**N431 Adult Health II**
**TEACHING PLAN INSTRUCTIONS AND EVALUATION**

STUDENT NAME: Ashely Bode                                            Date: 10/07/19
Use the format page included for preparing the written component of the teaching plan. Students will be evaluated on the written plan (15 points) and on the presentation of the teaching plan (10 points). Total Points possible = 25 points.

<u>SCORE</u>

I.    Evaluation of the **written component**

**Assessment of patient/client**

**(3 points)**            _____

Prior knowledge of subject to be taught
Determine patient's motivation to learn content
Health beliefs/values
Psychosocial adaptations/adjustment to illness
Compliance with health care protocols
Assess patient's ability to learn
Developmental level
Physical capabilities/health status
Language skills/literacy
Level of education

**Nursing Diagnosis Identified**            **(1 point)**            _____

**Planning**            **(3 points)**

_____

State objectives and outcomes: Include at least one from each learning domain:
Cognitive, Affective & Psychomotor

**Interventions**

**(2 points)**            _____

List the content to be included in instruction. Be specific and accurate.
Logical sequence.
Simple to complex.
Organized

**Methods/Teaching Tools**            **(2 points)**

_____

Instructional methods to be used:
Examples are: Discussion
Question & Answer
Demonstration/Return Demonstration
Strategies to keep patient's attention
Methods to include patient in teaching/participation

**Evaluation**            **(3 points)**

_____

Determine achievement of learning objectives based on expected
Outcomes. Identify strengths/weaknesses, Suggest modifications to plan;
i.e. what would have made it better?

**References Listed in APA format.**            **(1 point)**            _____

**TOTAL CONTENT**            _____/15

II.    Evaluation of **teaching presentation**            **(10 points)**            _____ /10
Introduction of content, Patient put at ease, Eye contact,
Clear speech and organized presentation, Environment conducive to learning,
Family included, Accuracy of info, Validation of learning status, Use of teaching aids,
Appropriate non-verbal body language etc.
Date Submitted:_____

**Total points** _____ **/25**

Student Name: Ashley Bode

Subject: Discharge Teaching new medication regime

Nursing Diagnosis: Deficient Knowledge r/l new medication regime

| Relevant Assessment Data (see instructions) | Patient Outcomes (see instructions re: 3 domains of learning) | Teaching Outline (be specific and use a logical sequence) | Teaching Tools (see instructions) | Evaluation (see instructions) |
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| Patient had very little medical history and has never been on any blooding thinning medications.<br><br>Patient was very cooperative and willing to learn needed steps for recovery.<br><br>Patient health beliefs are diet and exercise.<br><br>Patient has adjusted well to injury and understands compliance to following medical treatment plan.<br><br>Patient turned off TV and held discharge papers to focus on learning goals and to ask any questions. Patient had normal developmental level and was able to understand the teaching.<br><br>Patient has limited physical capabilities due to femur fracture.<br><br>Patient spoke clear and was able to read discharge papers. Patient has college degree. | Patient will demonstrate or verbally state understanding of discharge teaching<br><br>Patient will express positive attitude in learning<br><br>Patient will demonstrate skills required before discharge. | Patient was informed of discharge and handed discharge papers. First page included a summary of hospital stay including patients last set of vitals.<br><br>Patient was instructed on medications including a new start of low dose aspirin. Patient was instructed on taking low dose aspirin as prophylaxis to prevent blood clots. Verbally stated knowledge of receiving (lovenox) enoxaparin during hospital admission and taking aspirin would be a continuation.<br><br>Patient instructed to be non-weight bearing on fractured leg and instructed how and when to use crutches.<br><br>Explained to patient that follow up care would be required with several doctors and explained the appointments have been made. Patient given paper of all doctors' names, numbers, and locations of appointments.<br><br>Asked patient if they had any questions. Clarified doctors appoints. Patient had no further questions. | Patient was handed discharge papers and started at the top.<br><br>Went over diagnosis and last set of vital signs before being discharged.<br><br>Discussed medications and explained to patient that they will be started on a low dose (81 mg) aspirin and explained this is to prevent blood clots. Explained to patient they had received enoxaparin (lovenox) as prophylaxis for blood clots and taking the aspirin will continue this process.<br><br>Patient demonstrated ability to use crutches without difficulties.<br><br>Patient was asked to repeat instructions to assess comprehension of information. | Patient was able to understand discharge teaching and verbally express understanding.<br><br>Patient had positive attitude, listened and was willing to learn.<br><br>Patient demonstrated use of crutches and verbally stated understanding to be non-weight bearing.<br><br>A strength of the teaching was the patient understanding the teaching. Patient communicated well and fully understood the instructions being given.<br><br>Overall teaching went well. One thing that I would change is the pace of conversation. Patient was eager to leave and the teaching felt a little rushed. |

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**Reference(s):**

Hinkle, J. L., Brunner, L. S., Cheever, K. H., & Suddarth, D. S. (2014). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Lippincott Williams & Wilkins.

Ralph, S. S., & Taylor, C. M. (2014). *Sparks and Taylors nursing diagnosis reference manual*. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins Health.