Self Assessment of Nursing Practice Standards

Cheryl Howard

NURS 440 Ferris State University
Abstract

This paper is a self assessment of registered nurse and BSN nursing student Cheryl Howard’s nursing practice standards. First, Ms Howard’s personal nursing background is described. Then the American Nurses Association (ANA) practice standards and code of ethics is defined and explained. Ms Howard’s personal experience is applied to ANA practice standards. Lastly, Ms. Howard’s personal professional development plan is outlined which includes a goal, action plan and evaluation for every ANA practice standard.

Keywords: nurse, practice standards, personal development plan, RN
Self Assessment of Nursing Practice Standards

This paper will outline nursing practice standards then provide a self assessment of my (Cheryl Howard) personal nursing practice in each area. It is important for the professional nurse to evaluate personal nursing practice as it relates to professional nursing practice standards. Autonomy and self-regulation is a characteristic of professional nursing. Nurses are accountable to both themselves and also to their clients (Kearney-Nunnery, 2008). Self evaluation contributes personal accountability and upholds quality standards in order to provide critical analysis of individual nursing practice (Kearney-Nunnery, 2008). A professional development plan will then be explained in order to address goals in each of the practice standard areas.

**Personal Nursing Background**

I have a full time position as a registered nurse case manager (RNCM) for the MI Choice Medicaid Waiver Community Based Program focusing on clients transitioning from a nursing facility to a community setting. I have practiced case management nursing in this position since graduating with my Associates Degree in Nursing. Before my career as a registered nurse (RN), my former position was in social work as a home visiting educator and case manager. My career as an RN has further developed my case management skills from a holistic, medical, scientific, and evidence based practice perspective. Case management is “in my blood” and I enjoy the challenge of juggling a busy caseload. In order to gain a wider variety of skills in my nursing career, I also work as a registered nurse (RN) in a long term care (LTC) facility in a part time capacity. This position has allowed me to sharpen my clinical, hands on nursing skills by provision of direct care to clients, delegation to assistive personnel and collaboration with medical providers.
ANA Standards of Practice

The American Nurses Association (ANA) has developed nursing practice standards in the areas of assessment, diagnosis, outcomes identification, planning, implementation, coordination of care, and evaluation (2010). The ANA has also outlined a code of ethics as a standard of professional performance (2010). These principles are important because they hold nurses to a high standard. The American public views nursing as a trusted profession. Nursing is a trusted profession because there is a high degree of ethics expected in practice (Gallup, 2010). First, each of the ANA’s nursing practice standards and code of ethics will be defined. These principles will then be applied to my individual nursing practice. By doing this, I will examine my competency in each area in order to develop goals for personal professional development.

Assessment

ANA standard. “The registered nurse collects comprehensive data pertinent to the healthcare consumer’s health and/or the situation” (ANA, 2010, p. 32). Every person is unique and requires a systematic, multi-faceted assessment. Assessment should include the person’s preferences, needs and current knowledge using evidence based assessment techniques. Family dynamics should be taken into consideration and others included in the assessment. Barriers need to be identified. Data should be synthesized, prioritized and documented (ANA, 2010).

Personal behaviors. In my position as an RNCM, assessment is a skill used repeatedly on a daily basis. In order to plan effective services for clients, I have to focus intently on a detailed, person-centered assessment. If the client is in agreement, I always make an effort to include family members and significant others in the assessment because I have learned that they are an integral part of client’s environment and well being. My job requires that I use a computer program for assessment data collection called the Portable Information Collection Kit
There is also assessment paperwork used in this position. I have had extensive practice in collecting assessment data in both electronic and written formats. Based on assessment information, I prioritize the data for use in developing diagnoses and further planning.

In my position as a LTC RN, assessment is a skill I practice throughout every shift. I conduct physical assessments and document using computer charting to satisfy Medicare requirements and to assess residents who are exhibiting abnormal behaviors or physical symptoms.

**Diagnosis**

**ANA standard.** “The registered nurse analyzes the assessment data to determine the diagnoses or the issues” (ANA, 2010, p. 34). Diagnoses are derived from the validated assessment data. A standardized classification system and support tools are used when available. Actual and potential risks that affect a person’s health are identified and documented (ANA, 2010).

**Personal behaviors.** In my position as an RNCM, every nursing assessment results in multiple diagnoses. PICK assessment will automatically “trigger” certain diagnoses areas depending on areas in the assessment that were check-marked. There are also diagnoses that do not automatically trigger that I personally identify as a need. For example, many of my clients are fall risks so I always make sure to include this diagnosis when appropriate, even when this need is not automatically triggered so that a care plan can be developed to address this problem and prevent fall related injuries. One support tool that I use to identify additional diagnoses is the Nursing Facility Level of Care Determination (NFLOCD). This is a standardized tool widely used in the field of geriatrics in many settings.
In my position as a LTC RN, I do not formally develop written nursing diagnoses and care plans. I do, however, informally use established nursing diagnoses and care plans to carry out nursing activities. When there is a need for a new or modified nursing diagnosis based on my assessment I collaborate with the nurse manager so that she can adjust or develop care plans.

**Outcomes identification**

**ANA standard.** “The registered nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation” (ANA, 2010, p.35). Outcomes are developed with the person, family, and health care providers as appropriate. A risk, benefits, costs, evidence based practice, prognosis and values must be taken into consideration. Outcomes must be ethical, culturally sensitive, measurable, time sensitive, and facilitate continuity of care. Expected outcomes should be documented and modified according to changes in the person’s status (ANA, 2010).

**Personal behaviors.** In my position as an RNCM, I develop outcomes for the clients’ every diagnosis. I make a conscious effort to develop outcomes that are culturally sensitive and ethical. Due to the nature of the ongoing services planned, these outcomes are general and loosely structured as it relates to measurability.

In my position as a LTC RN, I do not formally develop care plans or outcomes. I do use the outcomes in established care plans as a guide for my care and documentation. I consult with the nurse manager for any modifications or consultation needed regarding care plan outcomes.

**Planning**

**ANA standard.** “The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes” (ANA, 2010, p.37). Planning should be individualized and take a holistic perspective and personal factors into account. The plan should be prioritized
and include the person, family and others as appropriate. Each diagnosis should be addressed and provide health promotion, prevention, support and alleviate suffering. The plan should incorporate a timeline, use evidence based practice and take economic factors into consideration. A teamwork approach should be used and alternatives should be explored with the person. Ongoing assessment and modification of the plan should be integrated with the individual’s response and outcome indicators. The plan should use standardized language and comply with regulatory standards (ANA, 2010).

**Personal behaviors.** In my position as an RNCM, every plan is individualized to meet the needs of that particular client. I develop the plan in a team effort with the client, their family, my social worker partner and nursing facility multi-disciplinary staff. Care planning is unique in long term, home-based services because it does not focus on acute problems. This is a type of care planning which is different than what I practiced during nursing school. Plans are usually focused on supportive services or education that will allow the client to live in a community setting. My care plans are evaluated and modified often in order to maintain the most effective plan possible. No matter how well a plan is laid out, there are always glitches; modifications must be made on an ongoing basis in order to support the objective (for the client to remain safe in a community setting). Any changes required are always discussed with the client in order to get their input.

In my position as a LTC RN, I do not participate in the formal planning process however, situations occur throughout my shift that I have to think on my feet and modify a plan to meet the residents’ needs. I can then document and discuss the modification with the nurse manager in order to address changes needed in the written care plan.

**Implementation**
ANA standard. “The registered nurse implements the identified plan” (ANA, 2010, p. 38). Evidence based interventions and treatments should be using caring behaviors and in a timely manner. The nurse partners with the person and others to implement care. Healthcare technologies are used measure and document care and optimize outcomes. Collaboration and different styles of communication are utilized. Appropriate knowledge about health problems and cultural diversity is implemented to promote the person’s optimal level of participation. Implementation includes coordination of care, health teaching and health promotion (ANA, 2010).

Personal behaviors. In my position as an RNCM, I am not the person who carries out most of the implementations developed in the plan. Case management is focused on care coordination rather than implementing individual interventions. There is constant communication in person, by fax, phone and email between myself, the client, caregivers, home care agencies, medical providers, supervision and any other entity involved in the client’s care. I use computerized progress notes to document the ongoing implementation of the plan. I follow strict program guidelines for follow up and monitoring timeliness of care plan implementation.

In my position as a LTC RN, care plan implementation is the bulk of my job duties. I administer medications and treatments. I conduct physical assessments and implement hands on interventions. I delegate duties and supervise assistive personnel and licensed practical nurses. I use health care technology such as computers, vital sign measurement tools, wound vats, oxygen, feeding and IV pumps. I am in constant communication with the LTC health care team such as physicians, therapists, dietician, management and clerical support staff.
Evaluation

ANA standard. “The registered nurse evaluates progress toward attainment of outcomes” (ANA, 2010, p. 45). Evaluation of the planned strategies is systematic and ongoing process following the care plan measurements that takes place. Diagnoses, outcomes, plans and implementations are reviewed revised as needed with the person and others involved. Evaluation data is disseminated within regulatory guidelines. Unwarranted or unwanted treatments are minimized by participation in intervention assessment. All evaluation results are documented (ANA, 2010).

Personal behaviors. In my position as an RNCM, I conduct and document detailed, formal reassessments every 3 months with every client. However, during those three months I am in constant communication with the person and others involved in order to evaluate the care plan and make revisions as necessary. I often rearrange home service providers, give teaching and instruction and arrange durable medical equipment to meet clients’ changing needs. Precise documentation is an ongoing process in my job that tells a “story” of what is happening with every client on my caseload. I strive to be compliant with program and legal guidelines in my documentation and care plan evaluations.

In my position as a LTC RN, I evaluate the effectiveness of my interventions on an ongoing basis throughout my shift. I document evaluations using the computer medical record software at my facility. I do not conduct formal and thorough evaluations of established care plan however I give evaluation feedback on an ongoing basis for residents through charting, collaboration with my nurse manager, in shift report and team meetings. I communicate with physicians as needed in reporting evaluation of assessments in order to address care needs and receive orders.
Ethics

**ANA standard.** “The registered nurse practices ethically” (ANA, 2010, p. 47). Ethical nursing includes protecting the person’s autonomy, dignity, rights, values, beliefs and health equity. Confidential should be upheld within regulatory guidelines. The patient and their family are included in the healthcare team; informed decision making is supported. Action should be taken when illegal, unethical or inappropriate situations may endanger the patient (ANA, 2010).

The nurse’s code of ethics further defines ethical nursing. Non-discriminatory care should be provided in a way that promotes and advocates for the health and safety of the patient. The nurse is responsible, accountable and obligated to provide optimum patient care. Integrity, safety and competence must be maintained. The nurse should focus on personal and professional growth as well as contribution to the nursing profession’s advancement as a whole. Professional association activity is necessary to collaborate with other professionals and the public to meet health needs, maintain integrity of professional practice and shape social policy (ANA, 2001).

**Personal behaviors.** In both of my positions as an RNCM and a LTC RN, I have a strong drive to practice ethical nursing. I believe that confidentiality, autonomy and health equity are of utmost importance. I ensure that my clients and residents values and wishes are respected. I always ensure who the legal decision maker is, before getting consent for care or developing care plans. I endeavor to provide quality, evidenced based care for my clients. Even in a very busy and hectic working situation I make every effort to maintain professionalism and practice ethically. I am a strong patient advocate; I voice my concerns and take action when their rights or wishes are not being followed. I believe in the importance of professional growth. I am currently taking nursing courses and will finish my Bachelor of Science in Nursing (BSN) this year. I plan to be certified in case management nursing in the future. I am currently a
member of the Michigan Nurses Association which is a professional organization that collectively addresses economic and nursing practice issues in Michigan (MNA, 2010).

**Professional Development Plan (PDP)**

A personal, individualized professional development plan has been created in order to articulate clear goals toward attaining and maintaining competency in each nursing practice standard. An action plan and evaluation plan have been designed in each of the nursing practice standard areas to help achieve these goals.

**Assessment PDP**

**Assessment PDP goal.** I feel that I even though I practice my assessment skills daily in both of my jobs, I think I would benefit from gaining assessment skills and experience in a nursing field other than case management or long term care. Therefore I would like to further develop my assessment skills by obtaining a part time position in an acute care nursing setting by December 31, 2013.

**Assessment PDP action plan.** In order to complete this goal I will first finish my BSN classes as planned by December 2012. Beginning January 2013, I will revise my resume and update my portfolio. Beginning March 2013, I will apply for at least three part time acute care nursing position near my residence. I will follow up those applications with an in-person, phone call or written contact. I will attend interviews as appropriate. If offered a position that fits my requirements, I will accept a part time acute care position by December 31, 2013 to supplement my full time case management position. I may or may not continue to work as a LTC RN depending upon the circumstances at the time.

**Assessment PDP evaluation plan.** To evaluate this plan I will re-evaluate my personal situation to see if this goal fits my wishes and circumstances. Ongoing re-evaluation of this goal
will take place in January 2013 and July 2013. By December 31, 2013, I will know if I have achieved my goal if I have gained a part time acute care nursing position.

**Diagnosis PDP**

**Diagnosis PDP goal.** The case management computer software used in my RNCM position currently “triggers” nursing diagnoses based on the computerized nursing assessment. I would like to make sure that I do not rely on automatic triggers for development of nursing diagnoses in clients’ care plans. Therefore, I have a goal to include at least one non-triggered diagnosis when possible for every new client I assess in order to make sure that I am critically thinking through my assessment information to develop thorough care plans. This goal should take place for every client on my caseload by December 2012.

**Diagnosis PDP action plan.** In order to complete this goal I will create a reminder sign to post at my desk near my computer. I will communicate this goal to my supervisor so that she can assist me in focusing on this goal. Every three months when reassessments and care plans reviews are due for my clients I will check to make sure that I have included at least one non-triggered diagnosis in each client’s care plan.

**Diagnosis PDP evaluation plan.** By December 31, 2012, I will evaluate every client’s care plan on my caseload to determine if there is one non-triggered diagnosis included.

**Outcomes Identification PDP**

**Outcomes identification PDP goal.** The outcomes I develop in my RNCM position are loosely structured and not time specific. I would like to be more precise with identification of outcomes. Therefore, I have a goal to increase specificity of my client’s care plan outcomes by using a measurable time frame for every outcome on every care plan by December 31, 2012.
Outcomes identification PDP action plan. The action plan for this standard will be similar to my diagnosis action plan. In order to complete this goal I will create a reminder sign to post at my desk near my computer. I will communicate this goal to my supervisor so that she can assist me in focusing on this goal. Every three months when reassessments and care plans reviews are due for my clients I will check to make sure that I have included a specific, measurable time frame on every outcome.

Outcomes identification PDP evaluation plan. By December 31, 2012, I will evaluate every client’s care plan on my caseload to determine if every client’s care plan outcomes have specific measurable time frames.

Planning PDP

Planning PDP goal. Care planning for home based services care management nursing was not something I learned in nursing school. Since I was hired as an RNCM, I have learned this type of care planning on the job for the most part. I would like to receive some formal training on creating care plans specifically focused on my program and case management nursing. This goal should take place by December 31, 2012.

Planning PDP action plan. I will discuss with my supervisor the desire to receive some type of formal care planning training related. If she is not able to connect me with formal training, I will seek out information regarding this topic. If I find an appropriate resource, I will request approval for my work to sponsor my case management care plan training. I will attend the training as arranged and scheduled.

Planning PDP evaluation plan. By September 30, 2012, I will evaluate the progress toward this goal as it relates to 1) my employers support of attending the desired training and 2) availability of case management care planning training. This half-way mark evaluation will be
done in order to see if modifications to my plan are needed. By December 31, 2012, I will evaluate my goal by having completed formal training in case management care planning.

**Implementation PDP**

**Implementation PDP goal.** Because I am a recent nurse graduate, I feel that I need continued practice in implementation of hands-on, direct care nursing. My goal in this area will be that I gain nursing experience by continuing to work a part time nursing job at least 2 days monthly in any field that will allow me to practice clinical, hands-on nursing intervention skills. This goal is ongoing and does not have an end date.

**Implementation PDP action plan.** To achieve this goal I will remain in my LTC RN position. If I am interested in another nursing field, I will go through the application process. I will not resign from my LTC RN position with 2 week’s notice until I have obtained another position. This will ensure that I continue to work toward my goal of working a minimum of 2 days monthly.

**Implementation PDP evaluation plan.** On a monthly basis on the last day of the month, I will review my schedule to determine if I have met my goal. If I have not met my goal, I will speak to my supervisor about increasing the number of days worked or seek a new position that will allow me to meet my goal.

**Evaluation PDP**

**Evaluation PDP goal.** As an RNCM, it is program policy to reassess and evaluate care plans of every client, every three months and ongoing as needed. Sometimes things can get very busy and I may not thoroughly evaluate care plans for clients until the three month mark. I would like to pay more attention to care plans throughout the three month reassessment cycle so that I can track effectiveness and modify care plans more frequently if needed. My goal is to evaluate
every client’s care plan outcomes on an ongoing basis at least once between the required three month reassessment cycles in order to be proactive for any needed care plan modifications.

**Evaluation PDP action plan.** I will keep a running log of all clients. In this log I will record the following data: name, date reassessment/care plan evaluation is due. For every client, I will write on my calendar the date which is 6 weeks prior to reassessment due date. In this way I can systematically ensure to review those client’s care plans between reassessments and work with the client to make adjustments as needed.

**Evaluation PDP evaluation plan.** By December 31, 2012, I will evaluate the effectiveness of my plan and outcome of my goal by checking my calendar. I will see if I was able to follow through with my plan and assess whether or not more frequent care plan evaluation has affected my clients’ services, health and well being in a positive way.

**Ethics PDP**

**Ethics PDP goal.** I have a strong drive to conduct myself in an ethical, honest and professional manner. I feel a responsibility personally and collectively to uphold ethical standards of a nurse. I have learned in my BSN classes how vitally important it is to advocate collectively for health care needs of the public and shape social policy. I believe in the progress and initiatives that the ANA works toward. My goal is to keep up to date with ANA posted information and officially become a member of the ANA by May 31, 2013.

**Ethics PDP action plan.** I will continue to visit the ANA website on a monthly basis to keep myself informed of ANA updates and information. By May 2013 I will purchase and enroll in an ANA membership. The ANA membership fee is $183 yearly. Currently I have no room in my budget for the membership fee. After my BSN classes are complete in December 2012, I will set money aside monthly in order to purchase an ANA membership in May 2013.
**Ethics PDP evaluation plan.** On May 31, 2012, I will evaluate whether or not I have met my goal of becoming an ANA member. If I have not met my goal at that time I will extend the time frame so that I can save enough money to purchase an ANA membership.

**Conclusion**

Professional nursing practice standards and ethics are vitally important principles that have shaped the face of nursing today. Ongoing self evaluation of these standards helps to guide personal nursing practice. ANA nursing practice standards include guidelines for assessment, diagnosis, outcomes identification, implementation, evaluation and a code of ethics. I am a recent RN graduate with work experience in case management and long term care nursing. I have systematically applied these professional standards to my personal practice in order to develop a PDP. This PDP has outlined professional goals that are specific and measurable, which I hope will improve my nursing practice and help me grow as a nurse.
References


# Checklist for Submitting Papers

<table>
<thead>
<tr>
<th>Date</th>
<th>Proofread for: APA Issues</th>
</tr>
</thead>
</table>
| 4-19-12 JA | 1. **Page Numbers:** Did you number your pages using the automatic functions of your Word program?  
[p. 230 and example on p. 40] |
| 4-19-12 JA | 2. **Running head:** Does the Running head: have a small “h”? Is it on every page? Is it less than 50 spaces total? Is the title of the Running head in all caps? Is it 1/2” from the top of your title page?  
(Should be a few words from the title of your paper).  
[p. 229 and example on p. 40] |
| 4-19-12 JA | 3. **Abstract:** Make sure your abstract begins on a new page. Is there a label of Abstract and it is centered at the top of the page? Is it a single paragraph? Is the paragraph flush with the margin without an indentation? Is your abstract a summary of your entire paper? Remember it is not an introduction to your paper. Someone should be able to read the abstract and know what to find in your paper.  
[p. 229 and example on p. 40] |
| 4-19-12 JA | 4. **Introduction:** Did you repeat the title of your paper on your first page of content? Do not use ‘Introduction’ as a heading following the title. The first paragraph clearly implies the introduction and no heading is needed.  
[p. 25 and example on p. 41] |
| 4-19-12 JA | 5. **Margins:** Did you leave 1” on all sides?  
[p. 229] |
| 4-19-12 JA | 6. **Double-spacing:** Did you double-space throughout? No triple or extra spaces between sections or paragraphs except in special circumstances. This includes the reference page.  
[p. 229 and example on p. 40-59] |
| 4-19-12 JA | 7. **Line Length and Alignment:** Did you use the flush-left style, and leave the right margin uneven, or ragged?  
[p. 229] |
| 4-19-12 JA | 8. **Paragraphs and Indentation:** Did you indent the first line of every paragraph?  
See P. 229 for exceptions. |
| 4-19-12 JA | 9. **Spacing After Punctuation Marks:** Did you space once at the end of separate parts of a reference and initials in a person’s name? Do not space after periods in abbreviations. Space twice after punctuation marks at the end of a sentence.  
[p. 87-88] |
| 4-19-12 JA | 10. **Typeface:** Did you use Times Roman 12-point font?  
[p. 228] |
| 4-19-12 JA | 11. **Abbreviation:** Did you explain each abbreviation the first time you used it?  
[p. 106-111] |
| 4-19-12 JA | 12. **Plagiarism:** Cite all sources! If you say something that is not your original idea, it must be cited. You may be citing many times…this is what you are supposed to be doing!  
[p. 170] |
| 4-19-12 JA | 13. **Direct Quote:** A direct quote is exact words taken from another. An example with citation would look like this:  
“The variables that impact the etiology and the human response to various disease states will be explored”  
(Bell-Scriber, 2007, p. 1).  
Please note where the quotation marks are placed, where the final period is placed, no first name of author, and inclusion of page number, etc. Do all direct quotes look like this?  
[p. 170-172] |
| 4-19-12 JA | 14. **Quotes Over 40 Words:** Did you make block quotes out of any direct quotes that are 40 words or longer?  
[p. 170-172] |
| 4-19-12 JA | 15. **Paraphrase:** A paraphrase citation would look like this:  
Patients respond to illnesses in various ways depending on a number of factors that will be explored (Bell-Scriber, 2007).  
It may also look like this: Bell-Scriber (2007) found that…… |
16. **Headings:** Did you check your headings for proper levels? [p. 62-63].

17. **General Guidelines for References:**
   - **A.** Did you start the References on a new page? [p. 37]
   - **B.** Did you cut and paste references on your reference page? If so, check to make sure they are in correct APA format. Often they are not and must be adapted. Make sure all fonts are the same.
   - **C.** Is your reference list double spaced with hanging indents? [p. 37]

### PROOFREAD FOR GRAMMAR, SPELLING, PUNCTUATION, & STRUCTURE

| 4-19-12 JA | 18. Did you follow the assignment rubric? Did you make headings that address each major section? (Required to point out where you addressed each section.) |
| 4-19-12 JA | 19. Watch for run-on or long, cumbersome sentences. Read it out loud without pausing unless punctuation is present. If you become breathless or it doesn’t make sense, you need to rephrase or break the sentence into 2 or more smaller sentences. Did you do this? |
| 4-19-12 JA | 20. Wordiness: check for the words “that”, and “the”. If not necessary, did you omit? |
| 4-19-12 JA | 21. Conversational tone: Don’t write as if you are talking to someone in a casual way. For example, “Well so I couldn’t believe nurses did such things!” or “I was in total shock over that.” Did you stay in a formal/professional tone? |
| 4-19-12 JA | 22. Avoid contractions. i.e. don’t, can’t, won’t, etc. Did you spell these out? |
| 4-19-12 JA | 23. Did you check to make sure there are no hyphens and broken words in the right margin? |
| 4-19-12 JA | 24. Do not use “etc.” or “i.e.” in formal writing unless in parenthesis. Did you check for improper use of etc. & i.e.? |
| 4-19-12 JA | 25. Stay in subject agreement. When referring to 1 nurse, don’t refer to the nurse as “they” or “them”. Also, in referring to a human, don’t refer to the person as “that”, but rather “who”. For example: The nurse that gave the injection….” Should be “The nurse who gave the injection….” Did you check for subject agreement? |
| 4-19-12 JA | 26. Don’t refer to “us”, “we”, “our”, within the paper…this is not about you and me. Be clear in identifying. For example don’t say “Our profession uses empirical data to support…” . Instead say “The nursing profession uses empirical data…..” |
| 4-19-12 JA | 27. Did you check your sentences to make sure you did not end them with a preposition? For example, “I witnessed activities that I was not happy with.” Instead, “I witnessed activities with which I was not happy.” |
| 4-19-12 JA | 28. Did you run a Spellcheck? Did you proofread in addition to running the Spellcheck? |
| 4-19-12 JA | 29. Did you have other people read your paper? Did they find any areas confusing? |
| 4-19-12 JA | 30. Did you include a summary or conclusion heading and section to wrap up your paper? |
| 4-19-12 JA | 31. Does your paper have sentence fragments? Do you have complete sentences? |
| 4-19-12 JA | 32. Did you check apostrophes for correct possessive use. Don’t use apostrophes unless it is showing possession and then be sure it is in the correct location. The exception is with the word it. It’s = it is. Its is possessive. |

Signing below indicates you have proofread your paper for the errors in the checklist:

---

**Cheryl Howard RN**
**DATE:** 4-18-12

A peer needs to proofread your paper checking for errors in the listed areas and sign below:

---

**Julie Artman RN**
**DATE:** 4-19-12

Revised Spring 2010/slc