Oakland University
School Of Nursing

Basic Clinical Competencies

NRS 2325 (286)
CRN #11538

Faculty:

SALLY O'MEARA, MSN, RN
Special Lecturer

Winter 2018

COURSE NUMBER	**NRS 2325 (286) - CRN #11538**		
CREDITS & HOUR ALLOCATION:	**Credits**	**Hrs/Wks**	**Total Hours Semester**
	2	**2 x 7**	**14**
COURSE TITLE:	**Basic Clinical Competencies**		
CLASS TIME & LOCATION:	**February 26, 2018 – April 25, 2018** **TBA**		
FACULTY OF RECORD:	**Sally O'Meara, MSN, RN** **Special Lecturer** **Office Hours: By Appointment Only** **E-mail: omeara@oakland.edu**		

FACULTY OF RECORD INFORMATION

Sally O'Meara MSN, RN

Office: 2044 HHB
Office hours by appointment only
E-mail: omeara@oakland.edu
Phone: 248-495-3617 (cell)

PREREQUISITES and/or CO-REQUISITES

Prerequisites: Students are required to successfully complete NRS 281, NRS 282, and NRS 283 in the first seven weeks of the semester in order to continue into NRS 286/381in the second seven weeks of the semester.
Co-requisites: NRS 2411 (380)

COURSE OVERVIEW

This course focuses on patient-centered nursing care for adult patients (18 years of age to death) and their families in an acute care environment. Students will apply the nursing process and ethical decision-making to adult patients and their families through the integration of theory, rationale, and specific nursing interventions.

COURSE OBJECTIVES

1. Utilize the nursing process to assess, diagnose, and develop appropriate expected outcomes, plan and implement patient-centered care, and evaluate the nursing care given to adults, families, and groups of diverse and vulnerable populations.

2. Integrate relevant findings from the arts, sciences, and nursing theory and apply them during the decision making process regarding the provision of nursing care given to adults, families, and groups of diverse and vulnerable populations.

3. Collaborate with adult patients, their families, and other health care professionals to plan, implement, and evaluate patient-centered nursing care.

COURSE OBJECTIVES (cont'd.)

4. Demonstrate ethical decision-making and personal and professional accountability in planning, implementing, and evaluating the care given to adult patients, their families, and groups of diverse and vulnerable populations in all settings.

5. Examine the role of the nurse in providing care that is respectful of and responsive to the health beliefs, practices, cultural and linguistic needs of diverse patient populations.

ESSENTIAL CONTENT

The Nursing Process

Nursing Care Planning

Therapeutic communication

Holistic health assessments

Ethical clinical reasoning/decision-making

TECHNICAL REQUIREMENTS

All e-Learning courses at Oakland University are delivered using a learning management system called Moodle that allows instructors to design entire courses online or to enhance a classroom-based course. The Moodle software resides on a server allowing students to access it via a web browser, e.g. Mozilla, Firefox. Each course is uniquely designed by the instructor who may include some of the following components in his/her web-based or web enhanced course: course syllabus, course material/content, course assignments, quizzes/tests, hyperlinks to other websites on the Internet and/or other OU web pages, discussion boards, Internal email, and the course grade book.

Logging into Moodle
Students login to Moodle with their NetID (oakland.edu email) account password. Please remember that anytime you change your NetID password, it will be reflected in your Moodle login.

- Open the Moodle Login page: https://moodle.oakland.edu
- Log-in using the first part of your NetID username and password, e.g. if your email is jwilson3@oakland.edu then:
    - Username: jwilson3
    - Password: whatever your Oakland University email password is

If you have any problems/issues with Moodle, you need to contact or fill out a help desk request form for e-Learning and Instructional Support.

To view course materials in MOODLE you will need the latest version of Adobe Reader that can be downloaded free of charge at www.adobe.com

COURSE REQUIREMENTS

1. To pass NRS 2325, students must achieve a minimum grade of 2.5 on the Undergraduate Clinical Evaluation Tool, 80% on the Clinical skills quiz and at least 70% on each of the two large care plans.

2. All students must satisfy the OU SON health, CPR and insurance requirements to participate in clinical and laboratory experiences. Students should see the SON Student Handbook for details.) Students who have not met these requirements are considered absent from clinical until notice is provided in writing by the student from the Advising Department to the clinical faculty.

3. During the clinical experience, students are expected to:
    - Provide care for the number of assigned patients including VS, hygiene, treatments
    - Safely pass medication to assigned patients
    - Collaborate with the staff nurses.
    - Perform at least one comprehensive physical assessment demonstrated in front of clinical faculty

4. Students are to complete the following:
    - Learning Needs Assessment Tool
    - Daily patient assessments with 5-minute care plans
    - Daily physical assessment flow sheets
    - Narrative notes
    - At least one nursing care plan
    - Weekly personal growth assessments/clinical journals

5. Students should check Moodle and OU e-mail at least every 48 hours for communication from clinical faculty and/or the faculty of record.

6. There are no off-site visits allowed. Students are not allowed to provide any type of patient care outside of the scheduled clinical hours.

STUDENT NURSE PROFESSIONALISM EXPECTATIONS

1. All students are expected to be consistently and thoroughly prepared for safe practice in the clinical setting. Faculty reserve the right to request that students complete additional assignments in order to fulfill this requirement. Students who are deemed to be unsafe will be asked to leave and be required to remediate prior to returning to the clinical site.

2. Students must follow the guidelines for professional attire and behavior that are outlined in the Student Handbook. Unprofessional attire or behavior will result in the student being sent home and that day will count as a clinical absence. Professional attire includes:
    - Neat, clean appearance with clean, pressed uniform
    - White scrubs, clean white shoes and underclothing
    - Hair completely off of the face
    - No false nails or jewelry except wedding band

ATTENDANCE AND TARDINESS POLICY

Attendance at all clinical experiences is mandatory in order to successfully complete NRS 2325. Clinical faculty will record all absences and instances of tardiness.

- The student is considered late when he/she is not in the clinical setting ready to begin the shift at the time stated by the clinical faculty. 1 point will be deducted from the clinical evaluation score for each 15 minutes that the student is late.

- Students are referred to the OU SON Student Handbook for information regarding excused absences and required physician documentation.

- Absence from clinical will be assessed as a percentage of the total hours for the clinical rotation. A student who misses more than 20% of the clinical hours will be assigned a final grade of 2.4 for the course. Clinical faculty and the faculty of record reserve the right to review extenuating circumstances for student absences from clinical.

- Assignments are due on the dates designated by the clinical faculty. Half credit will be given to assignments that are submitted late. Assignments that are more than 24 hours later will not be accepted and a "0" grade will be given.

COURSE EVALUATION

Undergraduate Clinical Evaluation Tool	50%	500 points
Care plan #1	10%	100 points
Care plan #2	10%	100 points
Clinical skills quiz	10%	100 points
5-minute NCPs	10%	100 points
Daily patient physical assessments	10%	100 points
Total		1000 points

REQUIRED TEXTBOOKS:

American Psychological Association. (2010). *Publication manual of the American Psychological Association.* (6th ed.). Washington, DC: Author.

Ignatavicius, D. & Workman, N. (2018). *Medical surgical nursing: Patient-centered collaborative care.* (9th ed.). St. Louis, MO: Saunders Elsevier.

RECOMMENDED TEXTBOOKS:

Ignatavicius, D., & Workman, L. (2018). *Clinical decision-making study guide for Medical surgical nursing: Patient-centered collaborative care*. (9th ed.). St. Louis, MO: Saunders Elsevier.

Ackley, B. & Ladwig, G. (2016). *Nursing diagnosis handbook: An evidence-based guide to planning care*. (11th ed.). St. Louis, MO: Mosby Elsevier.

**** Older editions of the Ackley book are acceptable and may be purchased cheaply on-line*

ALSO NEEDED:
Current diagnostic laboratory tests manual
Current nursing drug book
ANY NCLEX review book

REQUIRED MATERIALS

Stethoscope & penlight	Bandage scissors
Watch with second hand	Current diagnostic laboratory tests manual
Current nursing drug handbook	Folder for daily written assignments

COURSE ASSIGNMENTS & EVALUATION TECHNIQUES

1. Students will be evaluated on their clinical performance and written/oral assignments. To pass NRS 2325, students must achieve a minimum grade of 2.5 on the Undergraduate Clinical Evaluation Tool, 80% on the Clinical skills quiz and at least 70% on each of the two large care plans. Oral/written assignments will be graded according to the criteria listed in the grading rubrics. The clinical score is derived from evaluation of students' cognitive understanding and psychomotor skills. As both components are essential to demonstrating competency in the clinical experience, psychomotor and cognitive skills are recorded and weighed in the Undergraduate Clinical Evaluation Tool.

2. Patient assignments will be based on patient acuity, unit census and nurse staffing. The clinical instructor has the sanction and responsibility to assign additional care plans, assignments and/or activities to support student learning needs when the student's written work or clinical performance is not meeting expectations.

3. Students are expected to know about each medication that they administer to patients. The clinical instructor has the right to have the student to complete a medication error report if the student has insufficient knowledge about a medication. The report will help the student learn about the drug and remember information about it for the future. It will also help the instructor track how well students know their medications and their preparedness for the clinical day.

4. Faculty will provide students with a midterm evaluation using the Clinical Evaluation Tool at the halfway point of the clinical rotation. Students will receive a pass/fail grade at midterm with feedback about how to successfully complete the remainder of the course. The midterm evaluation may be completed at the clinical facility or on campus in the Human Health Building. Students will receive a final clinical evaluation and numeric final grade using the Clinical Evaluation Tool after the last clinical day has been completed. The final evaluation will be held on the OU main campus in the Human Health Building.

12-HOUR CLINICAL SCHEDULE

Day	Clinical activities
1	**Orientation: first 4 hours** Patient care & post-conference: last 8 hours
2	Patient care & post-conference: 12 hours 5-minute care plans and journal due
3	Patient care & post-conference: 12 hours 5-minute care plans and journal due **Nursing care plan #1 due**
4	Patient care & post-conference: 12 hours 5-minute care plans and journal due **Midterm evaluations**
5	Patient care & post-conference: 12 hours 5-minute care plans and journal due
6	Patient care & post-conference: 12 hours 5-minute care plans and journal due **Nursing care plan #2 due**
7	Patient care & post-conference: 12 hours 5-minute care plans and journal due
TBA	**Final evaluations on campus** Date/times TBA by clinical faculty & SON Total hours = 84

CLINICAL JOURNALS

Students will maintain a daily clinical journal documenting their experiences and progress. Students should also include relevant clinical learning opportunities and implemented skills. Clinical journals will be collected and reviewed weekly by the clinical instructor.

Clinical instructors will review the journal for accuracy, provide feedback and return the journal to the student in a timely manner. No points will be awarded for the clinical journal but points will be deducted from the student's final clinical evaluation score if the journal is not submitted weekly as directed by the clinical instructor.

The following questions should be answered in each journal entry:

1. What objectives did you set for clinical this week?
2. Did you meet your objectives? Why or why not?
3. What types of nursing interventions/skills did you perform/learn this week?
4. How did you prepare to care for your patients/families this week?
5. What were the strengths of your clinical performance this week?
6. What were the weaknesses of your clinical performance this week?
7. How were your learning needs supported?
8. What can your instructor do to better facilitate your learning?
9. Using the clinical evaluation tool criteria, how do you rate yourself on a 1-10 scale for this week's performance?

5-MINUTE CARE PLANS

Students will use a patient worksheet in order to keep track of information provided in report, assessment findings, laboratory results, and medications. An example is provided here but students are welcome to use whichever worksheet suits their individual organizational and learning needs best. **Shortly after getting report and completing the daily assessment during <u>each clinical day,</u> students should fill out the 5-minute care plan form <u>for each patient</u>. This is to decide on the priorities for each patient and the focus of care to be provided.** Guidelines for the 5-minute care plan include:

Shortly after getting report and completing the daily assessment during <u>each clinical day,</u> students should fill out the 5-minute care plan form <u>for each patient</u>. This is to decide on the priorities for each patient and the focus of care to be provided. Guidelines for the 5-minute care plan include:

- **One plan should be completed for each patient**
- **Be concise- keep it brief and to the point. No scientific rationales needed**
- **No formal nursing diagnoses are needed. Instead, use phrases/bullet points**
- **Make it quick – it should not take more than 5-10 minutes to complete**
- **Include feasible interventions and achievable goals**
- **Tailor the priorities and interventions to the patient**
- **<u>The care plan for each patient is to be completed by 10:00 a.m.</u>**

Students will review the care plan with the clinical instructor after it is completed to ensure that it is appropriate. **Students will implement the interventions and evaluate them at the end of the shift before post-conference.** The care plan and patient worksheet should be turned in to the clinical instructor at the end of post-conference. (Note: the 5-minute care plan and patient worksheet should be submitted with the larger nursing care plan when these assignments are due.)

Example of a 5-minute care plan:

Problem #1 Shallow breathing because of incisional pain	
Goals: 1. hourly use of IS 2. clear breath sounds bilat	
Interventions: 1. remind patient to use IS hourly 2. get patient up to chair twice	Evaluation of outcomes/Patient response: 1. patient did IS every 2 hours 2. patient up to chair once, exhausted afterward

5-MINUTE NURSING CARE PLAN TEMPLATE

Student name:

Date:	Patient room number:

Problem #1:	
Goal:	
Interventions: 1. 2.	Evaluation of outcomes/Patient response: 1. 2.

Problem #2:	
Goal:	
Interventions: 1. 2.	Evaluation of outcomes/Patient response: 1. 2.

5-MINUTE CARE PLAN GRADING RUBRIC

SCORE	GRADING CRITERIA
4 **Excellent**	All problems are high priority Goals are specific, appropriate and achievable All interventions are appropriate Patient outcomes/goal achievements are listed Care plan is completed by 10:00 a.m.
3 **Good**	Only one problem is high priority One goal is specific, appropriate and achievable Most interventions are appropriate Patient outcomes/goal achievements are listed Care plan is not completed by 10:00 a.m.

2 **Mediocre**	Only one problem is high priority One goal is specific, appropriate and achievable Some interventions are appropriate Patient outcomes/goal achievement are not listed Care plan is not completed by 10:00 a.m.
1 **Poor**	Neither problem is high priority Neither goal is specific, appropriate and achievable Some interventions are appropriate Patient outcomes/goal achievements are not listed Care plan is not completed by 10:00 a.m.
0	Assignment is more than 24 hours late or not handed in at all

PHYSICAL ASSESSMENT GRADING RUBRIC

SCORE	GRADING CRITERIA
4 **Excellent**	All body systems are assessed and documented in the patient's record Assessment is completed prior to medication administration Documentation is completed by the time indicated by the instructor Proper assessment techniques are always utilized by the student
3 **Good**	Most body systems are assessed and documented in the patient's record Assessment is completed prior to medication administration Documentation is completed by the time indicated by the instructor Proper assessment techniques are usually utilized by the student
2 **Mediocre**	Some body systems are assessed and documented in the patient's record Assessment is completed prior to medication administration Documentation is completed less than one hour after the due time Proper assessment techniques are sometimes utilized by the student
1 **Poor**	Few body systems are assessed and documented in the patient's record Assessment is not completed prior to medication administration Documentation is completed more than one hour after the due time Proper assessment techniques are rarely utilized by the student
0	The assessment is not completed or documented by the student

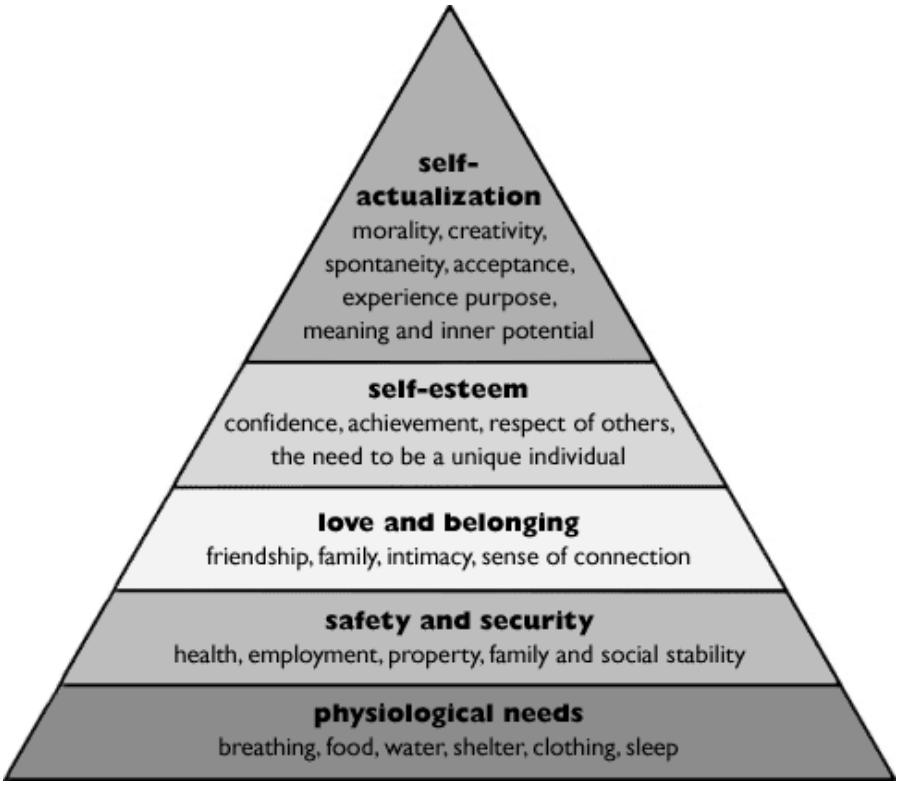
NURSING CARE PLAN ASSIGNMENTS

Students are to complete two nursing care plans during the clinical course using the care plan template posted on the course website in Moodle. There are four parts to be completed:

1. **Admitting diagnosis & patient assessment information:** Students are to list important assessment findings that impact nursing care planning. No complete sentences are needed; phrases with appropriate abbreviations may be used.
2. **Patient medication review:** Students are to list the generic and brand names for each medication so as to become familiar with both. Since many medications have multiple indications and some may be prescribed off-label, students are to indicate why THIS patient is taking the medication.
   - The last column is to list priority nursing considerations when giving the medication to THIS patient. This includes nursing assessments, precautions, review of relevant test results and patient teaching. Put information into your own words! Do not include irrelevant information (i.e. pregnancy category for male patients).
3. **Patient test results:** This includes abnormal laboratory blood test results as well as positive cultures, abnormal radiology and other types of diagnostic testing that was performed
   - The last column is to list priority nursing considerations when reviewing the test results for THIS patient. This includes relevance to prescribed and OTC medications, disease processes, precautions, nursing assessments and patient teaching.
4. **Nursing plan of care**: Students are to develop a full care plan for one of the problems identified in the 5-minute care plan. Students should utilize Maslow's hierarchy when setting patient priorities (see below). Students are to select the most relevant problems for the patient on that particular day, not why the patient was admitted.
   - Nursing diagnoses must be written out appropriately with *related to* and *as evidenced by* statements. (Remember that *risk for* diagnoses do not have *as evidenced by* statements because the condition has not occurred yet.) Make sure that sufficient patient assessment information is included to justify the use of the diagnosis. The evaluation portion of the care plan is to determine whether or not the patient goals were met, not whether or not the interventions were carried out.

The nursing care plan is to be submitted as .doc or .docx on the Moodle course website for grading. Students must score at least 70% on each care plan in order to pass NRS 2325.

MASLOW'S HIERARCHY OF NEEDS



Students should utilize this outline when prioritizing care for patients.

The needs at the bottom of the pyramid are most important and must be addressed before needs that appear higher up.

Patients cannot address high-level needs (i.e. friendship, inner peace) until the basic human physiology needs (breathing, water, food) have been met.

Maslow's physiological needs correlate with the ABCs of nursing care.

NURSING CARE PLAN GRADING RUBRIC

	Meets Criteria Fully	Somewhat lacking	Seriously lacking
Assessment (30 points)	**(30)** Medication and test lists filled out thoroughly and completely	**(20)** Medication OR test list is missing a few pieces of information	**(10)** Medication AND test lists are missing many pieces of information
Diagnosis (15 points)	**(15)** Nursing diagnoses are appropriate, high priority and in proper format Related problems are connected in concept map	**(10)** Nursing diagnoses are not appropriate/high priority OR are not formatted correctly Some related problems are connected in concept map	**(5)** Nursing diagnoses are not appropriate/high priority AND are not formatted correctly Related problems are not connected in concept map
Goals (15 points)	**(15)** Outcomes are specific, measurable and identified for priority diagnosis	**(10)** Outcomes are not specific, measurable OR are not identified for priority diagnosis	**(5)** Outcomes are not specific, measurable AND are not identified for priority diagnosis
Implementation (15 points)	**(15)** All interventions are appropriate to achieve outcomes	**(10)** Most interventions are appropriate to achieve outcomes	**(5)** Few interventions are appropriate to achieve outcomes
Evaluation (15 points)	**(15)** Evaluation is complete using SOAP format	**(10)** Evaluation is not complete OR is not in SOAP format	**(5)** Evaluation is not complete AND is not in SOAP format
APA format (10 points)	**(10)** Grammatically correct, fluid and well-written, without spelling or typing errors Meticulously follows APA style for references and internal citations. A properly formatted title page is included.	**(7)** No spelling errors, perhaps minor grammatical or punctuation errors Few errors in APA style for references and internal citations. An improperly formatted title page is included.	**(3)** Major spelling, grammatical or punctuation errors, awkward or confusing writing; Multiple errors in APA style for references and internal citations. No title page is included.

SUGGESTIONS FOR USING CLINICAL TIME WISELY

Before getting report:

- Long onto computer and get basic patient information (admitting diagnosis, history/physical, current plan of care, recent progress notes)
- Get a rhythm strip if patient is on Clinical skills
- Make note of any medications due within 60-90 minutes of shift, blood sugars, insulin

Report:

- Get report from nurse ASAP, complete patient assessment with vital signs
    - Physical assessment
    - LOOK HIGH- IVs, NG tubes, oxygen
    - LOOK LOW- foley catheters, chest tubes
- Give report to instructor with priority plan for day
- Check blood sugar and administer insulin if necessary
- Document patient assessment
- Let staff nurse know that you are interested in performing any procedures on other patients

Prepare for medication administration:

- All medication information, pertinent lab findings and vital signs must be written down along with assessment findings in order to pass medications
- Do not wait around to pass medications- finish assessments, assist other students while waiting

After medication administration:

- Finish any necessary documentation
- Provide hygiene, ambulation, turning, feeding
- Assist other students and staff if needed
- Perform necessary treatments (trach care, dressing changes, etc.)
- Look up lab results and radiology reports in computer
- Check vital signs if needed
- Review documentation with instructor

After break/mealtime:

- Pass next set of medications
- Check vital signs if needed
- Complete day shift charting (if 7 am- 7 pm shift)

Before leaving unit:

- Make final rounds on patients
- Ensure rooms tidy, empty linens and garbage
- Give report to the staff nurse
- Note achievement of goals on patient priority plan sheet

Work together as a team! Offer to help staff nurses and nursing assistants with other patients. Make sure to schedule your day according to your patient's needs and medication times. Bring some non-perishable snacks and drinks in case you can't get down to the cafeteria at meal times. Students should keep an extra pair of white scrubs in their car in case of contamination with body fluids.

CLINICAL EVALUATION TOOL

- This evaluation tool consists of 10 standards that are based on the ANA Standards of Practice and the AACN Essentials.
- Measurement criteria are listed for each standard. These criteria are intended to illustrate examples of expected objectives that should be mastered in clinical experiences. Please note that not every example will apply in every situation or at each level of the curriculum.
- Each standard has suggested criteria that should be met for the clinical experience. Some criteria may not be appropriate for all levels of the curriculum. For example, students at the sophomore level are expected to be aware of and show evidence of understanding each of the criteria and its applicability to clinical practice. At the junior level, students are expected to begin demonstrating use of the criteria during clinical practice situations. At the senior level, students are expected to articulate both their use of the criteria in clinical practice, and other nursing implications related to the criteria. Each level subsumes the ones under it, and student behaviors are expected to reflect this progression.

Instructions to clinical faculty:

- The midterm evaluation is to be given midway way through the clinical experience. Its purpose is to inform the student of their clinical performance and is graded on a pass (P)/fail (F) basis using the criteria outlined in each standard. This evaluation will include a written assessment (see Clinical Evaluation Tool Midterm Summary) highlighting the student's current strengths and areas for improvement for the remainder of the clinical experience. Clinical faculty may also provide additional information and anecdotal notes/work plan if needed.
- At the midterm evaluation, if a student earns a failing mark (6.9 or below) for a particular standard, specific documentation must be provided to support this failing mark. A plan should be developed with the student on how a passing mark can be achieved.
- The final evaluation is given to the student AFTER the entire clinical rotation is completed and MUST reflect faculty assessment through the last day of the clinical course. The student's performance will be evaluated for each standard using a 10 point scale (see next page). A total of 10 points can be earned for each of the 10 standards, so possible final evaluation scores may range from 0-100 points. A written assessment of the student's strengths and progress toward addressing areas for improvement for the future will also be included as well as any additional documentation necessary to explain the student's final grade (see Clinical Evaluation Tool Final Summary). The final clinical grade should be calculated as per instructions from the Faculty of Record (FOR).
- At the final evaluation, if a student earns a failing grade (6.9 or below) for a particular standard, specific documentation must be provided to support this grade.
- Complete tool using black or blue ink only

CLINICAL EVALUATION TOOL POINT SCALE

The following criteria will be used to evaluate the student's clinical performance within each standard.

9.0-10.0

- Applies theoretical knowledge accurately each time.
- Performs safely and accurately each time behavior is observed without supportive cues from the preceptor/instructor.
- Demonstrates dexterity.
- Spends minimal time on task.
- Appears relaxed and confident during performance of task.
- Focuses on client while giving care.

8.0-8.9

- Applies theoretical knowledge accurately with occasional cues.
- Performs safely and accurately each time behavior observed with supportive cues from the preceptor/instructor.
- Demonstrates coordination, but uses some unnecessary energy to complete behavior/activity.
- Spends reasonable time on task.
- Appears generally relaxed and confident; occasional anxiety may be noticeable.
- Focuses on client initially; as complexity increases, focuses on task.

7.0-7.9

- Identifies principles, but needs direction to identify application.
- Performs safely and accurately each time observed.
- Requires frequent supportive and occasional directive cues.
- Demonstrates partial lack of skill and/or dexterity in part of activity; awkward.
- Takes longer time to complete task; occasionally late.
- Appears disorganized in planning nursing intervention.
- Focuses primarily on task or own behavior, not on client.

6.9 and below

- Identifies fragments of principles or unable to identify principles at all.
- Applies principles inappropriately or is unable to apply principles at all.
- Performs safely under supervision, not always accurate or performs in an unsafe manner.
- Requires continuous supportive and directive cues.
- Demonstrates lack of skill; uncoordinated in majority of behavior or unable to demonstrate behavior.
- Performs tasks with considerable delay; activities are disrupted or omitted.
- Appears incapable of carrying out nursing intervention.
- Attempts activity or behavior, yet is unable to complete.
- Focuses entirely on task or own behavior.
- Lacks organization; non-productive.

Adapted from tool developed by Krichbaum, K. from Bondy, K. (1983). Crtierion-referenced definitions for rating scales in clinical evaluation. *Journal of Nursing Education, 22*, 376-382. (University of Minnesota School of Nursing)