (P) with a partner, then assessed (A)** | | |
| **P** | **P** | **Assess** |
| Identifies need |  |  |  |  |
| Gathers equipment:   * warm running water * soap * paper towels. |  |  |  |  |
| Prepares and assesses hands |  |  |  |  |
| Turns on and adjusts water flow |  |  |  |  |
| Wets hands, applies soap |  |  |  |  |
| Cleans under the fingernails when required |  |  |  |  |
| Thoroughly washes hands |  |  |  |  |
| Rinses hands |  |  |  |  |
| Turns off the water if elbow taps used. If ordinary taps, turns off after drying hands |  |  |  |  |
| Dries hands |  |  |  |  |
| Uses alcohol-based hand rub as an alternative to soap and water, when appropriate |  |  |  |  |
| Demonstrates ability to link theory to practice |  |  |  |  |

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| PNG Nursing Competency Standards – 1-4 | | |
| **Satisfactory: YES / NO** | **Date:** | **Signature:** |

**Basic First Aid**

First aid will be assessed during the identified clinical skills assessment weeks. This will be assessed as per the first aid competencies in the learning package.

**Assessment Task Two**

**Case Study**

Mary Kiap who is 26 years old, presents to the health clinic with a chief complaint of fever, chills, and weakness for the past week. She reports experiencing intermittent high fevers accompanied by profuse sweating and severe fatigue. She also complains of mild headache and muscle aches. Mary is concerned about her health because her symptoms have not improved with rest and local remedies.

**Medical History**

* Mary has a history of occasional episodes of malaria, which she typically treats with traditional herbal remedies.
* She has no known chronic medical conditions.
* She has no known allergies.
* Mary is not currently taking any prescription medications.

**Social History**

* Mary lives in a village in Papua New Guinea, where malaria is endemic.
* She works the garden and frequently spends time outdoors.
* She lives in a traditional house without screens on windows and doors.
* Mary does not use mosquito nets consistently and rarely uses insect repellent.
* She has no recent history of travel outside her village.

**Family History**

* Mary's family members have also experienced episodes of malaria in the past.

**Physical Examination**

Upon examination, Mary appears weak and fatigued. She has a temperature of 38.6°C. Her heart rate is elevated at 100 beats per minute, and her blood pressure is 105/60. On examination of her skin, no specific rashes or lesions are observed. Her abdomen is soft and slightly tender, on palpation splenomegaly (enlarged spleen) in noted. Conjunctiva clear though slightly pale.

**Diagnostic Workup**

* **Malaria Rapid Diagnostic Test (RDT):** A rapid diagnostic test for malaria is conducted, which returns a positive result for Plasmodium falciparum.
* **Complete Blood Count (CBC):** A CBC reveals mild anaemia and thrombocytopenia.
* **Blood Smear** A peripheral blood smear is performed, confirming the presence of Plasmodium falciparum parasites in the red blood cells.

**Diagnosis**

Mary is diagnosed with uncomplicated Plasmodium falciparum malaria.

**Treatment**

Mary is started on antimalarial therapy with artemether-lumefantrine, the recommended first-line treatment for uncomplicated falciparum malaria . She is also given supportive care to manage her fever, pain, and dehydration.

**Follow-Up**

Mary is advised to complete the full course of antimalarial treatment and to return to the clinic if her symptoms worsen or do not improve. She is educated on the importance of using mosquito nets consistently and taking preventive measures to reduce her risk of future malaria episodes.

**Health Education**

* Mary is counselled on the use of insecticide-treated bed nets.
* She is advised to wear long-sleeved clothing and use mosquito repellent when outdoors during peak mosquito activity hours.
* Her family members are encouraged to undergo screening and treatment if they exhibit similar symptoms.

Using this information, complete your nursing assessment. Complete the Nursing Care Plan below and apply what you have learned about the Nursing Process.

Once you have completed your nursing assessment and nursing diagnosis, complete the progress notes about your assessment and document Mary’s s observations in the correct place. Consider the legal and ethical requirements of documentation when completing your Nursing Care Plan.

* 1a. Identify subjective data

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* 1b. Identify objective data

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1. Select subject or objective data to create two nursing diagnosis (actual / potential issues) from the case study

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| --- | --- | --- |
| Nursing Diagnosis | Related to | Symptoms/ case study information |
|  |  |

1. Apply you two nursing diagnosis (either actual / potential issues) from the case study to develop a person-centred care plan as below

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Assessing | Nursing diagnosis | Plan | Implement | Evaluate |
|  |  |  |  |  |

1. Provide your nursing report about this patient including all relevant information for hand over to other staff, and ongoing treatment and care for this patient.

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1. Using the progress notes page and the observation graph chart, please document the person's assessment and plan of care using Subjective, Objective, Assessment & Planning (SOAP) framework.

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| **Health Services**   ꙱ A Hospital  ꙱ A clinic  ꙱ Village clinic  ꙱ Other: ……………………………………  **Progress notes** | | Patient Identification Label (stick here or complete details)   Surname: …………………………………………………….   UR: …………………………….   Other Names: ………………………………………………   Address…………………………………………………………………………………………………………………………………………………………………………………………………………………………………...  Ph No: …………………………………………………………………………………….  Date of Birth: ……………………………… Sex: ꙱ M     ꙱F    ꙱Other |
| Date & time | *Add signature, printed name, staff category, date and time to all entries.*  *MAKE ALL NOTES CONCISE AND RELEVANT.*  *Leave no gaps between entries.* | |
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| **Health Services**  ꙱ A Hospital  ꙱ A clinic  ꙱ Village clinic  ꙱ Other: ……………………………………  **Observation Sheet** | Patient Identification Label (stick here or complete details)   Surname: …………………………………………………….   UR: …………………………….   Other Names: ………………………………………………   Address………………………………………………………………………………………...  Ph No: …………………………………………………………………………………….  Date of Birth: ……………………………… Sex: ꙱ M     ꙱F    ꙱Other |

*Note: Numbers are aligned to the top line – i.e. Box 160 means top line= 160, bottom line = 150. Same with Temp*

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| Pain Score 0-10 | | |  |  |  |  |  |  |  |  |  |  |  |
| Respirations | | |  |  |  |  |  |  |  |  |  |  |  |
| O2 Saturation | | |  |  |  |  |  |  |  |  |  |  |  |
| FiO2 (O2 Flow Rate) | | |  |  |  |  |  |  |  |  |  |  |  |
| Pulse | | |  |  |  |  |  |  |  |  |  |  |  |
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| Signature | | |  |  |  |  |  |  |  |  |  |  |  |

**References**

Marking Criteria Assessment Task 2 - Nursing Documentation - Applying the Nursing Process to a Case Study

|  |  |
| --- | --- |
| Criteria | Description |
| Comprehensive Data Collection | * Gathered both subjective and objective data from the case study. * Demonstrated an understanding of the importance of thorough data collection in nursing practice. * Included relevant patient information, such as chief complaint, medical history, vital signs, and observations. |
| Accurate Subjective and Objective Data Differentiation | * Gathered both subjective and objective data from the case study. * Demonstrated an understanding of the importance of thorough data collection in nursing practice. * Included relevant patient information, such as chief complaint, medical history, vital signs, and observations. |
| Data Relevance and Pertinence | * Evaluated the collected data for its relevance to the patient's health status. * Discarded irrelevant or extraneous information that doesn't contribute to the nursing assessment. * Demonstrated critical thinking in selecting data essential for nursing diagnosis formulation. |
| Nursing Diagnosis Formulation | * Utilized the collected data to create appropriate nursing diagnoses. * Formulated nursing diagnoses using standardized language and following NANDA-I guidelines. * Demonstrated an understanding of how nursing diagnoses relate to patient assessment and care planning. |
| Clinical Reasoning and Justification | * Provided rationale for each nursing diagnosis based on the identified data. * Demonstrated the ability to connect specific data points to the chosen nursing diagnoses. * Showed critical thinking in explaining why certain nursing diagnoses were prioritized over others. |
| Evidence-Based Practice | * Incorporated current evidence-based information in the nursing diagnoses and rationale. * Demonstrated an awareness of research or guidelines supporting the chosen nursing interventions. * Indicated a commitment to providing patient-centered care grounded in evidence. |
| Clear and Organized Documentation | * Organized the nursing documentation in a clear and structured manner. * Used appropriate headings or sections for each aspect of the nursing process (assessment, diagnosis, rationale). * Presented information in a way that would facilitate communication and understanding among healthcare professionals. |
| Professionalism and Communication | * Maintained a professional tone and language in the documentation. * Utilized correct grammar, spelling, and formatting, reflecting attention to detail. * Conveyed information effectively for other healthcare team members to understand and collaborate. |
| Ethical Considerations and Patient Privacy | * Respected patient confidentiality and privacy in the documentation. * Adhered to ethical guidelines and standards for patient information protection. * Demonstrated awareness of the sensitivity of patient information and its proper handling. |
| Overall Quality and Presentation | * Presented a well-organized and thoughtfully prepared nursing documentation. Demonstrated a high level of engagement and effort in completing the assignment Showed creativity and innovation in the presentation while maintaining professionalism. |

Rubric – evaluating nursing documentation and nursing process.

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| Criteria | Excellent | Good | Satisfactory | Needs Improvement | Inadequate |
| Comprehensive Data Collection | Comprehensive data collection is evident and includes all relevant subjective and objective information from the case study. | Most of the relevant subjective and objective data from the case study are included. | Some relevant subjective and objective data are included, but some important information is missing. | Limited relevant data are included, and crucial patient information is omitted. | No relevant data included. |
| Accurate Subjective and Objective Data | Clear differentiation between subjective and objective data is consistently demonstrated, with accurate identification of each type. | Differentiation between subjective and objective data is mostly accurate. A few minor errors may be present. | Differentiation between subjective and objective data is attempted but not consistently accurate. Several errors may be evident. | Limited distinction between subjective and objective data; multiple errors in identification. | No clear distinction between subjective and objective data. |
| Data Relevance and Pertinence | All collected data is highly relevant, directly contributing to the nursing assessment and diagnosis process. | Most collected data is relevant to the nursing assessment and diagnosis process. Some minor irrelevant information may be included. | Some relevant data is included, but there is a noticeable presence of extraneous or irrelevant information. | Limited relevant data included; major portions of irrelevant information are present. | Data collected is largely irrelevant and doesn't contribute to the assessment or diagnosis. |
| Nursing Diagnosis Formulation | Accurately formulates nursing diagnoses based on comprehensive assessment data. Diagnoses are appropriate, concise, and follow NANDA-I guidelines. | Nursing diagnoses are accurately formulated, primarily based on the assessment data. Minor deviations from NANDA-I guidelines may be present. | Nursing diagnoses are formulated, but some inaccuracies or deviations from guidelines are evident. | Nursing diagnoses are partially formulated, with several inaccuracies and deviations from guidelines. | No nursing diagnoses or major inaccuracies present. |
| Clinical Reasoning and Justification | Rationale for nursing diagnoses is thoroughly supported with explicit connections to assessment data. Critical thinking is evident in explaining priority and relevance. | Rationale for nursing diagnoses is mostly supported with connections to assessment data. Some areas may lack thorough justification. | Rationale for nursing diagnoses is attempted but lacks consistent or strong connections to assessment data. | Limited rationale provided; connections between nursing diagnoses and assessment data are weak or missing. | No or insufficient rationale provided for nursing diagnoses. |
| Evidence-Based Practice | Nursing diagnoses and rationale are strongly supported by current evidence-based information. | Nursing diagnoses and rationale show some evidence-based support, with a few areas lacking clear evidence. | Evidence-based support for nursing diagnoses and rationale is minimal or inconsistent. | Limited or no evidence-based support is evident in nursing diagnoses and rationale. | No evidence-based support provided. |
| Clear and Organized Documentation | Documentation is exceptionally clear, organized, and easy to follow. Each section is well-structured with appropriate headings. | Documentation is clear and organized, with minor inconsistencies in structure or formatting. | Documentation is mostly organized, but structure and headings may not be consistently appropriate. | Documentation is somewhat disorganized and difficult to follow due to improper structure or formatting. | Documentation is unclear, poorly organized, and challenging to navigate. |
| Professionalism and Communication | Professional language and tone are consistently maintained. Grammar, spelling, and formatting are impeccable. | Professional language is mostly maintained, with a few minor errors in grammar, spelling, or formatting. | Professionalism in language and tone is somewhat lacking. Several errors in grammar, spelling, or formatting may be present. | Language and tone lack professionalism, with numerous errors in grammar, spelling, or formatting. | Unprofessional language and tone with multiple errors in grammar, spelling, or formatting. |
| Ethical Considerations and Patient Privacy | Patient privacy and confidentiality are strictly adhered to. Ethical guidelines are consistently followed. | Patient privacy and confidentiality are mostly respected, with a few minor lapses in adherence to ethical guidelines. | Patient privacy and confidentiality are somewhat compromised, and some ethical considerations are overlooked. | Patient privacy and confidentiality are significantly compromised, showing disregard for ethical guidelines. | Patient privacy and confidentiality are completely disregarded. |
| Overall Quality and Presentation | The documentation is of exceptional quality, reflecting thorough engagement, effort, creativity, and professionalism. | The documentation is of good quality, demonstrating effort, creativity, and professionalism. | The documentation is of satisfactory quality, though effort, creativity, or professionalism could be improved. | The documentation is of subpar quality, lacking effort, creativity, and professionalism. | The documentation is of poor quality, displaying no effort, creativity, or professionalism. |