2017 – 2018 Student Handbook

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SECTION ONE: GENERAL INFORMATION

MISSION

A mission is an organization’s reason for being, its purpose. The mission of the Rankin School of Nursing follows:

The St. Francis Xavier University Elizabeth and Thomas Rankin School of Nursing offers an innovative and responsive program that educates competent, safe, caring, evidence-informed, critical thinking baccalaureate-prepared nurses dedicated to promoting health, social justice, cultural safety, and equity.

VISION

A vision statement provides an inspiring description of what an organization hopes to be in the future. The 2021 vision for the Rankin School of Nursing appears below:

The St. Francis Xavier University Elizabeth and Thomas Rankin School of Nursing is an innovative leader in nursing education, research, community engagement, and collaborative partnerships locally, provincially, nationally, and globally. The vision provides the Rankin School of Nursing with direction over the next five years.

VALUES

As articulated in the StFX Strategic Plan 2017 – 2022: The Way University is Meant to Be, the Rankin School of Nursing is committed to excellence, equity, service, and dignity. As part of the StFX Faculty of Science, we believe in:

1. Interdisciplinary teaching, research, and collaboration that enriches academic learning, and,
2. High-quality interactions between students and all members of the Faculty of Science. The Rankin School of Nursing is dedicated to participating in and supporting all StFX initiatives designed to embrace and foster diversity. As a professional school, the Rankin School of Nursing also values:
3. Building collaborative partnerships among the School of Nursing and practice and research environments to enhance research and the teaching-learning process
4. Education that prepares safe and competent baccalaureate-prepared nurses to provide leadership related to current and future health care trends
5. Baccalaureate education that embodies best practices, College of Registered Nurses of Nova Scotia entry level competencies, standards of practice for registered nurses, and the Canadian Nurses Association Code of Ethics
A HISTORICAL PERSPECTIVE TO THE RANKIN SCHOOL OF NURSING

The St. Francis Xavier University Rankin School of Nursing (StFX) is one of the major legacies of the Sisters of Saint Martha who founded hospitals and nursing education in eastern Nova Scotia and elsewhere in the early 20th Century. The StFX School of Nursing began as a Department of Nursing, established in the 1920s which gave Registered Nurses the opportunity to complete courses towards a Bachelor of Science in Nursing. The integrated BScN program began admitting high school graduates to a 4-year program in the 1960s. Many of the early faculty members were Sisters of Saint Martha. The Sisters contributed immensely to a foundation for Nursing Education at StFX based on a philosophy of service to society grounded in compassion and humanitarian ethics, appreciation of the dignity of the human person, respect for life in all its stages, and principles of inquiry based on a search for truth.

Sister Simone Roach, who led the BScN program in the 1960s and 1970s, was the original author of the Canadian Nursing Association Code of Ethics (Storch, 2007) and a recipient of the Order of Canada in 2010 for her work in Ethics in health care.

When Sister Simone died in 2016 at the age of 93, she left a powerful legacy through her contributions to the CNA Code of Ethics, her many publications about the nature of caring in health care, and in the many people touched by her work. The imprint of Sister Simone’s philosophical scholarship and wisdom continues to be a ‘blueprint’ (Roach, 2002) to inform our curriculum, indeed “enduring values in changing times” (Storch, 2007).

In September 2016 the StFX School of Nursing was renamed the Elizabeth and Thomas Rankin School of Nursing. The Rankin School of Nursing was named in honour of Tom and Elizabeth’s long legacy of giving back, and in particular their support of health care.
PHILOSOPHY

The Rankin School of Nursing (SON) strives to provide the highest quality nursing educational experience in Canada in an environment where the student comes first.

In its commitment to excellence, the SON desires to enhance the intellectual, social, spiritual, cultural, and personal development of its constituents by integrating innovative teaching, rigorous research, holistic practice, and creative community outreach programs.

The SON endeavors to search for truth through the processes of professional caring, critical inquiry, reflection, and life-long learning.

The SON develops, advances, and disseminates nursing knowledge as well as proactively influences public policy that impacts on the health and wellbeing of individuals, families, groups/populations, and communities, including the global community.

The SON actualizes the values of academic freedom, academic honesty, and academic integrity while cultivating a culture of scholarship that includes the scholarship of discovery, teaching, application, and integration.

The SON aspires to uphold those spiritual values and principles that are integral to the dignity and worth of every human being.

The SON recognizes students, faculty, nurse educators, and staff from diverse backgrounds and respects the ideals of social justice, inclusivity, and equity.

Students, faculty, nurse educators, staff, alumni, and partners in the community and health care sector collaborate to support the mission and values of the school.

The call for ethical care and the primacy of caring has evolved towards greater inclusion in the curriculum about the importance of health care based on an appreciation of human rights. The school is guided by a philosophical focus on individuals, families, groups, and communities and within the last decade there has been an emphasis on population health and cultural diversity.

References


2.1 STATEMENT OF PROGRAM PURPOSE AND GOALS

The StFX educational unit offers a program of study leading to a Bachelor of Science in Nursing. Variation within this program of study (e.g., time frame for completion, program requirements, and course sequence) accommodates undergraduate transfer students, post-degree students, aboriginal students, and those students who possess RN diploma preparation in nursing. A designation of Advanced Major or Honours is available to qualifying students. The purpose in all program options is to prepare professional nurses who are proactive and responsive to the changing health needs of society and who are prepared to to engage in safe, competent, compassionate, ethical, evidence-informed nursing practice with clients across the life span and in a variety of settings. The program also provides a solid foundation for graduates who wish to pursue specialization in nursing, advanced nursing practice roles, or study at the graduate level.

Program Goals:
Irrespective of the program option completed, graduates will be able to:

1. Engage in evidenced-informed professional nursing practice that is directed toward promoting health, preventing illness, managing disease processes, restoring optimal function, and alleviating suffering in clients across the life span in a variety of settings and in accordance with the Standards for Nursing Practice (CRNNS, 2017), the Entry Level Competencies (CRNNS, 2013), and the CNA Code of Ethics (2017).
2. Incorporate and promote the principles of primary health care and population health.
3. Address the determinants of health and social determinants of health throughout all phases of the nursing process.
4. Apply professional, ethical/moral, and legal standards in decision-making with respect to health and health care delivery.
5. Use self-reflection and dialogue with other nurses and health-care providers as part of ethical practice.
6. Act and interact in a caring, compassionate professional manner.
7. Demonstrate accountability and responsibility in all nursing actions and interactions.
8. Implement nursing practice models that promote the principles of self-care and societal responsibility.
9. Uphold the ideals of social justice, inclusivity, advocate to create greater equity through respectfulness, cultural safety, and cultural competence.
10. Support inter-disciplinary and multi-sectoral collaborative participation in health care delivery and research.
11. Use facilitative and deliberate interaction in all client and family encounters.
12. Employ leadership and advocacy skills to positively impact on population health and health care policies.
13. Participate in activities that foster personal and professional growth and continuing competence.
14. Exemplify professional nursing practice that is proactive and responsive to the changing health needs of society.
15. Demonstrate critical thinking, flexibility, and creativity in unpredictable and complex situations.

Approved by the SON: June 2008; Minor revisions December 2008; Minor revisions: March 2009

2.2 Level Four Objectives

Irrespective of the program option in which the student is enrolled, the student at level four will.

1. Consistently engage in evidence-informed professional nursing practice that is directed toward promoting health, preventing illness, managing disease processes, restoring optimal function, and alleviating suffering in clients across the life span in a variety of settings and in accordance with the Standards of Practice for Registered Nurses (CRNNS, 2017), the Entry-level Competencies (CRNNS, 2009), and the CNA Code of Ethics (2017).
2. Consistently incorporate and promote the principles of primary health care (e.g., accessibility, public participation, health protection, health promotion, illness and injury prevention, appropriate use of technology, and inter-sectorial cooperation) and population health.
3. Consistently address the determinants of health throughout all phases of the nursing process (e.g., income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture).
4. Consistently attends to the unique spiritual values, beliefs, and preferences of clients in the planning and provision of care.
5. Consistently demonstrate application of professional, ethical/moral, and legal standards in decision-making with respect to health and health care delivery.
6. Consistently act and interact in a caring, compassionate and professional manner.
7. Consistently demonstrate accountability and responsibility in nursing actions and interactions.
8. Consistently implement nursing practice models that promote the principles of self-care and societal responsibility.
9. Consistently uphold the ideals of social justice, inclusivity, and equity through respectfulness, cultural competence, and cultural safety.
11. Consistently use facilitative and deliberate interaction in client encounters.
12. Consistently employ leadership and advocacy skills to positively impact on population health and health care policy.
13. Consistently participate in activities that foster personal growth and continuing competence.
14. Consistently exemplify professional nursing practice that is proactive and responsive to
the changing health needs of society.

15. Consistently demonstrate critical thinking, flexibility, and creativity in unpredictable and complex situations.

16. Consistently demonstrate competencies in inter-professional collaboration through understanding of the roles, responsibilities, and scopes of practice of other health care providers.

17. Students graduating with an Advanced Major will have disseminated evidence informed knowledge gained while partaking in a concentrated independent nursing practice experience in a clinical area of their choice.

18. Students graduating with Honours will have generated and disseminated new nursing knowledge by successfully completing and defending an Honours thesis.

Level Three

Irrespective of the program option in which the student is enrolled, the student at level three will:

1. Demonstrate the ability to engage in evidence-informed professional nursing practice that is directed toward promoting health, preventing illness, managing disease processes, restoring optimal function, and alleviating suffering in clients across the life span in a variety of settings and in accordance with the Standards of Practice for Registered Nurses (CRNNS, 2017), the Entry-level Competencies (CRNNS, 2009), and the CNA Code of Ethics (2017).

2. Demonstrate the ability to incorporate and promote the principles of primary health care (e.g., accessibility, public participation, health protection, health promotion, illness and injury prevention, appropriate use of technology, and inter-sectoral cooperation) and population health.

3. Demonstrate the ability to address the determinants of health throughout all phases of the nursing process (e.g., income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture).

4. Demonstrate increasing ability to attend to the unique spiritual values, beliefs, and preferences of clients in the planning and provision of care.

5. Demonstrate increasing ability to apply professional, ethical/moral, and legal standards in decision-making with respect to health and health care delivery.

6. Demonstrate increasing ability to act and interact in a caring, compassionate and professional manner.

7. Demonstrate accountability and responsibility in all nursing actions and interactions.

8. Demonstrate the ability to implement nursing practice models that promote the principles of self-care and societal responsibility.

9. Uphold the ideals of social justice, inclusivity, and equity through respectfulness, cultural competence, and cultural safety.

10. Demonstrate the ability to support inter-disciplinary and multi-sectoral collaborative participation in health care delivery and research.

11. Demonstrate the ability to use facilitative and deliberate interaction in client encounters.

12. Demonstrate the ability to employ leadership and advocacy skills to positively impact on population health and health care policy.
13. Participate in activities that foster personal and professional growth and continuing competence.
14. Demonstrate the ability to exemplify professional nursing practice that is proactive and responsive to the changing health needs of society.
15. Demonstrate the application of critical thinking, flexibility, and creativity in unpredictable and complex situations. Demonstrate competencies in inter-professional collaboration through understanding of the roles, responsibilities, and scopes of practice of other health care providers.
16. Demonstrate competencies in inter-professional collaboration through understanding of the roles, responsibilities, and scopes of practice of other health care providers.

Level Two

Irrespective of the program option in which the student is enrolled, the student at level two will:

1. Demonstrate a beginning ability to engage in evidence-informed professional nursing practice that is directed toward promoting health, preventing illness, managing disease processes, restoring optimal function, and palliating symptoms in clients across the life span in a variety of settings and in accordance with the Standards of Practice for Registered Nurses (CRNNS, 2017), the Entry-level Competencies (CRNNS, 2013), and the CNA Code of Ethics (2017).
2. Demonstrate a beginning ability to incorporate and promote the principles of primary health care (e.g., accessibility, public participation, health protection, health promotion, illness and injury prevention, appropriate use of technology, and inter-sectorial cooperation) and population health.
3. Demonstrate a beginning ability to address the determinants of health and social determinants of health throughout all phases of the nursing process (e.g., income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture).
4. Demonstrate beginning ability to attend to the unique spiritual values, beliefs, and preferences of clients in the planning and provision of care.
5. Demonstrate developing ability to apply professional, ethical/moral, and legal standards in decision-making with respect to health and health care delivery.
6. Demonstrate increasing ability to act and interact in a caring and professional manner.
7. Demonstrate accountability and responsibility in all nursing actions and interactions.
8. Demonstrate a beginning ability to implement nursing practice models that promote the principles of self-care and societal responsibility.
9. Uphold the ideals of social justice, inclusivity, and equity through respectfulness, cultural competence, and cultural safety.
10. Demonstrate a beginning ability to support inter-disciplinary and multi-sectorial collaborative participation in health care delivery and research.
11. Demonstrate a beginning ability to use facilitative and deliberate interaction in client encounters.
12. Demonstrate a beginning ability to employ leadership and advocacy skills to positively impact on population health and health care policy.
13. Participate in activities that foster personal and professional growth and continuing competence.
14. Demonstrate a beginning ability to exemplify professional nursing practice that is proactive and responsive to the changing health needs of society.
15. Demonstrate the application of critical thinking, flexibility, and creativity in unpredictable and complex situations.
16. Demonstrate competencies in inter-professional collaboration through understanding of the roles, responsibilities, and scopes of practice of other health care providers.

Level One

Irrespective of the program option in which the student is enrolled, the student at level one will:

1. Demonstrate awareness of the professional nurse’s role in providing evidence-informed care that is directed toward promoting health, preventing illness, managing disease processes, restoring optimal function, and alleviating suffering in clients across the life span in a variety of settings and in accordance with the Standards of Practice for Registered Nurses (CRNNS, 2017), the Entry-level Competencies (CRNNS, 2013), and the CNA Code of Ethics (2017).
2. Demonstrate an awareness of the principles of primary health care (e.g., accessibility, public participation, health protection, health promotion, illness and injury prevention, appropriate use of technology, and inter-sectorial cooperation) and population health.
3. Understand the importance of addressing the determinants of health and social determinants of health throughout all phases of nursing process the (e.g., income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture).
4. Understand the importance of attending to the spiritual values, beliefs, and preferences of clients in the planning and provision of care.
5. Demonstrate beginning ability to apply professional, ethical/moral, and legal standards in decision-making with respect to health and health care delivery.
6. Demonstrate beginning ability to act and interact in a caring and professional manner.
7. Demonstrate accountability and responsibility in all nursing actions and interactions.
8. Demonstrate a beginning understanding of a nursing practice model that promotes the principles of self-care and societal responsibility.
9. Uphold the ideals of social justice, inclusivity, and equity through respectfulness, cultural competence, and cultural safety.
10. Demonstrate an awareness of the importance of inter-disciplinary and multi-sectoral collaborative participation in health care delivery and research.
11. Demonstrate a beginning ability to use facilitative and deliberate interaction in client encounters.
12. Demonstrate an understanding of the importance of employing leadership and advocacy skills to positively impact on population health and health care policy.
13. Participate in activities that foster personal and professional growth and continuing competence.
14. Demonstrate a beginning ability to exemplify professional nursing practice that is proactive and responsive to the changing health needs of society.
15. Demonstrate an understanding of the importance of critical thinking, flexibility, and creativity in unpredictable and complex situations.
16. Demonstrate competencies in inter-professional collaboration through understanding of the roles, responsibilities, and scopes of practice of other health care providers.

2.3 Overview of the Curriculum Model

The curriculum model for the Rankin School of Nursing (SON) depicts a unified, coherent curriculum that is congruent with the SON’s mission, core values, philosophy, core curriculum concepts, intended curriculum goals, teaching-learning approaches, and key professional practice competencies. Through ongoing refinement, the SON strives to maintain a evidenced-informed, context-relevant and unified curriculum (Iwasiw, Goldenberg, & Andrusyszyn, 2015) that assists baccalaureate students to progressively develop the knowledge and skill that will enable them to engage in safe, competent, compassionate, culturally-sensitive, ethical, and professional nursing practice with individuals, families, groups, communities, and populations in a variety of settings. In keeping with the University’s liberal arts tradition, there is a deliberate attempt to foster life-long learning and to nurture the development of the whole person. Although the achievement of curriculum responsiveness to complex and ever-changing internal and external contextual factors is considered paramount, the curriculum is guided by several enduring principles which are explicated below.

The philosophical base upon which the curriculum rests is pluralistic in nature; however, the SON philosophy is heavily influenced by socioecological thought and the tenets of self-care. The core curriculum concepts (e.g., nursing’s metaparadigm concepts, primary health care, social determinants of health, social justice, cultural competence, critical thinking, leadership, advocacy, collaboration, caring) permeate the substance of the curriculum and are emphasized in nursing practice experiences.

Given the changing context in which the curriculum is executed, the nursing curriculum remains dynamic and innovative, calling forth the creativity and ingenuity of its developers as it evolves at both the macro and micro level. While the curriculum is predominantly delivered by traditional means, with face-to-face instruction in the classroom, laboratory, simulation and clinical practice environment, students do have the option to complete elective and/or non-nursing courses via distance delivery, either from StFX or from other comparable institutions, pending approval from the Director and the Dean of Science.

The selection and organization of the curriculum content is an intentional blending of nursing and non-nursing courses in each year of the program. The curriculum is student-centered with
student interests accommodated (e.g., students are permitted choice in their elective options and, to the extent possible, choice in the location and type of clinical practice experiences they will pursue), student input sought (e.g., student representation on the curriculum committee, completion of course and program evaluations, evaluation of nurse educators in both the classroom and clinical practice setting), and student-centered approaches to learning incorporated throughout the program (e.g., active learning is promoted, responsibility for one’s own learning is encouraged, learner diversity is considered, self-evaluation of clinical practice performance is expected). Likewise, the curriculum is **adult-education-oriented**. For example, to the extent that the curriculum embraces self-directed learning, promotes inquiry and autonomy, values the experiences of students, provides experiential learning, and encourages reflection on experiences, key elements of adult learning are supported. The pattern of course sequencing is mixed, with several configurations possible. For example, some courses have practical and theoretical portions running concurrently while others have a consolidated practice experience following completion of the theoretical component or a combination of both of the above. Course content is sequenced such that teaching proceeds in a **hierarchical and circuitous** fashion, with foundational content building in depth and complexity over time. Thus, teaching proceeds in a manner that is closely aligned with the principles that enhance learning; that is, from the simple to the complex, from the known to the unknown, and from the concrete to the abstract. A similar process occurs with respect to experiential learning in the practice area wherein students are assigned to increasingly complex clients and client situations as they progress through the program.

In keeping with the eclectic spirit of the SON, a mix of **traditional** and **contemporary** teaching-learning strategies are used. Accordingly, the more traditional strategies such as lecture, discussion, case study, seminar, demonstration, questioning, and so forth co-exist with the more contemporary strategies of multimedia application, simulation, laboratory, debate, reflective journaling, role-playing, and student presentation, to mention a few. The sum totality of these strategies coupled with various clinical teaching-learning strategies (e.g., pre-and post-conferences, on the spot consultations, direct care provision, observation, peer teaching, and care planning) optimize student learning in the cognitive, affective, behavioral, and psychomotor domains enhancing students’ achievement of curriculum goals and key professional practice competencies.

Reference

2.4 **Skill Acquisition**

**End of Level Four**

Please note that the skills listed in each of the columns have been demonstrated and practiced in laboratory settings. Fourth year nursing students may have had additional opportunities to practice skills depending on their experiences in the nursing practice setting. Although students may request/require preceptor supervision/assistance when performing certain psychomotor skills, all nursing students do require direct supervision when preparing and administering IV medications and when preparing unfamiliar, or high alert, parenteral drugs (e.g., insulin, heparin). Students must never administer drugs by “IV push”! Legally, a student nurse is never in the position to use or carry the “narcotic keys”.

- taking, head to toe physical exam
- Hand washing
- Bed making: unoccupied, occupied & post-op
- Pre & postoperative care
- Admission, transfer & discharge
- Assisting with bowel elimination: enema, colostomy care
- Assisting with bladder elimination: insertion, care, and removal of urinary catheters (e.g., straight, foley, Texas), and bladder irrigation (CBI)
- Transferring: to stretcher, wheelchair
- Ambulation, ROM
- Use of cane, crutches, walker
- Cast care
- Use of proper body mechanics
- Positioning
- Medication administration: PO, IV, SQ (including Butterfly), IM, S/L, PR, inhaled, topical, via gastric tubes
- Management of narcotics
- Sterile technique
- Donning sterile gloves/gown
- Wound care & dressings: simple wet or dry & occlusive
- Compresses: warm, cool, ice pack
- Oral feeding
- Referral
- Monitoring, measuring/recording intake & output
- CBI monitoring
- Administration of oxygen: face mask, nasal prongs, portable oxygen
- Pulse oximetry
- Peak flow measurement
- Naso-gastric tube insertion, ongoing care, and removal
- Enteral feeding: NG, G-tube, and J-tube
- Foley catheter removal
- Peripheral IV therapy management
- Care of saline lock flush
- Removal of IV intercath
- Care of central lines
- Administering TPN
- Wound irrigation
- Care of hemovac, Jackson Pratt drain
- Shortening of a penrose drain
- Tracheostomy care
- Care of chest tubes
- Assisting with bathing, grooming, and dressing (e.g., complete bed bath, oral hygiene, eye care, hair care, nail care, back care, HS care, sitz bath)
- Delegation
- Preparation for common diagnostic tests (e.g., blood studies, electrodiagnostic, endoscopic, fluid analysis, nuclear scanning, ultrasound, urine studies, radiological) and follow-up care.
- Teaching & discharge planning
- Teamwork, team leading, & conducting post-conferences
- Chest physiotherapy (percussion, vibration, postural drainage)
- Suctioning: oral, nasal, nasotracheal
- Blood glucose monitoring
- Administration of blood & blood products
- OR & delivery room observations
- Obtain specimens for culture and sensitivity (e.g., urine [MSSU & catheter], stool, sputum, wound, throat)
- Removal of sutures/clips
- Post mortem care
- Vital signs
- Measurement of height and weight
- Telemetry set-up
- Documentation: flow sheets, progress notes
- Reporting: end of shift; unit to unit
- Pre op check list
- General pre and post-op care, including “preps” (e.g., skin, bowel)
- OR scrub, gown, glove
- Bandaging
- Isolation technique
- Assisting with common medical procedures (e.g., thoracentesis, LP, suturing, minor surgery, BMA)
- Relaxation techniques
- Pain assessment & management
Please note that the skills listed in each of the columns have been demonstrated and practiced in laboratory settings. Third year nursing students may have had additional opportunities to practice skills depending on their experiences in the nursing practice setting. Although students may request/require preceptor supervision/assistance when performing certain psychomotor skills, all nursing students **do require** direct supervision when preparing and administering IV medications and when preparing unfamiliar, or high alert, parenteral drugs (e.g., insulin, heparin). Students **must never** administer drugs by “IV push”! Legally, a student nurse is never in the position to use or carry the “narcotic keys”.

- History taking, head to toe physical exam
- Hand washing
- Bed making: unoccupied, occupied & post-op
- Pre & postoperative care
- Admission, transfer & discharge
- Assisting with bowel elimination: enema, colostomy care
- Assisting with bladder elimination: insertion, care, and removal of urinary catheters (e.g., straight, foley, Texas), and bladder irrigation (CBI)
- Transferring: to stretcher, wheelchair
- Ambulation, ROM
- Use of cane, crutches, walker
- Cast care
- Use of proper body mechanics
- Positioning
- Medication administration: PO, IV, SQ (including Butterfly), IM, S/L, PR, inhaled, topical, via gastric tubes
- Management of narcotics
- Sterile technique
- Donning sterile gloves/gown
- Wound care & dressings: simple wet or dry & occlusive
- Compresses: warm, cool, ice pack
- Oral feeding
- Referral
- Monitoring, measuring/recording intake & output
- CBI monitoring
- Administration of oxygen: face mask, nasal prongs, portable oxygen
- Pulse oximetry
- Peak flow measurement
- Naso-gastric tube insertion, ongoing care, and removal
- Enteral feeding: NG, G-tube, and J-tube
- Foley catheter removal
- Peripheral IV therapy management
- Care of saline lock flush
- Removal of IV intercath
- Wound irrigation
- Care of hemovac, Jackson Pratt drain
- Shortening of a penrose drain
- Assisting with bathing, grooming, and dressing (e.g., complete bed bath, oral hygiene, eye care, hair care, nail care, back care, HS care, sitz bath)
- Delegation
- Preparation for common diagnostic tests (e.g., blood studies, electrodiagnostic, endoscopic, fluid analysis, nuclear scanning, ultrasound, urine studies, radiological) and follow-up care.
- Teaching & discharge planning
- Chest physiotherapy (percussion, vibration, postural drainage)
- Suctioning: oral, nasal, nasotracheal
- Blood glucose monitoring
- Administration of blood & blood products
- OR & delivery room observations
- Obtain specimens for culture and sensitivity [e.g., urine [MSSU & catheter], stool, sputum, wound, throat]
- Removal of sutures/clips
- Post mortem care
- Vital signs
- Measurement of height and weight
- Telemetry set-up
- Documentation: flow sheets, progress notes
- Reporting: end of shift; unit to unit
- Pre op check list
- General pre and post-op care, including “preps” (e.g., skin, bowel)
- OR scrub, gown, glove
- Bandaging
- Isolation technique
- Assisting with common medical procedures (e.g., thoracentesis, LP, suturing, minor surgery, BMA)
- Relaxation techniques
- Pain assessment & management
End of Level Two

The skills listed in each of the columns have been demonstrated and practiced in the lab setting, many of them during N252 intercession. By the end of second year nursing students will have had an opportunity to practice these skills in the lab and, depending on their nursing practice experiences, to perform them in the practice setting. Although students may request/require preceptor supervision/assistance while performing certain psychomotor skills, all nursing students do require direct supervision when preparing and administering IV medications and when preparing unfamiliar, or high alert, parenteral drugs (e.g., insulin, heparin). Students must never administer drugs by “IV push”! Legally, a student nurse is never in the position to use or carry the “narcotic keys”.

- History taking, head to toe physical exam
- Hand washing
- Bed making: unoccupied, occupied & post-op
- Pre & postoperative care
- Admission, transfer & discharge
- Assisting with bowel elimination: enema, colostomy care
- Assisting with bladder elimination: insertion, care, and removal of urinary catheters (e.g., straight, foley, Texas), and bladder irrigation (CBI)
- Transferring: to stretcher, wheelchair
- Ambulation, ROM
- Use of cane, crutches, walker
- Use of proper body mechanics
- Positioning
- Medication administration: PO, IV, SQ (including Butterfly), IM, S/L, PR, inhaled, topical, via gastric tubes
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- Foley catheter removal
- Peripheral IV therapy management
- Care of saline lock flush
- Removal of IV intercath
- Wound irrigation
- Care of hemovac, Jackson Pratt drain
- Shortening of a penrose drain
- Assisting with bathing, grooming, and dressing (e.g., complete bed bath, oral hygiene, eye care, hair care, nail care, back care, HS care
- Preparation for common diagnostic tests (e.g., blood studies, electrodiagnostic, endoscopic, fluid analysis, nuclear scanning, ultrasound, urine studies, radiological) and follow-up care.
- Teaching & discharge planning
- Suctioning: oral, nasal, nasotracheal
- Blood glucose monitoring
- Administration of blood & blood products
- OR & delivery room observations
- Obtain specimens for culture and sensitivity (e.g., urine [MSSU & catheter], stool, sputum, wound, throat)
- Removal of sutures/clips
- Post mortem care
- Vital signs
- Measurement of height and weight
- Documentation: flow sheets, progress notes
- Reporting: end of shift; unit to unit
- Pre op check list
- General pre and post-op care, including “preps” (e.g., skin, bowel)
- OR scrub, gown, glove
- Bandaging
- Isolation technique
- Relaxation techniques
- Pain assessment & management
End of Level One

- Hand washing
- Basic infection control (i.e., medical asepsis)
- General safety (e.g., prevention of falls)
- Bed making: unoccupied, occupied, and post-operative
- Assistance with bathing, grooming and dressing (e.g., complete bed bath, oral care, eye care, hair care, nail care, foot care, back care, HS care)
- Assistance with feeding
- Positioning
- Range of motion exercise, ambulation
- Transfer to stretcher, wheelchair
- Use of cane, crutches, walker
- Use of good body mechanics
- Basic sterile technique (e.g., donning sterile gloves, opening a dressing tray)
- Assisting with bowel and bladder elimination (e.g., PR suppositories, enemas, ostomy care)
- Catheter care
- Monitoring, measuring, and recording output
- Nutrition via a NG tube in situ
- Vital signs
- Measurement of height and weight
- Isolation technique
- Collecting specimens for culture and sensitivity (e.g., urine, sputum, stool, wound, throat)
- Blood sugar testing using a Glucometer
- Basic therapeutic communication techniques
- Basic interviewing skills (e.g., history taking)
- Basic application of the nursing process and Orem’s theory of self-care
- Health teaching

Please note that the skills in the above lists are primarily psychomotor in nature and that they do not include of all the skills required by nurses. For example, nurses are also expected to have other “skills”, so to speak. They must be able to communicate therapeutically, behave professionally, think critically, problem solve adequately, and make decisions wisely, and so forth.
### 2.5 COMMON DESCRIPTIVE TERMS

Please note that appendices often contain a list of terminology, prefixes, and suffixes. For example, see Appendix T in the 2006 edition of “Clinical nursing skills & techniques” by Perry and Potter.

<table>
<thead>
<tr>
<th>Assessment of…</th>
<th>Idea or Observation to be Communicated</th>
<th>Term Suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>Bloated, filled with gas</td>
<td>Tympanic/distended</td>
</tr>
<tr>
<td></td>
<td>Hurts when touched</td>
<td>Tender to palpation</td>
</tr>
<tr>
<td></td>
<td>Hard, boardlike</td>
<td>Rigid</td>
</tr>
<tr>
<td></td>
<td>Large, extends out</td>
<td>Protruding</td>
</tr>
<tr>
<td></td>
<td>Filled with fluid</td>
<td>Ascites</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts</td>
<td>Large amounts</td>
<td>Copious, profuse</td>
</tr>
<tr>
<td></td>
<td>Very small amounts</td>
<td>Scant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td>Thin and undernourished</td>
<td>Emaciated/cachexic</td>
</tr>
<tr>
<td></td>
<td>Overweight</td>
<td>Obese</td>
</tr>
<tr>
<td></td>
<td>Bluish color</td>
<td>Cyanotic/mottled</td>
</tr>
<tr>
<td></td>
<td>Skin yellowish</td>
<td>Jaundiced</td>
</tr>
<tr>
<td></td>
<td>Puffy or swollen</td>
<td>Edematous/edema</td>
</tr>
<tr>
<td>Appetite</td>
<td>Loss of appetite</td>
<td>Anorexic/anorexia</td>
</tr>
<tr>
<td>Arm</td>
<td>Shoulder to elbow</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Elbow to wrist</td>
<td>Lower arm/forearm</td>
</tr>
<tr>
<td></td>
<td>In bend of elbow</td>
<td>Antecubital fossa</td>
</tr>
<tr>
<td>Back (spine)</td>
<td>Upper back</td>
<td>Thoracic, interscapular</td>
</tr>
<tr>
<td></td>
<td>Small of back</td>
<td>Lumbar area</td>
</tr>
<tr>
<td></td>
<td>End of spine</td>
<td>Sacral area</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding</td>
<td>Nosebleed</td>
<td>Epistaxis</td>
</tr>
<tr>
<td></td>
<td>Blood in vomitus</td>
<td>Hematemesis</td>
</tr>
<tr>
<td></td>
<td>Blood in urine</td>
<td>Hematuria</td>
</tr>
<tr>
<td></td>
<td>Blood in sputum</td>
<td>Hemoptysis</td>
</tr>
<tr>
<td></td>
<td>Blood in stool</td>
<td>Melena</td>
</tr>
<tr>
<td></td>
<td>Obscure or hidden from view</td>
<td>Occult</td>
</tr>
<tr>
<td></td>
<td>Bruise</td>
<td>Hematoma</td>
</tr>
<tr>
<td>Breathing</td>
<td>Difficulty breathing</td>
<td>Dyspnea/dyspneic</td>
</tr>
<tr>
<td></td>
<td>Absence of breathing</td>
<td>Apnea/apneic spells</td>
</tr>
<tr>
<td></td>
<td>Rapid breathing</td>
<td>Tachypnea/tachypneic</td>
</tr>
<tr>
<td></td>
<td>Difficulty breathing supine</td>
<td>Orthopnea/orthopneic</td>
</tr>
<tr>
<td></td>
<td>Breath odor</td>
<td>Halitosis</td>
</tr>
<tr>
<td>Consistency</td>
<td>Remains together/retains shape</td>
<td>Formed</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Running like water</td>
<td>Liquid</td>
</tr>
<tr>
<td></td>
<td>Thick and sticky</td>
<td>Viscous</td>
</tr>
<tr>
<td></td>
<td>Looks like mucus</td>
<td>Mucoid</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cough</th>
<th>Coughs material from trachea and lungs</th>
<th>Expectorate/productive cough</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coughs without ejecting material</td>
<td>Non-productive cough</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dizziness</th>
<th>Feeling unsteady/unstable</th>
<th>Vertigo</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Drainage</th>
<th>Watery from nose</th>
<th>Coryza</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contains pus</td>
<td>Purulent</td>
</tr>
<tr>
<td></td>
<td>Bloody</td>
<td>Sanguinous</td>
</tr>
<tr>
<td></td>
<td>Watery/Bloody</td>
<td>Serosanguinous</td>
</tr>
<tr>
<td></td>
<td>Mucus and Pus</td>
<td>Mucopurulent</td>
</tr>
<tr>
<td></td>
<td>Contains bowel material</td>
<td>Fecal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ears</th>
<th>Ringing sensation</th>
<th>Tinnitus</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emesis</th>
<th>Return of swallowed food into mouth</th>
<th>Regurgitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Material coming from stomach</td>
<td>Emesis</td>
</tr>
<tr>
<td></td>
<td>Emesis ejected forcefully without warning</td>
<td>Projectile</td>
</tr>
<tr>
<td></td>
<td>Medication given to induce vomiting</td>
<td>Emetic</td>
</tr>
<tr>
<td></td>
<td>Medication given to stop vomiting</td>
<td>Antiemetic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Active exercise performed against stable resistance, without change in length of the muscle</th>
<th>Isometric</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Active exercise without appreciable change in the force of muscular contraction, with shortening of muscle</td>
<td>Isotonic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Ability to see</th>
<th>Visual acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inability to see clearly</td>
<td>Blurred vision</td>
</tr>
<tr>
<td></td>
<td>Sees double/ double vision</td>
<td>Diplopia</td>
</tr>
<tr>
<td></td>
<td>Drooping eyelid</td>
<td>Ptsis</td>
</tr>
<tr>
<td></td>
<td>Whites of the eyes appear yellow</td>
<td>Icterus</td>
</tr>
<tr>
<td></td>
<td>Discomfort from light</td>
<td>Photophobia/photophobic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Face</th>
<th>Without normal pink color</th>
<th>Pale/pallor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unusually pink</td>
<td>Flushed</td>
</tr>
<tr>
<td><strong>Fever</strong></td>
<td>No fever/temp normal</td>
<td>Afebrile</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>T &gt; normal</td>
<td>Pyrexia/pyrexic/febrile</td>
</tr>
<tr>
<td></td>
<td>Medication to reduce fever</td>
<td>Antipyretic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gas</strong></th>
<th>Abdominal distention by gas</th>
<th>Flatulence/flatus</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Hair</strong></th>
<th>Absence of</th>
<th>Alopecia</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Head</strong></th>
<th>Forehead</th>
<th>Frontal area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Near ear</td>
<td>Temporal area</td>
</tr>
<tr>
<td></td>
<td>Side of head at top</td>
<td>Parietal area</td>
</tr>
<tr>
<td></td>
<td>Back of head</td>
<td>Occipital area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Heart rate</strong></th>
<th>Irregular</th>
<th>Dysrrhythmia/arrhythmia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 60</td>
<td>Bradycardia/bradycardic</td>
</tr>
<tr>
<td></td>
<td>&gt; 100</td>
<td>Tachycardia/tachycardic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hives</strong></th>
<th>Raised reddened areas on skin (allergic)</th>
<th>Hives/Urticaria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Itching</td>
<td>Pruritus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Joints</strong></th>
<th>Bent</th>
<th>Flexion/flexed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Straightened</td>
<td>Extension/extended</td>
</tr>
<tr>
<td></td>
<td>Turned downward</td>
<td>Pronation</td>
</tr>
<tr>
<td></td>
<td>Turned upward</td>
<td>Supination</td>
</tr>
<tr>
<td></td>
<td>Move away from center</td>
<td>Abduction</td>
</tr>
<tr>
<td></td>
<td>Move toward center</td>
<td>Adduction</td>
</tr>
<tr>
<td></td>
<td>Stiff joint</td>
<td>Ankylosos/ankylosed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Legs</strong></th>
<th>Between knee and hip</th>
<th>Thigh</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thigh to knee</td>
<td>Upper leg</td>
</tr>
<tr>
<td></td>
<td>Knee to ankle</td>
<td>Lower leg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Lips</strong></th>
<th>Blue in color</th>
<th>Cyanotic/circumeral cyanosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With tiny cracks</td>
<td>Fissured</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Location</strong></th>
<th>Toward the end of a reference point (or joint)</th>
<th>Distal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Closest to the point of reference (or joint)</td>
<td>Proximal</td>
</tr>
<tr>
<td></td>
<td>Pertaining to the body as a whole</td>
<td>Systemic</td>
</tr>
<tr>
<td></td>
<td>In the area of ribs</td>
<td>Costal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Memory</strong></th>
<th>Loss of memory</th>
<th>Amnesia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Muscle</strong></td>
<td>Loss of normal tone or size/muscle wasting</td>
<td>Atrophy</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>Increased tone</td>
<td>Spastic</td>
</tr>
<tr>
<td></td>
<td>Decreased tone</td>
<td>Flaccid</td>
</tr>
<tr>
<td><strong>Paralysis</strong></td>
<td>Face</td>
<td>Facial paralysis</td>
</tr>
<tr>
<td></td>
<td>Lower extremities</td>
<td>Paraplegia</td>
</tr>
<tr>
<td></td>
<td>One side of body</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td></td>
<td>Four extremities</td>
<td>Tetraplegia/Quadriplegia</td>
</tr>
<tr>
<td></td>
<td>Single limb</td>
<td>Monoplegia</td>
</tr>
<tr>
<td><strong>Positions</strong></td>
<td>Flat, on back</td>
<td>Supine</td>
</tr>
<tr>
<td></td>
<td>On back with head elevated</td>
<td>Semi-fowler's</td>
</tr>
<tr>
<td></td>
<td>On back with knees flexed</td>
<td>Dorsal-recumbent</td>
</tr>
<tr>
<td></td>
<td>On back with pelvis higher than head</td>
<td>Trendelenburg</td>
</tr>
<tr>
<td></td>
<td>On abdomen with head turned to one side</td>
<td>Prone</td>
</tr>
<tr>
<td><strong>Skin</strong></td>
<td>Redness caused by increased blood flow</td>
<td>Erythema</td>
</tr>
<tr>
<td></td>
<td>Injury by rubbing or scraping</td>
<td>Abrasion</td>
</tr>
<tr>
<td></td>
<td>Artificially created opening between a body cavity and the body's surface</td>
<td>Stoma</td>
</tr>
<tr>
<td></td>
<td>-Excessive hardness or firmness at a body site</td>
<td>Induration</td>
</tr>
<tr>
<td></td>
<td>-Removal of dead tissue from a wound</td>
<td>Debridement</td>
</tr>
<tr>
<td></td>
<td>-Dead tissue</td>
<td>Necrosis/necrotic</td>
</tr>
<tr>
<td></td>
<td>-Decreased blood supply to tissue</td>
<td>Ischemia/ischemic</td>
</tr>
<tr>
<td></td>
<td>-Softened by excessive moisture</td>
<td>Maceration/macerated</td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td>Unable to sleep</td>
<td>Insomnia</td>
</tr>
<tr>
<td></td>
<td>Unable to be understood</td>
<td>Incoherent</td>
</tr>
<tr>
<td></td>
<td>Runs words together</td>
<td>Slurred</td>
</tr>
<tr>
<td></td>
<td>Difficulty speaking</td>
<td>Dysphasia</td>
</tr>
<tr>
<td></td>
<td>Ability to express oneself verbally is impaired</td>
<td>Expressive/motor aphasia (Broca’s aphasia)</td>
</tr>
<tr>
<td></td>
<td>Unable to understand spoken words</td>
<td>Receptive/sensory aphasia (Wernicke’s aphasia)</td>
</tr>
</tbody>
</table>
|            | **if both types are present = (Global aphasia)**
<p>| <strong>Teeth</strong> | Decay                                    | Caries |
|            | Without teeth                            | Edentulous |
| <strong>Throat</strong> | Difficulty swallowing                    | Dysphagia |
| <strong>Treatment</strong> | To prevent                               | Prophylactic |
|            | To give relief of symptoms (no cure)     | Palliative |</p>
<table>
<thead>
<tr>
<th>Urination</th>
<th>Void/micturate/urinate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass fluid from bladder</td>
<td></td>
</tr>
<tr>
<td>Unable to control urination</td>
<td>Incontinent</td>
</tr>
<tr>
<td>Large amount at once</td>
<td>Diuresis</td>
</tr>
<tr>
<td>No Urine</td>
<td>Anuria</td>
</tr>
<tr>
<td>Frequent night urination</td>
<td>Nocturia</td>
</tr>
<tr>
<td>Frequent and much urination</td>
<td>Polyuria</td>
</tr>
<tr>
<td>Pus in urine</td>
<td>Pyuria</td>
</tr>
<tr>
<td>Sugar in urine</td>
<td>Glycosuria</td>
</tr>
<tr>
<td>Albumin in urine</td>
<td>Albuminuria</td>
</tr>
<tr>
<td>Protein in urine</td>
<td>Proteinuria</td>
</tr>
<tr>
<td>Ketones in urine</td>
<td>Ketonuria</td>
</tr>
<tr>
<td>Blood in urine</td>
<td>Hematuria</td>
</tr>
<tr>
<td>Scantiness of urine (&lt; 30cc/hr in an adult)</td>
<td>Oliguria</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stools</th>
<th>Defecation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passage of stool</td>
<td></td>
</tr>
<tr>
<td>Sticky/contains blood</td>
<td>Tarry</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perspiration</th>
<th>Diaphoresis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive perspiration</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thirst</th>
<th>Polydipsia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive thirst</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
<th>Noxious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Painful or unpleasant stimulus</td>
<td>Exacerbation</td>
</tr>
<tr>
<td>Worsening of disease, marked by greater</td>
<td></td>
</tr>
<tr>
<td>intensity in signs and symptoms</td>
<td></td>
</tr>
</tbody>
</table>
2.6 Overview of Orem’s Self-care Deficit Nursing Theory

A basic overview of the main concepts of Orem’s Self-care Deficit Nursing Theory is presented below, the intent of which is to reinforce the classroom content. The complete theory is explicated in Orem’s (2001) text entitled “Nursing: Concepts of practice (6th ed.).”

According to Orem (2001), health and well-being are two different, but related, human states. Health represents a state of structural and functional wholeness or integrity and not merely the absence of disease; whereas well-being refers to “individuals’ perceived condition of existence” (Orem, 2001, p. 187). As Orem (2001) further elaborates:

- Well-being is a state characterized by experiences of contentment, pleasure, and kinds of happiness; by spiritual experiences, by movement toward fulfillment of one’s ideal; and by continuing personalization. Well-being is associated with health, with success in personal endeavors, and with sufficiency of resources. However, individuals experience well-being, and their human existence may be characterized by features of well-being even under conditions of adversity, including disorders of human structure and functioning. (p. 186)

Deliberate action, known as self-care, carried out by adults for themselves and their dependents is necessary for maintaining a state of health. It basically refers to the personal care necessary each day to regulate functioning and development, whether it is performed by one’s self or by a self-care agent (e.g., parent, guardian) on the behalf of dependants (e.g., infants, children). Although the ability to engage in the activities of self-care evolve from a base of education in self-care acquired in the home, at school, and from practical experiences in self-care, level of maturity, life experiences, habits of thought and body, as well as mental state further influence the actual performance of self-care. In circumstances where individuals are no longer able to provide continuously for themselves (of their dependents) the amount and quality of self-care that is therapeutic in sustaining life and health, in recovering from disease or injury, or coping with their effects, nursing is required.

Orem (2001) considers persons as beings who function biologically, symbolically, and socially, and who have potential for learning and development. As such, persons, as individuals and as members of families, groups, and communities, have a host of self-care requisites, in several realms; namely universal self-care requisites, developmental/maturational self-care requisites, and, in the event of illness, injury, or disability, therapeutic self-care requisites. The sum totality of self-care requisites is referred to as the therapeutic self-care demand (TSCD) and can be expressed in the equation: TSCD = USCR + DSCR + HDSCR. Although they are specific to individuals, there are commonalties in requisites based on comparable age, developmental state, and health state, among others. The factors that may influence an individual’s TSCD as well as their ability to meet these demands in any time-place situation are known as the basic conditioning factors. These factors include (see Orem’s text, pp. 245-247):

- age
- gender
- developmental state
- health state
- socio-cultural orientation
• health care system factors
• family system factors
• pattern of living
• environmental factors
• resource availability and adequacy

**Universal self-care requisites** (USCR) are those that are common to all individuals (i.e., they are “universal”) and must be met in order to maintain human life, human structure, and human functioning and in turn support human development and maturation. As a component of the TSCD, they are influenced by the basic conditioning factors. They include (see Orem’s text, pp. 225-229):

• the maintenance of a sufficient intake of air
• the maintenance of a sufficient intake of water
• the maintenance of a sufficient intake of food
• the provision of care associated with elimination processes and excrements
• the maintenance of a balance between activity and rest
• the maintenance of a balance between solitude and social interaction
• the prevention of hazards to human life, human functioning, and human well-being
• the promotion of human functioning and development within social groups in accordance with human potential, known human limitations, and the human desire to be normal, in short, the promotion of “normalcy”

**Developmental self-care requisites** (DSCR) (see Orem’s text, pp. 230-233) are those self-care requisites that sponsor human development across the life span, beginning in the intrauterine stage and continuing through to the neonatal stage, infancy, childhood (including adolescence), and the various stages of adulthood as well as during pregnancy. In addition to being able to meet the requirements that promote development, DSCR also include requisites that demand self-engagement in the process of development, and requisites that will help to prevent the occurrence of deleterious effects on development or, in the event of their occurrence, to mitigate or overcome them.

**Health-deviation self-care requisites** (HDSCR) (see Orem’s text, pp. 233-235) are those self-care requisites that arise because of health deviations; for example, injury or illness, defects or disabilities, and/or the mere fact that an individual has a medical diagnosis and is undergoing medical treatment. If individuals are to successfully manage and cope with the effects of their pathologic conditions, continue to develop as individuals, and to experience a sense of well-being, they must able to meet the following HDSCRs:

• to seek and secure appropriate and timely assistance from health care professionals
• to be aware, and take care, of the effects of pathological conditions
• to effectively carry out medically prescribed diagnostic, therapeutic, and rehabilitative measures
• to be aware, and take care, of the discomforting or deleterious effects of medical care measures performed or prescribed by the physician, including effects on development
• to modify one’s self-concept and self-image in accepting oneself as being in a particular health state and in need of health care
to learn to live with the effects of pathological conditions and states and their associated treatments in a life-style that continues to promote personal development

As allude to above, under so-called normal circumstances, individuals have the capacity for self-knowledge, can rationally engage in deliberate action, interpret experiences, and perform beneficial actions; therefore, they are capable of engaging in self-care activities. When they adequately engage in self-care, they are said to possess adequate self-care agency. However, in situations in which they are unable to provide the kind and amount of self-care activity required in the time-place situation (e.g., dependants, the ill) a self-care deficit exists. In other words, they are in situations in which the sum totality of their therapeutic self-care demands exceeds their ability to meet them. Thus, they will require assistance from others, and most likely nurses.

As Orem (1971) indicated in earlier work and continues to purport, “Nursing has as its special concern [the individual’s] need for self-care action and the provision and maintenance of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects (pp. 1-5). Nursing actions are deliberate and are directed toward one or all of the following broad goals: meeting self-care requisites, helping individuals to undertake responsible actions in matters of self-care, and increasing family members’ (or non-nurse attendees’) competence in attending to matters of self-care. Contrary to the erroneous belief of many, the promotion of self-care does not mean that individuals are left to fend for themselves; nor does nurses’ performance of self-care activity to meet the TSCD of others foster dependence.

Broadly speaking, the series and sequences of deliberate practical actions that nurses perform are based on the individual’s particular situation and constitute what is referred to as a nursing system (or helping system). Accordingly, the choice of nursing system is based on who can or should perform the self-care actions required to meet the individual’s TSCD. If the answer is solely the nurse, the nursing system is wholly compensatory; if it is the nurse and the individual, the nursing system is partly compensatory; and, if it is solely the individual, the nursing system is supportive-educative (see Orem’s text, pp. 350-355). For example, as it is only the nurse who can perform the self-care activities to meet the TSCD of a comatose individual, a “wholly compensatory nursing system” is required. On the other hand, a “partly compensatory nursing system” would be appropriate for a debilitated elderly individual who, with a little support, is quite capable of feeding him or herself. To do otherwise would actually contravene the philosophical underpinnings of Orem’s self-care deficit nursing theory. Finally, if a woman wants to learn to breastfeed or a man needs to learn about the effects of a certain medication, it is appropriate that the nurse use the educative-supportive nursing system.

A helping method “is a sequential series of actions, which, if performed, will overcome or compensate for the health-associated limitations of individuals to engage in actions to regulate their own functioning and development or that of their dependents” (p. 55). Nurses use five helping methods, often in combination, to compensate for or overcome the limitations of others to act for themselves to meet their self-care requisites. These five helping methods are (see Orem’s text, pp. 55-61):

• acting for or doing for another
• guiding another
• supporting another
• providing a developmental environment
• teaching another

Just as self-care agency describes an individual’s ability to care for oneself, nurse agency refers to the nurse’s ability to compensate for or help someone overcome his or her limitation for self-care. Like self-care agency, nurse agency is a set of abilities developed by the nurse through education and experience.

PH (2009)
2.7 The Metaparadigm Concepts

The Nature of Persons

The nature of persons reflects the variable nature of client (e.g., populations, communities) and the nuances of nursing practice as enacted in various specialty areas (e.g., perinatal) and settings (e.g., community). Persons are viewed as embodied beings who live, function, and develop physiologically, psychologically, socially, and spiritually in their environments as unique individuals and as members of families, groups, communities, and populations. They influence and are influenced by their environments. Persons have the capacity to know by sensing, reflecting, reasoning, and understanding. Persons uniquely experience and assign meaning to common human experiences. They can possess an awareness of self and the environment, making decisions, and engaging in deliberative action to attain ends or goals. Persons have free will and the right to make choices; yet, they “have requirements and responsibilities for self-maintenance, self-management, care of dependents, and fulfillment of their human potential” (Orem, 2001, p. viii). The SON embraces the view that all people possess the gift of intrinsic worth, irrespective of social status, race, culture, ethnicity, gender, achievement, utility, desirability, physical or mental ability, personal values, beliefs, preferences or practices, and so forth. “To be a person is always to be in relationship, to live in a community of persons, to seek a community embraced by love …as the human person is created from love, for love, to be love (Roach, 2002, p.8).” As an element of human love, people possess an innate capacity to care and show concern for others. In the unfolding of this capacity, human development and human fulfillment are achieved (Roach, 2002), and the moral response of reverence is expressed and preserved.

The Nature of Health and Well-Being

In attempting to be comprehensive, the SON endorses several different, but compatible and expanding, perspectives on the nature of health: the health of individuals, families, communities, and populations, which subsumes groups. Health as a multi-dimensional concept has physical, psychological, social, and spiritual aspects. It is influenced by several, often interrelated, determinants: income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture (Health Canada, 2011). As such, health is a societal responsibility as well as an individual one (Orem, 2001).

Personal health and its counterpart, well-being, are two different, but related, human states (Orem, 2001). Health represents a state of structural and functional wholeness or integrity and not merely the absence of disease; whereas well-being refers to the individual’s “perceived condition of existence” (p. 186).

Well-being is “characterized by experiences of contentment, pleasure, and kinds of happiness; by spiritual experiences; by movement toward fulfillment of one’s ideal; and by continuing personalization” (Orem, 2001, p. 186). Although the experience of well-being is “associated with health, success in personal endeavors, and …sufficiency of resources”, individuals may still
experience well-being “under conditions of adversity, including disorders of human structure and functioning” (Orem, 2001, p. 186).

Deliberate action, known as self-care, is necessary for maintaining health. Such action evolves from a base of education in self-care acquired in the home, at school, and from practical experiences in self-care (Orem, 2001). The performance of self-care activities fulfills those self-care requisites that maintain life, health, continuing development, and a sense of well-being. Given the complex interactions between social and economic factors, the physical environment, and behavior that influence health, approaches to promote, maintain, and restore health of individuals, families, groups, communities, and populations must extend beyond self-care to include socio-ecological approaches which, in addition to the goal stated above, also work toward eliminating health disparities. Out of necessity, socioecological approaches must be multi-sectoral and collaborative in nature.

The SON espouses the Vanier Institute of the Family’s (2007) definition of family as:

*any combination of two or more persons who are bound together over time by ties of mutual consent, birth, and/or adoption or placement and who, together, assume responsibility for variant combinations of some of the following: physical maintenance and care of group members; addition of new members through procreation or adoption; socialization of children; social control of members; production, consumption, distribution of goods and services; and, affective nurturance love”*(p.1).

As such, the family is the primary social context in which self-care is learned and enacted. The health of the family unit is influenced by many factors (e.g., relationships, beliefs, values, practices, economic resources, political and policy decision-making contexts, geographical boundaries, coping capacity, support systems, and access to health care services). These in turn influence the health of its members, the community, and the larger population. A healthy family is one that:

*is able to integrate the need for stability with the need for growth and change, ...has a structure that allows adaptable performance of tasks and acceptance of help from outside the family system, ... has control over the environment, [and] ...exerts influence on the immediate environment of home, neighborhood, and school (Ross-Kerr & Wood, 2006, pp. 299-300)*.

A healthy community is one that possesses the following attributes: a clean and safe environment; peace, equity, and social justice; adequate access to food, water, shelter, income, safety, work, and recreation for all; adequate health care services; opportunities for learning and skill development; strong, mutually supportive relationships and networks; workplaces that are supportive of individual and family well-being; wide participation of residents in decision making; strong local cultural and spiritual heritage; diverse and vital economy, protection of the natural environment; and, responsible use of resources to ensure long term sustainability (Ontario Healthy Communities Coalition, 2003)

“A healthy population is composed of healthy individuals, and the health of individuals is considered an overall aggregate that reflects an average or general healthiness or health status” (Ross-Kerr & Wood, 2006, p. 53). The health status of a population is determined and measured
by such indicators as well-being, life expectancy, incidence and prevalence rates, crude death rate, mortality rates, burden of illness, and case fatality rate (Shah, 2003) as well as by the influence of the determinants of health as outlined above.

The Nature of Environment

Persons exist within complex interacting physical, chemical, biologic, and socioeconomic-cultural environments that influence their self-care requisites and their self-care capabilities and in turn positively or negatively affect their lives, health, development, and well-being (Orem, 2001). Ideally, persons are capable of controlling, protecting, or improving certain aspects of their environments in the interest of maintaining life, healthy functioning, continuing development, and well-being. However, for those aspects of the environment that are not amenable to action at the personal level (e.g., poverty, oppression, climate change) and also influence the health of collectives (i.e., families, groups, local and global communities, and populations), action at the community level involving interdisciplinary collaboration and multi-sectoral collaboration between the health care sector and others such as government, education, agriculture, business, to mention a few, is required (Ross-Kerr & Wood, 2006). By incorporating and promoting the principles of primary health care (CNA, 2015) in the delivery of services in various settings, such action to enhance the health of individuals, families, groups, communities, and populations is achievable while simultaneously working toward creating a model of care that is affordable, accessible, equitable, participatory, and sustainable.

The Nature of Nursing

We, the SON, recognize nursing as both a practical science and an art. The science of nursing seeks generalizable knowledge for the practical end of nursing. The art of nursing is “the ability to nurse well” (Johnson, 1991, p. 10). The art of nursing implies the achievement of a particular end or goal in a particular client situation and thus embodies scientific knowledge, skill, understanding of the particular situation, and prudent judgment (Johnson, 1991). The establishment of a nurse-client relationship and a committed stance on the part of the nurse is assumed (Hawley, 2005, p.13). Intuition, wisdom, creativity, moral insight, and personal knowledge of both client and self also contribute to the achievement of particular ends or goals and, therefore, also fall under the rubric of nursing art (Hawley, 2005). That being said, the knowledge used within nursing is multi-faceted, comprising both theoretical and practical knowledge, and necessarily requires methodological pluralism for its development. Nursing, as a human service, is concerned with what is good and desirable for human beings (e.g. health and well-being) and thus constitutes a moral enterprise. Caring is an important and essential aspect of nursing, providing the moral impetus to act and signifying the affect that, when conveyed, humanizes care in a way that is therapeutic (Hawley, 2005). At the individual or personal level, the goal of nursing is to promote, maintain, and restore health and wellbeing through self-care. At the collective level, the goal of nursing also includes eliminating health disparities. Accordingly, nursing actions also embrace advocating for healthy public policy, collaborating with multiple sectors, and engaging in socio-political action (Ogilvie & Reutter, 2003).
The Nature of Nursing Education

The SON aspires to provide an educational experience that fosters life-long learning and nurtures the development of the whole person in service to humanity. The development of the whole person goes beyond the development of intellect and encompasses the emotional, socio-cultural, and spiritual dimensions of personhood. The liberal arts focus plays a critical role in developing practitioners of nursing who think critically, rationally, reflectively, and creatively, problem solve effectively, and assume leadership roles in a rapidly changing health care environment. In keeping with a balanced and dynamic approach to education, the nursing curriculum is based on an eclectic philosophical approach that incorporates the principles of adult learning and employs a variety of traditional and innovative teaching strategies with the intent to equip beginning practitioners for professional nursing practice that is based on empiric, ethical, personal, aesthetic, and emancipatory knowledge (Chinn & Kramer, 2008). Consequently, the curriculum represents an intentional blending of professional nursing courses with liberal arts and science courses. Evidence-informed practice is emphasized in conjunction with understanding of the particular client situation, skill, and artistic nursing prudence in achieving particular ends or goals. Teaching is an interactive process that facilitates learning, enhances praxis, and raises socio-political awareness. It requires attentiveness to best practices in education. Learning is part of the growth process and the means by which skills, knowledge, values, attitudes, and emotions are acquired. Learning is influenced by the context in which it occurs, the ability, motivation, and stance of the student, and the extent to which the student is actively involved, self-directed, and values the content being learned. Learning is both hierarchical (i.e., it progresses from simple to complex, concrete to abstract, and known to unknown) and circuitous. Reflection on experience serves as a rich resource. Learning is enhanced in a climate of physical comfort, mutual trust and respect, openness, and acceptance of differences and when past experience is acknowledged and valued. Learning is a life-long process and, for the professional nurse, a life-long commitment. Students have preferred styles of learning and are exposed to an array of teaching strategies. They are expected to take ownership of their learning, utilize and integrate previous knowledge, skill, understanding, and experience, identify their strengths and areas in need of improvement, and, in collaboration with faculty members or nurse educators, devise and implement appropriate strategies to address their individual learning needs. Students require opportunities to give and receive constructive feedback and ought to participate in ongoing curriculum evaluation and design. Faculty members and nurse educators are mentors and role models. They possess expert knowledge and engage in evaluative processes that determine student progression. Despite the teacher-learner power differential, faculty members and nurse educators are considered to be partners in the learning process. In the presence of learning challenges, they work collaboratively with students in an attempt to achieve student success. They set clear and realistic expectations and their evaluative processes are consistent and fair. They are concerned about student well-being and, to the extent possible, accommodate individual or personal needs. Faculty members and nurse educators strive to be non-threatening and supportive of students in creating and maintaining a safe learning environment. They reward curiosity, stimulate critical thinking, cultivate self-reflection, foster self-directedness, promote leadership skill development, enhance problem solving ability, and encourage independence.
The Nature of Nursing Scholarship

Scholarship encompasses a full range of intellectual and creative activities that include the generation, validation, synthesis, and/or application of knowledge to advance science, teaching, and practice. Scholarship domains include inquiry that builds a scientific body of knowledge (Scholarship of Discovery), inquiry that supports the pedagogy of the discipline and a desire to understand how students learn and how teaching influences this process (Allen & Field, 2005) (Scholarship of Teaching), the advancement of knowledge related to expert practice (Scholarship of Application), and the development of new insights as a result of integrative, interdisciplinary, and synthesizing work (Scholarship of Integration) (Boyer, 1990). The SON endorses CASN’s definition of scholarship which embraces the scholarship of discovery, the scholarship of teaching, the scholarship of application, and the scholarship of integration (CASN, 2013).

References
2.8 GUIDELINES FOR COMPLETING A NURSING CARE PLAN

Although the expectations may vary for each year of the program as well as for the area of nursing practice, the following guidelines will assist students to develop and complete holistic and individualized nursing care plans for their clients.

**Please note** that the term client may refer to individuals, families, groups, populations, or communities.

*Assessment and Client Situation*

The plan of care for a client emerges from the baseline (and ongoing) assessment (i.e., the database) of the client. The collection of assessment data using the appropriated assessment form as a guide helps students to identify, outline, and prioritize nursing diagnoses. The assessment form includes information that the client reports (history data), findings on physical assessment, relevant laboratory and diagnostic test results, diagnostic tests planned, procedures/therapies in progress (e.g. the presence of an IV or a foley catheter), procedures/therapies planned, current medications (including OTC drugs and herbal remedies), and so forth. Use of the assessment form ensures that students capture data that is holistic in nature; that is, data that captures the psychosocial and spiritual dimensions of clients in addition to the physical dimensions. It also facilitates collection of the social determinants of health, data that must also be considered when planning appropriate (e.g., individualized) care for particular clients. A description of the client situation provides an overall summary of the client’s current health status, priorities for care, identified risks and available supports. It only needs to appear once in the written care plan that is submitted for marking.

*Nursing Diagnostic Statements*

Nursing Diagnostic Statements are formulated based on client assessment and situational information. They may contain one, two, or three of the following elements: a nursing diagnosis, an etiology (underlying cause), and the defining characteristics (e.g., the signs and symptoms that together provide supporting evidence for the nursing diagnosis).

**Nursing Diagnosis related to {r/t} (Etiology) as manifested/evidenced by {amb/aeb} [Defining Characteristics].**

**Please note the following examples:**

- Health promotion/wellness diagnosis (1 part): Readiness for enhanced parenting
- Health promotion/wellness diagnosis (2 part): Sustained awareness of pedestrian safety related to (supportive community programs)
- Illness diagnosis: Altered Nutrition-less than body requirements related to (anorexia) as manifested by [a body weight of 10% below ideal for height and frame and decreased serum albumin]
Nursing Diagnosis

A nursing diagnosis is a label that reflects the client’s self-care deficits, self-care strengths, or both in response to actual or potential health status changes, life processes, or life events. “Nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable” (Carpenito-Moyet, 2010, p. 10). Detailed information regarding approved diagnostic categories may be found in Carpenito-Moyet (2010).

Please note that actual, possible, risk/high-risk, wellness, or syndrome diagnoses may be incorporated into the care plan. These types of diagnoses and their components are further explained in the 2010 edition of Carpenito-Moyet (pp. 13-19).

Collaborative problems should also be a consideration, most commonly in states of illness. They are outlined in Section Three (pp. 843-953) of Carpenito-Moyet (2010). “Collaborative problems are certain physiologic complications that nurses monitor to detect onset or changes in status. Nurses manage collaborative problems using physician-prescribed and nursing-prescribed interventions to minimize the complications of the events (Carpenito-Moyet, 2010, p. 24).” Collaborative problems are written as potential complications (e.g., PC: Pulmonary Embolism; PC: Hypovolemic Shock; PC: Postpartum Hemorrhage; PC: Septic Shock; PC: Medication Therapy Adverse Effects; PC: Atelectasis/Pneumonia). The etiology is not included in the diagnostic statement but rather it is discussed in the rationale where the risk of this problem for this client is explained. Likewise, there are no clinical manifestations (i.e., amb/aeb) as the problem does not exist (and with an appropriate plan of care will, hopefully, be prevented).

It is important to read any “Author’s Note” sections shaded in blue when selecting a nursing diagnosis. They provide qualifying statements that help to clarify the appropriateness of the nursing diagnosis being considered. For example, deficient knowledge is a related factor that can contribute to a particular nursing diagnosis such as risk for injury. In other words a client may be at risk for a particular injury because of insufficient knowledge about protection from, or prevention of, the injury (see Carpenito-Moyet, 2010, p. 347). Carpenito-Moyet (2010) also included shaded boxes entitled “Errors in Diagnostic Statements”. They too may provide important qualifying information and thus should also be read.

Etiology

The etiology refers to the contributing, influencing, or risk factors related to the nursing diagnosis. The nature of the etiology may be pathophysiologic (biologic or psychological), treatment-related, situational (environmental, personal), maturational, and/or spiritual. The etiology must be precise in order to direct the interventions. In cases where the etiology is complex, it may need to be explained further in order to direct the interventions. Use of the phrase “secondary to” is helpful (e.g., Altered Nutrition (less than body requirements) r/t anorexia secondary to {2 0} chemotherapy amb a body weight of 10% below ideal for height and frame and decreased serum albumin). For some nursing diagnosis, more than one etiology may apply for a particular client. In such circumstances, all etiologies should be listed and considered so that interventions will be directed toward all applicable contributing, influencing, or risk factors (e.g., Impaired skin integrity r/t bowel incontinence, immobility, and obesity).
In some cases the etiology may be unknown and therefore more data needs to be collected before an accurate etiology can be established. In the interim, however, only general interventions can be implemented and part of the plan of care will be to collect more data as the clinical situation unfolds.

*Defining Characteristics (Signs {objective}, Symptoms {subjective}, and other relevant data)*

The defining characteristics for each nursing diagnosis represents the data that, when clustered together, support the existence of, or validate, the diagnosis. They are designated as major and minor. To be a legitimate nursing diagnosis, a major defining characteristic must be present.

Please note, however, that risk/high risk diagnoses and collaborative problems (i.e., potential complications) do not have defining characteristics as they do not exist; they remain a potential only. In the case of risk/high risk diagnoses, interventions take the form of preventive actions and close monitoring of the client’s condition. In the case of collaborative problems, physician-prescribed and nursing-prescribed interventions are directed toward prevention, and in the event of occurrence, early detection, emergency management, and prompt reporting.

*Rationale for Nursing Diagnostic Statement*

In the rationale for a nursing diagnostic statement, the reason for the inclusion of this particular nursing diagnostic statement into the client’s nursing care plan needs to be explained. Two types of rationale are needed: 1) evidence from the current literature (e.g., scientific and theoretical) to support the diagnostic statement and 2) data from the client’s situation that more readily personalizes the diagnostic statement and supports the etiology of the nursing diagnosis.

*Literature-Based Rationale*

Sources of literature-based rationale may include scientific research-based and/or theoretical information from current nursing and/or health-related texts and journals. Sources must be cited using APA format.

When developing literature-based rationale the following questions must be answered:

1. How can the relationship between the etiology and the diagnosis be explained?
2. How can the appearance of the defining characteristics be explained? Why do they exist?

Pathophysiology may be especially pertinent in this section.

For a collaborative problem, the reason why the client is at risk for the complication must be explained.

Please note that if the complication has arisen (i.e., the client is experiencing the actual complication), the nursing diagnosis should reflect the client’s responses to the complication. For
example, if the complication is pneumonia, the following nursing diagnoses would be appropriate:

1. Risk for fluid volume deficit r/t  fluid loss 2° fever and hyperventilation
2. Ineffective airway clearance r/t weak cough and  tracheobronchial secretions amb crackles auscultated on inspiration in RLL, CXR report reveals consolidation in RLL,  vocal and tactile fremitus in RLL

Activity intolerance r/t insufficient oxygenation 2° impaired gas exchange amb dyspnea on exertion, tachycardia with exertion, C/O shortness of breath and easy fatigue, SaO₂ 88% on room air.

Client Situation Rationale

The client’s situational data, supporting the nursing diagnosis statement, must be identified in order to further individualize/personalize the client’s nursing care plan. It is essential that the data reflect a holistic view of the client’s life and clinical situation. As this data is gleaned from the original data base it may include data obtained directly from the client (e.g., nursing history, physical exam), the individual client’s family, other health care team members, or the client’s health record (e.g., lab and diagnostic test results). Similarly, situational data regarding client as family or community would be gleaned from the respective databases and would include data obtained directly from individual members, spokespersons, or both.

When determining client situation rationale the following question must be answered: Considering all aspects of the client’s life and clinical situation, has all the relevant data that supports this nursing diagnosis for this client been included?

Client Goals

Goals are broad conceptual statements that reflect a desired health state/level of self-care for the client (e.g., involving problem resolution, growth & development, successful transition, a higher level of wellness, etc.) and thus direct the prioritizing, planning, and implementation of care. To the extent possible, client goals are developed collaboratively, that is, between the client and the nurse.

An example of a goal for a parenting education program would be:
All program participants will be confident in their parenting skills.
An example of a goal for a surgical client would be:
The client’s surgical incision will heal without complications.

Client Outcomes

On the basis of identified nursing diagnoses and client goals, expected outcomes are decided. Expected outcomes, also known as evaluative criteria, are those desired behaviors or responses (e.g., physiological, psychological, spiritual, and lifestyle) that the nurse and, where applicable,
the client anticipate occurring as a result of the actions/interventions undertaken by the nurse, the client, or both. They enable the nurse (and client) to evaluate to what extent the plan of care has been successful in achieving the goals (i.e., they provide the evidence to support the extent of client goal achievement). Expected outcomes should be:

1. client centered (i.e., specify an outcome for the client, not the nurse)
2. singular (i.e., each statement should specify only one outcome)
3. measurable to the extent possible (i.e., the desired outcome can be assessed as being achieved or not achieved, for example, a desired behavior is present or absent, a desired verbalization is made or not made, the frequency can be counted, or the amount can be measured or weighed, and so forth)
4. client specific (i.e., where applicable, the degree of proficiency or conditions required for the outcome to be considered achieved by the client should be specified)
5. time limited (i.e., where appropriate, the time frame for an expected response should be specified)
6. mutual (i.e., where possible, the client should be in agreement with the outcomes to ensure a greater chance of success)
7. realistic (i.e., the outcomes must be attainable)

The following list provides some examples of measurable verbs to help formulate appropriate client outcomes. This list is a guide and is not all inclusive:

...will maintain..., will return to..., will remain free of..., will not sustain..., will show evidence of..., will show no evidence of..., will have an increase in..., will have a decrease in..., will have an absence of (a sign), will report an absence of (a symptom), will demonstrate..., will comply with..., will select, will decide to..., will administer..., will document..., will state..., will communicate..., will consult..., will delegate..., will discuss..., will identify..., will report..., will participate in..., will restrict..., will engage in..., and so on.

Examples of Client Outcomes

The following example is related to a prenatal education program.

At least 50% of program participants will breastfeed exclusively (i.e., with no supplementation) at 6-8 weeks postpartum.

The following example refers to a client who is experiencing mouth ulcers due to chemotherapy.

Client will have intact, pink, and moist oral mucus membranes with no evidence of inflammation or infection and no complaints of pain or difficulty swallowing by 1-week post chemotherapy.

Please note that the client outcomes are often closely linked to the defining characteristics as outlined in the diagnostic statement. Consider the client who has a fluid volume deficit r/t decreased fluid intake secondary to nausea and vomiting amb C/O thirst, concentrated urine, diminished skin turgor, dry skin and oral mucous membranes, ↑BUN and HCT, and so on. In this case the goal would be that the client would return to a state of hydration, exhibiting such
expected outcomes as dilute urine, moist skin & oral mucous membranes, elastic skin turgor, absence of thirst, a BUN & HCT within normal parameters, and so on.

**Interventions**

The client’s nursing care plan includes two types of interventions, nursing interventions and, when applicable, client interventions. Interventions are those actions derived in partnership with the client, others (e.g., family, other members of the health care team) or both in order to meet the client goals/expected outcomes and can be implemented by the nurse, the client, or a family member, depending, in part, on the knowledge and skill required. Interventions must be specific and address the need or desire for a change in client response within the context of a particular situation. While there are often several interventions derived for each diagnosis, some interventions can only be implemented by the client. For example, it is the client who uses an incentive spirometer q1h while awake, it is the client who attends the fitness program three times a week, it is the client who engages in active ROM exercises bid, it is the client who does the deep breathing and coughing exercises q2h while awake, it is the client who self-administers insulin q am, it is the client who does calf pumping exercises hourly, it is the client who reports an episode of chest pain to the nurse stat, it is the client who ambulates in the hallway bid, etc. If knowledgeable, skilled, and motivated, the client can also do many other things to help achieve the client goals/expected outcomes, such as measure peak flows bid, weigh self every morning before breakfast, record intake and output on an ongoing basis, record dietary intake after meals, etc.

**Please note** that client interventions do not mirror nursing interventions. For example, if the nurse administers an oral medication, one can assume the client will swallow it. If not, then it would be appropriate for the nurse to make a diagnosis that reflects the situation, for example, noncompliance or impaired swallowing and derive an appropriate plan of care. If the nurse is going to assist the client with something (e.g., assist with dressing), there is no need for a corresponding client action. To do so is redundant. There are times, however, when a nursing action must precede a client action such as would be the case when the nurse must teach the client how to do something and then the client can proceed unassisted. In this case the nursing intervention is “to teach” and, following successful implementation of this intervention, the client intervention is “to do”.

**Writing/Formatting Interventions:**

Interventions must be written in the following format: Verb – Noun – Modifier

Where applicable, the action (verb) should be accompanied by what (noun) as well as by how much, how often, and/or under what conditions/circumstances (modifiers).

<table>
<thead>
<tr>
<th>Verb</th>
<th>Noun</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer</td>
<td>Tylenol 325 mg.</td>
<td>for temp &gt; 38.5</td>
</tr>
<tr>
<td>Discuss</td>
<td>Client’s</td>
<td>support system</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Irrigate</td>
<td>Client’s N/G tube</td>
<td>with 30cc’s H₂O q4h</td>
</tr>
</tbody>
</table>

Interventions (using action verbs) may include, but are not limited to those listed in the categories below:

1. **Act for/do for**: adjust, aspirate, decrease, empty, give, assess, auscultate, examine, measure, monitor, note, observe, palpate, percuss, watch, measure, monitor, observe, palpate, watch, collaborate, advocate, confer, consult, discuss, refer, request, administer, insert, report, anticipate, remove, reposition, suction, self-administer, ambulate, dress, and so forth.
2. **Guide**: guide, inform, discuss, show, counsel, assist, and so forth.
3. **Support**: share, suggest, talk, promote, encourage, assist, maintain, explain, ask, reinforce, and so forth.
4. **Teach**: demonstrate, discuss, explain, inform, instruct, list, reinforce, review, show, and so forth.
5. **Provide an environment that promotes physical, psychosocial and spiritual development and/or positive lifestyle change**: provide, promote, encourage, suggest, give, etc.

*Literature-Based Rationale for Interventions*

The literature-based rationale for interventions describes/explains the basis for the interventions. The rationale is based on scientific research-based and/or theoretical information from current nursing and/or health-related texts and journals. Sources must be cited using APA format.

**Please note that additional rationale may emerge from situational data and it should be included in this section whenever possible.**

*Evaluation*

Evaluation involves assessing or reflecting on how effective the care plan interventions were in achieving the client goals/expected outcomes. It is assumed that the interventions listed in the intervention columns (nurse, client, or both) were carried out, and therefore, there is no need to list them again in this section. Rather, this is the time to evaluate whether in fact the client goals/expected outcomes were met, partially met, or not met. If the client goals/expected outcomes were not met or only partially met, this is the time to reflect and comment on what interventions were not helpful and why. It is also the time to discern and propose what interventions might be helpful if faced with similar circumstances or client situations in the future. In other words, it is a time to troubleshoot and grow in the practice of nursing. To assist in the overall evaluation phase, the following questions may be helpful:

- Have the client goals/expected outcomes been met?
• If so, what nursing/client interventions helped?
• If the client goals/expected outcomes were not met, why? What factors or variables may have interfered with the achievement of the client goals/expected outcomes? What challenges in nursing judgment existed in the planning and implementation of the care plan? Is it possible that the client was misdiagnosed? Is it possible that the interventions were not appropriate? Is it possible that the goals/expected outcomes were unrealistic given the client situation, the etiology, or the time frame?
• If I had to care for this client again, what would I do differently? What new or alternative interventions would I consider in future situations? What interventions, if any, would I delete?

Please note that in some circumstances, especially given the short contact time with the client, it may not be possible to evaluate all aspects of the care plan. On the other hand, there may be enough time to do an “interim” evaluation, so to speak, and to modify the plan of care accordingly.

References


Revised September 2009 ©P. Hawley
SECTION THREE: NEW CURRICULUM

3.1 STATEMENT OF PROGRAM PURPOSE AND GOALS

The School of Nursing began offering a new curriculum in the Bachelor of Science in Nursing program in September 2016. The programs are founded on a new integrated concept-based and competency-based curriculum that supports best practice pedagogies and practice experiences. There are two options for completion of the BScN in the new curriculum:

1. The Traditional Four-Year option is completed over four academic years (Sept-Apr) and includes eight semesters of study. This option primarily targets students entering from high school. During semesters one (Sept-Dec) and two (Jan-Apr), students in the four-year option will complete the required 30 credits of arts and science. During semesters three through eight, the students will be primarily immersed in nursing courses, with the exception of semesters six and seven, when students have the option to take six credits of either nursing or non-nursing electives. The four-year option gives students the choice to seek employment during summer breaks and provides flexibility to participate in extracurricular university activities scheduled throughout the academic calendar year (i.e., service learning opportunities, athletics, student union, etc.).

2. The Accelerated Two-year Program primarily targets students who have completed the university-level entrance requirements for nursing. Students in this option began in January 2017 and will complete six continuous semesters over 24 months, with two-three week breaks between semesters. Students are immersed in nursing courses during semesters three through eight, with the option to take six credits of either nursing or non-nursing electives during semesters six and seven. Graduation is at the December ceremony.

The SON concept-based program at StFX delineates the curricular elements for building the baccalaureate nursing curriculum including curricular themes, leveled competencies, corresponding concepts, concept scopes, attributes, and theoretical links, location in the curriculum and exemplars. The key curricular themes were derived from our Graduate Attributes and align with recommendations from key regulatory and nursing leaders (e.g. College of Registered Nurses of Nova Scotia, the Canadian Nurses Association, Canadian Association of Schools of Nursing, and Institute of Medicine) and from landmark documents related to core knowledge, judgment, skills and attributes (attitudes, values, and beliefs) expected of entry-level nursing graduates.

3.2 PROGRAM GOALS

1. Provides a nursing curriculum that builds on the StFX values and its academic mission
2. Provides a unified, evidence-informed, meaningful nursing curriculum that meets Provincial and national standards (i.e., accreditation standards, Code of Ethics, regulatory competencies)
3. Provides a curriculum that is founded on nursing knowledge, in conjunction with a liberal education and consideration of previous learning that prepares learners to enter practice with broad knowledge and competencies.
4. Provides a curriculum that supports a collaborative model of undergraduate nursing education in the province of Nova Scotia that facilitates Nursing students to move more effectively through the educational system
5. Supports educational and practice partnerships that are key to inform and sustain a current and relevant curriculum.
6. Provides opportunities for student voice in curricular issues
7. Provides a curriculum that flexible, based on evidence of current health and societal needs, and provides progressive opportunities for learners to develop personally and professionally as nurses through engagement in activities that apply knowledge
8. Prepares safe and competent graduate nurses that achieve successful pass rates on national exam to practice and who are responsive to current and future health care trends, population health issues, and 21st century nursing practice demands.
9. Meets standards for nursing education as set out by the College of Registered Nurses of Nova Scotia (CRNNS, 2012b) and the Canadian Association of Schools of Nursing (CASN, 2014a).

3.3 GRADUATE OUTCOMES
1. Have a strong conceptual base and specialized knowledge, skill, and attributes to provide safe, competent, and compassionate person/client/patient-centered nursing care.
2. Exhibit a strong sense of personal and professional identity and deliver nursing care that is consistent with moral, altruistic, legal, ethical, and regulatory standards/principles.
3. Apply critical thinking including clinical reflection, clinical reasoning and clinical judgment to arrive at decisions about what is most relevant and salient to person/client/patient care.
4. Committed to evidence-informed practice through action to enhance professional competence and motivation for continued critical inquiry, curiosity, creativity, scholarship, and life-long learning.
5. Engage in collaborative leadership that is essential to enhanced person/client/patient outcomes, effective health system functioning, and health and social reform.
6. Engage in relational practice, communicate effectively within various professional roles and use informational and communication technologies to manage nursing and patient care.
7. Apply the principles of primary health care, population health promotion, and social justice to address inequities and determinants of health affecting persons, families, groups, communities and populations.
8. Demonstrate compassionate, culturally safe, relationship-centered care with indigenous, Black, immigrant, refugee, and other marginalized populations
9. Be prepared as generalists with knowledge, skills, and attributes for innovation within evolving health, health systems, and nursing scopes of practice.
3.4 **Key Features of the New Curriculum Framework**

The following provides an explanation of the key features of the new curriculum followed by an overview of the curriculum framework and the sequencing of courses. The nursing courses required in Semester 3 through 8 are primarily delivered by nursing faculty. The following section provides an overview of the structure of the integrated concept-based and competency-base curriculum. For more details see Appendix B.

**Key Features:**

1. **Progression through Health-Illness Continuum Across the Life Span**
   - The curriculum is designed to begin with learning about supporting health and wellness and the care of care of clients and families in transition, progressing to the care of clients experiencing acute, episodic, and life-threatening, and advancing to the care of clients experiencing co-morbidities, chronic illness, end of life, and complex health challenges. Health and illness are examined at various developmental stages.

2. **Working with Individuals/Families, Groups, Communities and Populations**
   - The curriculum is designed to begin with learning about a broad understanding of health and wellness of communities and populations (and what influences health), progressing to a focus on the health of individuals and families, and advancing to population/public health/global health and health system issues.

3. **Vertical and Horizontal Integration of Nine Curricular Themes and Corresponding Concepts**
   - The curriculum is underpinned by nine core curricular themes. Each curricular theme has several corresponding concepts. The curricular themes are:
     1. Professional & Ethical Practice
     2. Theoretical Understanding & Application
     3. Critical Thinking
     4. Inquiry & Scholarship
     5. Communication & Informatics
     6. Leadership & Collaboration
     7. Local & Global Citizenship
     8. Health-Illness Body & Structures
     9. Practice Competencies
   - The curricular themes provide the organizational framework and structure for the curriculum and are the foci within courses/modules. Concepts are taught through the use of exemplars.
   - The curricular themes are integrated both horizontally (across all years of the program) and vertically (within each semester), and loosely tied to four broad concentrations of study (see description of concentrations of study below)
   - There is flexibility in mapping the concepts, whereby concepts can be applied to various areas of nursing focus or exemplars (e.g., fluid and electrolyte imbalance can be introduced when discussing childbirth or acute illness). The main goal is to ensure that all
concepts are introduced, with the expectation that the application of knowledge and skills learned are carried forward.

- Exemplars that are selected will represent individuals across the life span and in various settings to allow students to apply concepts in a variety of client/patient contexts. Incidence and prevalence will serve as one criterion for selecting exemplars (e.g., high prevalence of cancer and heart disease warrants their inclusion as exemplars). Context and opportunity will also serve as a basis for selecting exemplars (e.g., given StFX SON geographics and population, rural and Aboriginal health would be an applicable exemplar).

4. Integration of Four-Broad Concentrations of Study

- Courses within each 15-credit semester are divided among four-broad concentrated areas of study.¹

- **The Discipline & Professional Practice (Yellow):** this area of focus includes standards, ethics, jurisprudence/legalities; evidence-informed practice; and collaboration. The four curricular themes that are introduced and then gradually integrated into areas of increasingly complex nursing practice situations include:
  - Professional & Ethical Practice
  - Critical Thinking
  - Inquiry & Scholarship
  - Leadership & Collaboration

- **Supporting Health (Blue):** this area of focus includes attention to broad cognitive and psychomotor skills necessary to provide care to various clients along the health-illness continuum. This area complements the concepts and competencies learned in the “science of health & nursing section”. The three curricular themes that are introduced and then gradually integrated into areas of increasingly complex nursing practice situations include:
  - Communication & Informatics
  - Health-Illness Body Structures & Functions
  - Practice Competencies

- **The Science of Health & Nursing (Pink):** this area of focus includes theory and principals and their application related to clients experiencing diverse degrees of health and wellness; acute, episodic, and life-threatening challenges; and co-morbidities, chronic disease, and end of life in diverse settings. The two curricular themes that are introduced and then gradually integrated into areas of increasingly complex nursing practice situations include:
  - Theoretical Understanding & Application
  - Local & Global Citizenship

- **Integrating Nursing Roles & Practice (Green):** this area of focus include the application of cognitive, psychomotor, and affective skills gained from the other areas of focus and requires the integration of all curricular themes. Application occurs through simulated

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¹ The curriculum design builds on the University of Calgary’s successful integrated undergraduate nursing curriculum framework (http://www.ucalgary.ca/pubs/calendar/current/nu-4-1.html)
and practice setting experiences. Table 3 provides an Overview of Courses and Their Sequencing in the Proposed New 8-Semester Program.

*NOTE: Some concepts are introduced then carried forward to the other concentrated areas of study for application.

### 3.4 Glossary of Terms

**Competence:** Refers to the integrated knowledge, skills, attitudes, abilities and judgment required to practice nursing safely and ethically (Adapted from CRNNS, 2013a; Tuning Project, 2007). Competences in this nursing curriculum are based on Bloom’s behaviourist philosophy to describe learning in three learning domains that include: (1) Cognitive Domain: that includes mental skills or knowledge - defined as facts and ideas relevant to nursing practice (Bloom’s Taxonomy; Fater, 2013); (2) Affective Domain: that includes the manner in which one deal with things emotionally including attitude. Attitudes entails beliefs & values to act consistently in professional nursing practice; (Bloom’s Taxonomy; Fater, 2013); and (3) Psychomotor Skills that is defined as the ability to carry out nursing practice activities and includes physical movement, coordination, & use of motor-skills indicated through speed & precision in the execution of procedures or technique. Entry-level competences expected of students at the point of their graduation are identified by the CRNNS and include: (1) Professional Responsibility and Accountability; (2) Knowledge-Based Practice; (3) Ethical Practice; (4) Service to the Public; and (5) Self-Regulation.

**Competency:** The ability of the student to demonstrate a competence. Example competency statements are listed in the CRNNS (2013) Entry-Level Competencies document. Additional entry-level competencies related to specialty fields are also identified by the Canadian Association of Schools of Nursing (CASN). These competencies reflect the regulatory body’s entry-to-practice but are more detailed and specific in specialty fields to offer greater guidance to students and nurse educators. CASN entry-level competencies are available for palliative care (CASN, 2011); Entry-level competencies for informatics (CASN, 2012); Entry-level competencies for public health (CASN, 2014); and Entry-level competencies for mental health and addictions (CASN, 2015). Competencies reflect a progression of learning from a basic (beginning), to an intermediary, to a final advanced level that reflects what is expected as an entry-level graduate.

- **Basic:** Refers to preliminary or beginning knowledge, skill, and attributes expected of nursing students. Students at a beginning level are expected to recognize the relevant aspects of a situation, and have and apply knowledge, skills, and attributes in routine and predictable situations. Students require guided support.

- **Intermediary:** Students at an intermediary level are able to recognize the relevant aspects of a situation and anticipate potential complications. Students are expected to have and apply knowledge, skills, and attributes in increasing complex situations and take action in the face of unforeseen events. Students practice with increased autonomy and require support for situations that are not routine and predictable.
• **Advanced:** Students at an advanced level consistently recognize relevant aspects of a situation and anticipate potential complications. Students are expected to have and apply knowledge, skills, and attributes in complex situations in a broad range of contexts and for situations that are unpredictable. Students practice with increased autonomy and responsibility, seeking guidance as necessary.

**Concept-Based and Competency-Based Curriculum.** For the purposes of this curriculum, a concept-based and competency-based curriculum refers to the use of concepts as an organizing framework for curriculum and courses. Concepts represent categories of principles or mental constructions that contain defining attributes of nursing graduates derived from an analysis of population and societal needs and nursing scope of practice. Concepts are integrated both vertically and horizontally throughout the curriculum and are taught through the use of exemplars. Competencies derive from the concepts and define the knowledge, judgment, skills and attributes (attitudes, values, and beliefs) expected of graduates from the StFX nursing program.

**Graduate Profile Goals:** Refer to general/broad statements of intent, aspiration, or attributes. Provides a framework that describe the educational designation to be reached by graduating students (“what the graduate will look like”).

**Leveled Learning Competencies:** Leveled learning competencies in this nursing curriculum are based on Bloom’s behaviourist philosophy to describe learning within three domains: cognitive, affective, & psychomotor. The leveled learning competencies provide a guiding framework to describe a progression of learning from a basic, to an intermediary, to a final advanced level that reflects what is expected as an entry-level graduate.

• **Basic:** Refers to preliminary or beginning knowledge, skill, and attributes expected of nursing students. Students at a beginning level are expected to recognize the relevant aspects of a situation, and have and apply knowledge, skills, and attributes in routine and predictable situations. Students require guided support.

• **Intermediary:** Students at an intermediary level are able to recognize the relevant aspects of a situation and anticipate potential complications. Students are expected to have and apply knowledge, skills, and attributes in increasing complex situations and take action in the face of unforeseen events. Students practice with increased autonomy and require support for situations that are not routine and predictable.

• **Advanced:** Students at an advanced level consistently recognize relevant aspects of a situation and anticipate potential complications. Students are expected to have and apply knowledge, skills, and attributes in complex situations in a broad range of contexts and for situations that are unpredictable. Students practice with increased autonomy and responsibility, seeking guidance as necessary.
**Person/Client/Patient:** For the purposes of this curriculum, person/client/patient refers to recipients whom health-care providers establish a relationship for the purposes of partnering for health. The term person is inclusive of the following: individual, client, patient, resident, consumer, families, groups, communities, and population. (Adapted from RNAO, 2015).

**Attribute:** A quality or characteristic that is associated with the concept that helps to clarify or confirm a concept (Giddens, 2017, p. 463)

**Concept:** An organizing principle or mental construction representing categories of information that contain defining attributes of nursing graduates. Concepts are taught through the use of exemplars.

**Curricular Theme:** Represents overarching subject matter or area that comprises the StFX SON curriculum. The themes are organized into key concepts that support the development of knowledge, skills, judgment and attributes within a theme that will be acquired by students as part of nursing education program.

**Exemplar:** Health related issue serving as a model or example in the context of the client/patient for the purpose of learning about a concept. For example, asthma would be an exemplar for the concept of oxygenation.

**Scope:** The extent of the area of the subject matter to be covered. References to scope is leveled indicates that part of the scope of a concept is continued in another semester

**Theoretical Links:** Refers to the theories, models, frameworks, and principles that serve as the lens to view the concept

See Appendix G – Key Concepts
SECTION FOUR: GUIDELINES FOR THE BScN WITH ADVANCED MAJOR N499

Description:

The N499 Advanced Major 3 credit course permits students to pursue an individual program of study in a clinical practice setting that may or may not normally be offered by the School of Nursing. The Advanced Major course N499 allows students to apply nursing knowledge, as well as knowledge from related disciplines, in a clinical practice experience of their choice. Students must meet the admission requirements (see below). Students must apply to the School of Nursing Coordinator of the BScN Advanced Major program by March 15th, of their sophomore year.

Admission Requirements:

To qualify for admission, students must have:
- A minimum average of 65% in both their freshman and sophomore years (St. Francis Xavier University Academic Calendar, 2015-16, p. 25, Chart 7.1.5).
- A minimum grade of 65% in each nursing course.
- Demonstrated acceptable performance in nursing practice (i.e., no nursing practice alert).

In order to advance from the junior to the senior year of the advanced major program, candidates must have:
- A minimum average of 70%.
- A minimum grade of 70% in each nursing course.
- Demonstrated acceptable performance in nursing practice (i.e., no nursing practice alert).

In order to graduate with the advanced major declaration, candidates must have:
- A minimum average of 70%
- A minimum grade of 70% in each nursing course
- Demonstrated acceptable performance in nursing practice (i.e., no nursing practice alert)
- Fulfilled the course requirements of the School of Nursing
- Fulfilled the additional requirements associated with the option chosen (see BScN Advanced Major N499 Course Description).

Candidates who fail to meet the requirements for the degree for which they have applied, may be eligible for another degree provided those requirements are met.

Exceptions to these requirements need the approval of the Dean of Science and the Assistant Director of the School of Nursing.

Application Process:

1. By March 31, 2018 of their Sophomore Year, potential candidates must apply to the Coordinator of the BScN with Advanced Major program.
   - Submit in writing a one page letter of intent to include your proposed location for a clinical practice experience and why you are interested in this nursing practice area.
Submit the BScN Advanced Major Application Form. Available from the Dean of Science Website, Undergraduate Student Resources, Declaration Forms - http://sites.stfx.ca/dean_of_science/sites/sites.stfx.ca.dean_of_science/files/BSC%20NURS%20AM.pdf

2. The School of Nursing reviews all applications once the Final Transcripts for second year students are available. The Chair of the School of Nursing signs the applications from candidates who fulfill requirements, and forwards applications to the Dean of Science.

3. The Office of the Dean of Science carries out the final decision, and will notify the candidate of the decision.

4. Accepted candidates must register in N499 in their senior year.

A course outline for N499 BScN Advanced Major will be provided for students and advisors yearly.

*Minor date and reference to Academic Calendar revisions Aug 2015*
SECTION FIVE: GUIDELINES FOR THE BScN WITH HONOURS

Students wishing to apply for an honours program are advised to consult with the School of Nursing Chair as early as possible to facilitate course selection. Students must apply to the Dean of Science for admission to the honours program by March 31 of their sophomore year. The completed application must be signed by the SON Chair prior to submission. Qualifying students will be notified in the summer following submission.

To qualify for admission, students must have:
- A minimum average of 75% in both their freshman and sophomore years.
- A minimum grade of 70% in each nursing course.
- Demonstrated acceptable performance in nursing practice (i.e., no nursing practice alert).

In order to advance from the junior to the senior year of the honours program, candidates must have:
- A minimum average of 75%.
- A minimum grade of 70% in each nursing course.
- Demonstrated acceptable performance in nursing practice (i.e., no nursing practice alert).

In order to graduate with the honours declaration, candidates must have:
- A minimum average of 75%.
- A minimum grade of 70% in each nursing course.
- Demonstrated acceptable performance in nursing practice (i.e., no nursing practice alert).
- Fulfilled the course requirements of the School of Nursing, including Nurs/Soci 300, Nurs 496, and Nurs 498.
- Fulfilled the additional requirements associated with thesis completion.

Candidates who fail to meet the requirements for the degree for which they have applied may be eligible for another degree, provided those requirements are met. Exceptions to these requirements need the approval of the Dean of Science and the School of Nursing Chair.

In the next three pages the deadlines for the BScN Honours program are outlined for the academic year. As such, the dates will fluctuate in subsequent years. That being said, the process and timeframe required for thesis completion will not change.

Procedure for Selecting a Thesis Supervisor and Second Reader

In October of the students’ junior year, the honours coordinator will meet with honours students to discuss the program requirements and expectations. The honours coordinator will provide students with a copy of the research interests of the School of Nursing members. Honours students may work on a component of a Faculty or Nurse Educator’s current research program or select a topic that she/he is interested in pursuing. The students will be encouraged to meet with potential thesis supervisors to discuss their proposed research ideas after the initial meeting with the honours coordinator. Honours supervisors must be a full time Faculty or Nurse Educator in the School of Nursing and have a minimum of a Master’s degree. Once a Faculty or Nursing Educator agrees to be
the thesis supervisor, the supervisor and student will, together, select a second reader. The second reader may be either someone from the School of Nursing or who works in another department in the university or in a health care setting with substantive expertise in the area of study. The student and thesis supervisor must inform the honours supervisor about whom they have selected for second reader by February of their junior year.

Note: If students are working on an existing research project, the dates below will be determined in consultation with the supervisor and second reader. There will also be ongoing communication with the Honours Coordinator regarding the dates and progress of the student (s) during this time.