A POLYTECHNIC INSTITUTION

Course Outline

School of Health Sciences
Program: Bachelor of Technology in Nursing
Option:

NURS 1019
Clinical Techniques — Introduction to Assessment

Start Date:	January 10, 2006			**End Date:**	March 2, 2006		
Total Hours:	55	**Total Weeks:**	8	**Term/Level:**	1	**Course Credits:**	3.5
Hours:	54.5	**Lecture:**	7	**Lab/Seminar:**	25.5	**Shop:**	**Clinical Agency:**	22

Prerequisites

Current CPR certificate and RNABC Membership application. Failure to present this documentation will result in removal from the practicum setting.

NURS 1019 is a Co-requisite for:

Course No.	Course Name
NURS 1030	Nursing Practicum 1

v Course Description

This course presents essential behaviors for conducting psychosocial and physical assessment. It includes techniques for taking a health history in order to identify health needs. Opportunity for practice and demonstration of learned skills is provided.

v Detailed Course Description

NURS 1019 provides a basis for understanding and conducting a physical examination and health assessment. The aim is to develop the student's beginning ability to take a health history and conduct psychosocial and physical assessments.

v Evaluation

1.	Analysis of Assessment Data: Practicum Assignment. Three written assignments based on assessments done in practicum in Weeks 3, 4 and 5 are required.	20%	All assignments must be completed for a passing grade.
2.	Demonstration of Assessment Skills.	30%	
3.	Short Answer Exam.	50%	
TOTAL		100%	

v Course Learning Outcomes/Competencies

Upon successful completion, the student will be able to:

1. recognize the difference between a comprehensive and focused assessment and when these are used.
2. demonstrate correct assessment techniques during physical and psychosocial assessment with the aim of recognizing normal findings.
3. recognize abnormal findings and begin to recognize significant patterns in assessed data and formulate hypotheses /potential problems.
4. begin to relate assessment findings to nursing action.
5. demonstrate ability to communicate assessment findings in a professional manner.

6. begin to recognize how to individualize health status assessment based on development and cultural needs.

v Process Learning Threads

Professionalism: With assistance, students develop an understanding of assessment as a foundation of professional practice. They are accountable for developing assessment guides and strategies for use in the clinical portion of the course.

Communication: Students begin to establish relationships with clients based on shared meaning and partnership. They begin to validate assessment findings and health issues with the patients. They begin to document assessments in assignments and charts.

Systematic Inquiry: Students begin to reason critically about assessment data and patient concerns. They begin to appreciate that health issues can be perceived from multiple perspectives.

Professional Growth: Students take responsibility for their learning and for preparing material assessment guides that are accurate and relevant. They demonstrate responsibility for attaining and maintaining a safe level of skill performance. They are responsible and accountable for their actions.

Creative Leadership: Students are becoming assertive with clients and colleagues as they learn assessment skills. They learn to explain their role to health colleagues and patients.

Technical Skills: Students demonstrate correct assessment techniques during physical and psychosocial assessment to recognize normal findings and significant patterns of illness.

The specific skills included are:

- the health assessment process.
- the health history, functional, nutritional, growth and development, cultural assessment.
- physical assessment — the general survey — measurement of temperature, pulse, respiration, blood pressure, height and weight.
- body review — skin, head, neurological system and mental status.
- respiratory, cardiovascular, peripheral vascular and lymphatic assessment.
- heart and chest sounds.
- assessment of abdomen, urinary and musculoskeletal systems.
- assessment of breast and external male and female genitalia on mannequins.

v Verification

I verify that the content of this course outline is current.

Authoring Instructor	Date

I verify that this course outline has been reviewed.

Jain Verma	December 15, 2005
Program Head/Chief Instructor	Date

I verify that this course outline complies with BCIT policy.

L Johnson	December 16, 2005
Dean/Associate Dean	Date

Note: Should changes be required to the content of this course outline, students will be given reasonable notice.

v Instructor(s)

Level 1 Instructors	Office Location: SE12–418	Office Phone:	Lynn Johnson	451 - 6951
	Office Hrs.: See posted hours at instructor's office		Susan McKenzie	432 - 8914
			Brenda Rosenau	431 – 4975
			Connie Evans	432 - 8687
			Jeff Dyck	432 – 8411
			Doris Henderson	454 - 2217
			Kathy Martin	TBA

v Learning Resources

Required:

Assessment

Jarvis, C. (2003). *Physical Examination and Health Assessment* (4th ed.), (Textbook and User's Guide Package for Health Assessment Online). Philadelphia: W.B. Saunders.

Supplemental:

The following textbooks are compulsory for other courses but will be used as a supplement to NURS 1019.

1. **Medical-Surgical Nursing Textbook**

Black, J.M. & Hawks, J.H. (2005). *Medical-surgical Nursing: Clinical Management for Positive Outcomes* (7th ed.). Philadelphia: Saunders.

2. **Dictionary**

Taber, C.W. (2001). *Taber's Cyclopedic Medical Dictionary* (20th ed.). Philadelphia: F.A. Davis.

3. **Drug Handbook**

Spratto, J. R. and Woods, A.L. (2005) PDR Nurses Drug Handbook. New York: Thompson Delmar Learning.

Equipment: 1 watch with second hand
1 good quality stethoscope*
pen light

* a good quality stethoscope will have the following characteristics:

- X Diaphragm and bell are heavy enough to lie firmly on the body surface.
- X Tubing is thick, stiff and heavy.
- X Length of tubing is between 12 to 18 inches.
- X Earpieces fit snugly and comfortably.
- X Angled binaurals point the earpieces toward the nose.

v Information for Students

1. This course has been designed to develop your ability to ***talk with*** (interview) patients about their health and health concerns and to conduct an effective but ***very basic*** physical examination of body systems. Emphasis will be placed on developing assessment skills ***while*** establishing partnerships with patients. Attention to the communication aspect of the nurse's role will be continually reinforced and form part of the evaluation process.

2. This course will be delivered in both the classroom and practicum setting (Acute and Subacute Medicine). In these settings, students will work in small groups (approximately eight students with one nursing instructor).

3. In the classroom students will participate in a variety of structured learning activities aimed at developing assessment knowledge and skills. During practicum experiences students will be assigned patients to interview and to conduct basic physical examinations. It is expected that students will ***actively*** participate in both the classroom and the practicum setting.

4. This course is of short duration. Therefore, students **must complete aspects of this course independently**. You will receive a schedule for all required independent study. Independent learning activities include reading, viewing videos, animations and practice quizzes online and completing written assignments.

Makeup Tests, Exams or Quizzes: There will be **no** makeup tests, exams or quizzes. If you miss an exam you will receive zero marks. Exceptions may be made for **documented** medical reasons or extenuating circumstances. In such a case, it is the responsibility of the student to inform the instructor **immediately**.

Ethics: BCIT assumes that all students attending the Institute will follow a high standard of ethics. Incidents of cheating or plagiarism may, therefore, result in a grade of zero for the assignment, quiz, test, exam or project for all parties involved and/or expulsion from the course.

Attendance: The attendance policy as outlined in the current BCIT Calendar will be enforced. Attendance will be taken at the beginning of each session. Students not present at that time will be recorded as absent. **Regular attendance in lecture, seminars and laboratory periods is required of all students.** If a student is absent for any cause for more than ten percent (10%) of the time prescribed for any subject, he/she ***may be prohibited*** from completing the course (4.07, 10 BCIT Policy Manual). If a class or practicum experience is missed the student is responsible for the missed content.

Illness: A doctor's note is required for any illness causing you to miss assignments, quizzes, tests, projects, or exam. At the discretion of the instructor, you may complete the work missed or have the work prorated.

Attempts: Students must successfully complete a course within a maximum of three attempts at the course. Students with two attempts in a single course will be allowed to repeat the course only upon special written permission from the Associate Dean. Students who have not successfully completed a course within three attempts will not be eligible to graduate from the appropriate program.

Course Outline Changes: The material or schedule specified in this course outline may be changed by the instructor. If changes are required, they will be announced in class.

v Clinical Techniques — Assessment: Course Failure

******* A student who is unsatisfactory in the assessment course will be removed from the Nursing Practicum 1 – NURS 1030.**

v Written Assignment Details

Due Dates:	Assignment #1	Friday, January 27 at 0830
	Assignment #2	Friday, February 3 at 0830
	Assignment #3	Friday, February 10 at 0830

Analysis of Assessment Data: Assignments

The assessment process involves the simultaneous enactment of two interrelated processes: Assessment and Data Gathering and Diagnostic Reasoning. In other words, before, during and following the process of data collection nurses engage in the critical thinking process of diagnostic reasoning (analysis and synthesis of data). This process is crucial to the accurate identification of patient concerns, problems, issues, evaluation of outcomes and in the making of appropriate clinical judgements. It is also part of the assessment phase of the nursing process. This assignment is done weekly in weeks 3, 4 and 5 and is based on assessments completed on assigned patients in practicum areas.

Purpose of this Assignment
The purpose of the assignment is to assist students to develop knowledge and skill in the analysis and synthesis of assessment data by analyzing and synthesizing assessment data collected in practicum on an assigned patient(s).

How to do this Assignment

1. The process of analysis and synthesis (diagnostic reasoning) may be a new experience for you or a familiar one but in a new context. To accommodate for these differences in experience this assignment is set up as a **walk through the process**. You will analyze patient data by responding to a series of questions. Answer these questions thoroughly and to the best of your ability.

2. The analysis of data is a recurring, ongoing process during the assessment phase and, therefore, should be repeated many times during the data collection process. In each assignment you will analyze data before, during and following collection of assessment data.

3. These assignments are to help you ***develop*** knowledge and skill in the analysis and synthesis of assessment data. They are not a test of your ability to enact these processes. You are, therefore, encouraged to work in collaboration with classmates, instructors and other health care professionals to assist you in this learning process.

4. You will not be graded on the first 2 assignments, but will receive detailed feedback to assist you with writing your 3 rd assignment which will be graded out of 20 marks. The criteria on the next page describe the expectations for the assignment.

5. Practicum instructors may ask you to answer additional questions to assist you in the analysis process. Try not to think of these as extra work, but as helping you to more fully develop your reasoning skills so that you will make more appropriate and accurate nursing judgements about a patient's health status.

6. Be sure to hand in your assessment findings with your analysis. Assessment findings include: physical and interview data; vital signs; medications; clustered data; and identification of patient problems.

Assignment Criteria (20 marks)

A. Analysis of Assessment Data:

1. ***Prior to going to the hospital (the night before clinical)***

- Describe the information (eg patient diagnosis, disease process or illnesses) that you received from your instructor the day before clinical?
  What did you ***research***? Your research should include a **definition** or **description of the disease or illness,** the **pathophysiology of the disease**, the **normal physiology of the organ or physical system** involved and what **complications or problems that you will anticipate** and assess for in your patient. Include this research as part of your assignment.
- Based on your research of the patient's medical diagnoses, describe what ***potential problems*** you have come up with, and give the rationale for the problem if possible.
- Based on your research and the potential problems that you have identified the patient is at risk for, describe how this information will ***influence your assessment*** of this patient. Consider how you will assess or what you will look for or ask the patient to help validate the potential problems.

2. ***After you have assessed your patient (the night after clinical)***

Now that you have collected a substantial amount of assessment data it is suggested you review all of the data to get a sense of the ***"whole"*** patient and any patterns or clustering of data that seem to fit together.

- While you conducted your health assessments were you aware of any information that signaled you to take a course of action?
- If so, describe the course of action you took, e.g., "I noticed that the patient was in a lot of pain, so I informed the RN before proceeding with my interview."
- After reviewing your assessment data look to see if some of these pieces of information seem to fit together (as in a pattern) and /or what questions arise from this information? E.g. "My patient has been falling a lot at home recently and has been admitted to hospital several times in the last few months with various injuries. I wonder why she keeps falling?"
- Based on any emerging patterns, what hypothesis can you make? e.g. I wonder if there's something wrong that is causing her to fall? She is a diabetic, and has high blood pressure, I wonder if she's taking her medications properly?
- Based on these questions or hypotheses that you have developed, what additional data did you obtain to try and validate the problem. If you did not have a chance to collect this information during your clinical time, describe what information you would like to have collected, or asked the patient about. E.g. I would have asked the patient about what, when and how she takes her medications to see if she was taking them as prescribed. I would also have checked her blood sugar levels to see if they were abnormal.

3. ***Conclude with a patient problem or nursing diagnosis***

- Go back to your original list of potential problems to see if these problems are different from the ones that you made as a result of doing your assessment with your patient?

- If they are different, how do you account for these differences?
  If you are confident your hypotheses are correct or valid, formulat ions.
  These conclusions can be expressed as a patient concern, a patient nt, or
  what some people call a nursing diagnosis. For example: "risk for th" or
  "abdominal pain" are actual or potential patient problems.

Max length incl ref 5-6 pg's (excluding pt id data) ??

B. Journalling

Reflect on your hospital or clinical experience and the process of data synthesis. In a half to one page (handwritten or word processed), record your tho your experience in the last 2 days and consider what you could do to impro or analysis skills – what went well and what didn't, and what will you do ou are not graded on your journals, nor are they used for evaluation purposes.

Please refer to the handout, titled "Journalling" for more detailed information.

Please hand in or email your journaling with your assignment each week as per your instructor's direction.

Now that you have worked through this diagnostic reasoning process and have arrived at some conclusions you ***may*** be ready to proceed to the next step in the nursing process which is to decide on appropriate nursing interventions. During your practicum experiences in Nursing 1030 you will be expected to use this process in the planning and delivery of nursing care.

v Testing of Assessment Skills **Date: March 2, 2006 – week 8**

In the assessment skills test, you will be given 20 minutes to individually perform a focused interview and physical assessment of a patient volunteer. First, you will be given a short scenario to read, then you will complete an assessment of the patient and lastly, you will be asked several questions relating to you assessment findings.

Demonstration of assessment skill is worth 30% of your final grade. Your demonstration of specific skills will be graded satisfactory/unsatisfactory according to criteria on a checklist that you will see prior to the test. If you meet all criteria, you will receive a satisfactory and be granted 30 marks (30%) of your final grade. You will have one opportunity to retake this test using one of the other scenarios. If the second demonstration is satisfactory you will be awarded 15%. However, if your second demonstration is unsatisfactory, you will receive 0 out of 30 marks.

Schedule

Date	Material Covered	Course Site and Rooms
	WEEK 1	
Tuesday **January 10, 2006** **0830–1000 hrs**	Introduction to NURS 1019 • course delivery methods • course outline • overview of the course Assessment for Health and Illness • purpose of assessment • types of assessment • health assessment and the nursing process • critical thinking and the diagnostic reasoning process	SW 3 Room 3615
1000-1030	Break	
1030-1230	Introductions Establishment of partnerships Initial and Emergency Assessment – the ABC's and Pain assessment General Survey – Head to Toe Assessment	Lynn and Doris SE 12 -301 Connie and Brenda SW - 3195 Susan and Kathy SW 1 -3170 Jeff SW 1 -2590
	* **Please note that your small group rooms are not always the same each week.**	

Date	Material Covered	Course Site and Rooms
Wednesday, January 11/06 **0830–1000**	**Introduction to Basic Interviewing Skills**	**SW 1 -2020**
1000 – 1030	**Break**	
1030 - 1530	Complete Health History (includes cultural considerations, developmental tasks and functional assessment) ** practice interviewing skills Mental Status Assessment Nutritional assessment Skin, hair and Nails Assessment Documentation and Charting - practice charting assessments *** bring stethoscopes to class next week**	Lynn and Doris SW 1 -3195 Connie and Brenda SW 1 - 3585 Susan and Kathy SW 1 - 1525 Jeff SW 1 - 2590
Tuesday **January 17/06** **0830–1000 hrs**	**WEEK 2** Introduction to physical examination techniques • inspection, palpation, percussion, auscultation	SW 3 - 3615
1000-1030 hrs	Break	
1030- 1430	*Practice* Physical Examination Assessment Techniques • assessment of head and neck • assessment of eyes and ears • assessment of vital signs – pulse, respirations blood pressure, oxygen saturation and temperature (Practice charting assessments)	Lynn SE 12 - 301 Brenda SE 42 - 200 Connie SW 1 - 3585 Jeff ~~SE 3 - 3745~~ SW 1 - 358 Doris SW 1 - 1525 Susan and Kathy SW 1 - 3195

Date	Material Covered	Course Site and Rooms
Wednesday January 18 /06	**Practicum - Hospital/Ward Orientation** *Patient assignment to achieve the following:* • establishment of a partnership with patient • initiation of an interview **Specific Assessments**: • ABCs general survey and pain assessment • completion of a health history • mental status assessment • nutritional assessment • skin, hair and nails assessment • head and neck assessment • eyes and ears assessment • practice vital signs – pulse, respirations, BP, oxygen saturation and temperature * bring stethoscopes to class next week (Tuesday)	**Practicum** (times as per area) Kathy LGH Susan LGH Lynn MSJ Jeff BGH Brenda MSJ Connie BGH Doris BGH

Date	Material Covered	Course Site and Rooms
Tuesday January 24/ 06 **0830–1000 hrs**	**WEEK 3** Heart and Neck Vessels – the cardiac cycle and cardiac output Thorax and Lungs – ventilation, respiration and oxygen exchange • normal breath sounds • abnormal or adventitious sounds (crackles and wheezes)	SW 3 - 3615
1000-1030	Break	
1030- 1430	Assessment of Heart and Neck Vessels • landmarking and listening for apical pulse and normal heart sounds (S1 and S2) Assessment of Thorax and Lungs • landmarking and listening for air entry and quality of breath sounds Assessment of the Peripheral Vascular System and Lymphatics (Practice charting assessments)	Lynn SE 12 -301 Brenda SE 42 - 200 Jeff ~~SW 3 - 3745~~ SW 1 - 3585 Doris SW 1 - 1525 Connie SW 1 - 3585 Susan and Kathy SW 1 - 3195
Wednesday January 25 /2006	**Practicum** - *Patient assignment to achieve the following:* • establishment of a partnership with patient • expanding and improving accuracy of last week's assessment • assessment of thorax and lungs • assessment of heart and neck vessels • assessment of peripheral vascular system and lymphatic system • practice vital signs – T, P, R, BP and O_2 saturation	**Practicum** (times as per area) Kathy LGH Susan LGH Lynn MSJ Jeff BGH Brenda MSJ Connie BGH Doris BGH
Friday, January 27/ 2006	**Assignment #1 – due at 0830 hrs**	

Date	Material Covered	Course Site and Rooms
	WEEK 4	
Tuesday, January 31/ 2006 **0830–1000 hrs**	Assessment of the Abdomen and Genitourinary System • major organs and functions • landmarking for bowel sounds • location of bladder for palpation Neurological Assessment – cerebral perfusion and increased intracranial pressure - Glasgow Coma Scale - Pupil Response - Movement - Sensation	NE 1 226
1000-1030 hrs	Break	
1030 – 1430 hrs	Practice Abdominal and Genitourinary Assessment Practice Neurological Assessment Review and practice Musculoskeletal Assessment Breast Assessment (BSE) (discussion only) **Review and practice all assessments and practice vital signs** (Practice charting assessments)	Connie SW 1 -3585 Brenda SE 42 -200 Lynn SE 12 – 301 Doris SW 1 – 1525 Jeff ~~SW 3 – 3745~~ SW 1 - 3585 Susan and Kathy SW 1 -3195
	Practicum – Patient assignment to achieve the following: Establishment of a partnership with a patient Abdominal and Genitourinary assessment Neurological assessment (neurological vital signs) Musculoskeletal assessment Vital signs	**Practicum** Kathy LGH Susan LGH Lynn MSJ Jeff BGH Brenda MSJ Connie BGH Doris BGH
Friday, Feb 3/06	**Assignment #2 Due at 0830**	

Date	Material Covered	Course Site and Rooms
Tuesday and Wednesday, Feb 7 and 8/06	**WEEK 5** **Practicum** Practice interviews and assessments in preparation for skill testing. Familiarize self with equipment at bedsides and emergency equipment eg suction set up	**Practicum** Kathy LGH Susan LGH Lynn MSJ Jeff BGH Brenda MSJ Connie BGH Doris BGH
Friday, Feb 10/ 06	**Assignment # 3 Due at 0830**	
Tuesday, Feb 14/06	**Week 6** **N 1019 Short Answer Exam (1 hour)**	To be written at your clinical site (time and place TBA)
Thursday, March 2/06	**Week 8** **N1019 Assessment Skills Evaluation Day** 0900–1130 1230–1500 } Testing of Assessment Skills (30 minutes each) A schedule for individual testing will be posted	SE12–416/417