A POLYTECHNIC INSTITUTION

School of Health Sciences
Program: Bachelor of Science in Nursing

Course Outline

NURS 1019
Clinical Techniques — Introduction to Assessment

Start Date: August 15, 2006 **End Date:** September 21, 2006

Total Hours: 70 **Total Weeks:** 6 **Term/Level:** 1 **Course Credits:** 3.5 **(1.9+1.6 cr)**

Theory Hours: 29 **Lecture:** 10 **Seminar**: 19 hrs.
1.6 cr

Clinical Agency: 41 hrs**(1.9 cr)**

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

NURS 1019 is a pre-requisite for: NURS 1030

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, performing assessments, physical assessments and. opportunity for practice and demonstration of learned skills.

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.

Evaluation

1.	Analysis of Assessment Data: Practicum Assignment. One written assignment based on a case study in week 3.	30%	All assignments must be completed in order to achieve a passing grade in NURS 1019
2.	Demonstration of Assessment Skills.	30%	
3.	Final Exam.	40%	
TOTAL		100%	

Course Learning Outcomes/Competencies

Upon successful completion of **NURS 1019**, 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.

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 — head to toe assessment (the general survey)— measurement of temperature, pulse, respiration, blood pressure, oxygen saturation, 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.

Verification

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

Authoring Instructor — Date: June 1/06

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — Date: June 1st, 2006.

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — Date: JUN 0 1 2006

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

Instructor(s)

Level 1 Instructors	Office Location: SE12–418	Office Phone:	Lynn Johnson	451-6951
	Office Hrs.: See posted hours at instructor's office		Connie Johnston	451-7189
			Susan McKenzie	432-8914
			Brenda Rosenau	431-4975
			Jody Little	TBA
			Jeff Dyck	432-8411
			Judi Campbell	TBA
			Merry Van der Gracht	TBA

Learning Resources

Required Texts:

Assessment

Jarvis, C. (2004). *Physical Examination and Health Assessment* (4th ed.), (Textbook and User's Guide Package for Health Assessment Online). Philadelphia: W.B. Saunders.

Ross-Kerr, Janet & Wood, Marilynn (2006) *Canadian Fundamentals of Nursing* (3rd ed) Toronto:Elsevier Mosby

Supplemental Reading:

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.

4. **Nursing Care Planning texbook**

   Gulanick, M. et al. (2003) *Nursing Care Plans: Nursing Diagnosis and Intervention* (5th ed.). Mosby

   Doenges, M.E., et al. (2002) *Nursing Care Plans: Guidelines for individualizing Patient Care (6th ed.) Philadelphia: F.A. Davis*

5. **Med Math**

   Boyer, M.J. (2006) *Math for nurses: a pocket guide to dosage calculation and drug preparation*(6thed.) Lippincott

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

* a good quality stethoscope will have the following characteristics:

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

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 course leader **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 two attempts at the course. Students with two attempts in a single course may be allowed to repeat the course only upon special written permission from the Associate Dean.
BCIT Nursing Program Student Guidelines, Policies and Procedures which are located online at http://www.bcit.ca/health/nursing/state: Students who have any combination of two instances of withdrawal or failure in a nursing theory course will be readmitted to the program " with written permission from the Associate Dean, who will detail any special considerations".

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.

Clinical Techniques — Assessment: Course Failure

******* A student who is unsatisfactory in the assessment course will not be permitted to proceed to Nursing Practicum 1 – NURS 1030.**

Written Assignment Details

Due Dates:	Assignment #1	Friday, September 1 at 0830
	Assignment #2	Friday, September 8 at 0830
	Assignment#3- Case Study	Friday, September 15 at 0830

Analysis of Assessment Data: Weekly 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. **There are two assignments done in weeks 3 and 4** and they are based on assessments completed on assigned patients in practicum areas for these weeks.

Purpose of this Assignment
The purpose of this 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 these first two assignments, but will receive detailed feedback to assist you on the third assignment which will be graded out of 30 marks. The criteria on the following page will be used to grade your third assignment.

5. Practicum instructors may ask you to answer additional questions to assist you in the analysis process. These questions are designed to help to more fully develop your critical thinking/diagnostic reasoning skills so that you will make more accurate and appropriate nursing judgments about a patient's health status and clinical situation.

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

Assignment Criteria (30 marks)
Graded Case Study:
Due Friday, September 15/06

You will be given a case study with patient diagnoses, medications, lab values and other pertinent information. It will represent the type of patients that are seen in level one practicum. Below is an example of what types of information are relevant to this assignment. The marking guide that follows will provide the criteria for marking assignment #3.

A.

- Describe the information (eg patient diagnoses, disease process or illnesses) that you presented in the case study. What did you research?
  Using the assessment and Medical Surgical Nursing textbooks and any other pertinent references including the internet., include a **definition** or **description of the disease or illness, the pathophysiology of the disease,** that you would anticipate and assess for in this case study patient.
- Based on your research of the case study patient's medical diagnoses, describe what ***potential problems*** you anticipate this patient may have 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 would influence your ***assessment*** of this patient. Consider how you

would do the assessment or what you would will look for or ask the patient in order to help validate the potential problems.

B.

When you have researched a substantial amount of assessment information, 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.

- When researching the health problems, were you aware of any information that might signal you to take a course of action?
- If so, describe the course of action you might take took, e.g., "I assumed that this type of patient might experience pain, so I would inform the RN before proceeding with my interview."
- After reviewing your data, look to see if some of these pieces of information would fit together (as in a pattern) and /or what questions might arise from this information? E.g. If falls is a diagnosis, consider what might be causing these falls or if chest pain was a diagnosis, provide potential reasons why patients experience chest pain
- 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?
- What additional data would you obtain or would you like to have obtained to try and validate the problem. Describe what information you would like to collected, or asked the patient about. e.g. I would have asked the patient about what, how and when 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."

C.

Conclude with a patient problem or nursing diagnosis

- Go back to your original list of patient problems. Prioritize you list.
  These conclusions can be expressed as a patient concern, a patient issue, a clinical judgement, a nursing diagnosis or a positive outcome. For example: "risk for falls, shortness of breath or "abdominal pain" are actual or potential patient problems. Do not worry about the exact wording of the problems nor a specific nursing diagnosis. Instead describe the patient problem in your own words as shown in the previous examples above.

D.

Provide information on medications that the patient is on including a rationale for each med.
Analyze the lab values and provide explanations for them
Analyze the vital signs. What might these vital signs indicate?

Journalling

At the end of each week, reflect on your hospital or clinical experience and your learning. In a half to one page (handwritten or word processed), record your thoughts and feelings about your experience (s) and consider what you could do to improve your assessments and/or analysis skills – what went well and what didn't, and what will you do differently next time. You 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.

Assessment Skills Evaluation Date: September 21, 2006 – week 6

In the assessment skills test, you will be given 30 minutes to individually perform a focused interview and physical assessment of a patient volunteer. You will be given a short scenario (case study) to read, then you will complete an assessment of the patient. At the end of your skill testing scenario, you will be asked some questions relating to your assessment findings.These questions will be similar to those that you answered in assignment #3.

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. If you are not successful on the first test, you will be given another opportunity to retake this test using one of the other scenarios. If the second skill test is satisfactory you will be given 15%. However, if your second test is unsatisfactory, you will receive 0 out of 30 marks.

Your final mark in **NURS 1019** is out of 100% and will be calculated by adding your marks obtained in the three evaluation components of the course: Assignment #3, Final exam and Skill testing. **You must complete all components in order to pass NURS1019.**

Date and Location	Material Covered	Readings
	WEEK 1	
Tuesday **August 15, 2006** 0830–1030 Common Hours Rm: SW3–1750	Introduction to NURS 1019 • course outline • course delivery methods • overview Assessment for Health and Illness • what is assessment? • types of assessment What are Patient Problems? What is a Nursing Diagnosis? ***Break***	**Jarvis:** Ch. 1 Course Outline **Ross-Kerr:** Ch. 12, 13, 14 Ch. 28 pp. 617–619
1030–1230 Brenda NE1–406 Connie NE1–405 Jeff NE1–403 Jody NE1–401 Judi SE12–309 Lynn SE12–307 Merry SE12–302 Susan SE12–301	Meet with Clinical Instructor and Group Introductions Partnerships Head-to-Toe Assessments ABCs and Pain Assessments (General Survey) Emergency, Focused, Ongoing Assessments *Please note small group locations change weekly.*	**Jarvis:** Ch. 4 Ch. 10 Handouts
Wednesday **August 16, 2006** 0830–1030 Common Hours Rm: SW3–1750	Introduction to Basic Interviewing Skills Functional Assessment Documentation • what is charting? • why is it done? • template reviews ***Break***	**Jarvis:** Ch. 4 Ch. 6 Ch. 7
1030–1530 Brenda NE1–401 Connie NE1–403 Jeff NE1–405 Jody NE1–406 Judi SE12–301 Lynn SE12–302 Merry SE12–307 Susan SE12–309	Complete Health History • cultural considerations • developments/tasks Mental Status Assessment Nutritional Assessment Assessment of Skin, Hair, Nails *Bring stethoscope to class next week.	**Jarvis:** Ch. 2, 3 Ch. 7, 8 Ch. 12 **Ross-Kerr:** Ch. 28 pp. 659–660

Date and Location	Material Covered	Readings
	WEEK 2	
Tuesday **August 22, 2006** 0830–1030 Rm: SW3–1750 1030–1430 Brenda SE12–301 Connie SE12–302 Jeff SE12–307 Jody SE12–309 Judi NE1–401 Lynn NE1–403 Merry NE1–405 Susan NE1–406	Introduction to Physical Assessment • inspection, palpation, percussion, auscultation Peripheral Vascular Assessment • arteries and lymphatics, venous flow, pulses ***Break*** Physical Assessment Techniques • vital signs: blood pressure, pulse, respirations, temperature, oxygen saturation • head and neck • eyes and ears Practice V/S	**Jarvis:** Ch. 9 Ch. 10 Ch. 13, 14, 15 Ch. 20 **Ross-Kerr:** Ch. 27 Ch. 28 pp. 621–634 **Jarvis:** Ch. 13, 14, 15
Wednesday **August 23, 2006** 0800–1330/1330–1800 Brenda – BGH Connie – LGH Jeff – BGH Jody – LGH Judi – BGH Lynn – MSJ Merry – BGH Susan – LGH ***Times vary with each clinical site.***	Hospital/Ward Orientation (brief) Patient Assignment: Goals • establish partnership • initiate patient interview Assessments to Practice (as many as time permits) • ABCs, head-to-toe, pain assessment • health history • assessment of mental status • nutritional assessment • assessment of skin, hair, and nails • assessment of head and neck • assessment of eyes and ears • practice vital signs (T, P, R, BP, O_2 sat) Documentation • initiate charting formats using template	

Date and Location	Material Covered	Readings
	WEEK 3	
Tuesday **August 29, 2006** 0830–1030 Common Hours Rm: SW3–1750	Heart and Neck • the cardiac cycle • the vessels • cardiac output Thorax and Lungs • ventilation • respiration • oxygen exchange • the "triad" • abnormal sounds (adventitious sounds, crackles, and wheezes) ***Break***	**Jarvis:** Ch. 18 Ch. 19 **Kerr-Ross:** Ch. 28 pp. 706–710 p. 682 p. 690 p. 696
1030–1430 Brenda NE1–406 Connie NE1–405 Jeff NE1–403 Jody NE1–401 Judi SE12–309 Lynn SE12–307 Merry SE12–302 Susan SE12–301	Assessment of Heart and Neck Vessels • landmarking apical pulse Assessment of Thorax and Lungs • landmarking and listening for air entry • quality of breath sounds • practice charting assessments	
Wednesday **August 30, 2006** 0800–1330/1330–1800 Brenda – BGH Connie – LGH Jeff – BGH Jody – LGH Judi – BGH Lynn – MSJ Merry – BGH Susan – LGH ***Times vary with each clinical site.***	**Practicum** Patient Assignment: Goals • establish partnership • assessment of thorax and lungs • assessment of heart and neck vessels • practice vital signs • practice charting	
Friday **September 1, 2006**	**Assignment #1 due at 0830**	See Course Outline

Date and Location	Material Covered	Readings
	WEEK 4	
Tuesday **September 5, 2006** 0830–1030 Common Hours Rm: TBA	Assessment of Abdomen and Genitourinary System • major organs and functions • bowel sounds — landmarking • bladder — landmarking and palpation Neurological Assessment — Cerebral Perfusion and Increased Intracranial Pressure • Glasgow Coma Scale • pupillary responses • movement and sensation	**Jarvis:** Ch. 21 pp. 562–565 pp. 566–586 pp. 589–600 Ch. 23 Ch. 20 **Ross-Kerr:** Ch. 28 pp. 720–727 Ch. 40
Wednesday **September 6, 2006** 0800–1330/1330–1800 Brenda – BGH Connie – LGH Jeff – BGH Jody – LGH Judi – BGH Lynn – MSJ Merry – BGH Susan – LGH	**Practicum** Patient Assignment: Goals • establish of a partnership • abdomen and genitourinary assessment • neurological assessment • musculoskeletal assignment • vital signs	**Jarvis:** Ch. 22
Friday **September 8, 2006**	**Assignment #2 due at 0830**	See Course Outline

Date and Location	Material Covered	Readings
	WEEK 5	
Tuesday & Wednesday **September 12 &13, 2006** 5.5 hr – Tuesday 6.5 hr – Wednesday ***Clinical Sites:*** Brenda – BGH Connie – LGH Jeff – BGH Jody – LGH Judi – BGH Lynn – MSJ Merry – BGH Susan – LGH	Practice Interviews and Assessments Prepare for Skill Testing Familiarize Self with Equipment for Emergency and Suction Review Assessment Systems	Patient Assignment from Instructor
Friday **September 15, 2006**	**Case Study Assignment due at 0830**	Refer to Handout and Course Outline

Date and Location	Material Covered	Readings
	WEEK 6	
Tuesday **September 19, 2006** ***Clinical Sites:*** Brenda – BGH Connie – LGH Jeff – BGH Jody – LGH Judi – BGH Lynn – MSJ Merry – BGH Susan – LGH	**NURS 1019 Final Exam (1 hour)** (written at your clinical site)	**Jarvis & Ross-Kerr:** selected chapters
Thursday **September 21, 2006** Set A: 0900–1130 Set B: 1230–1500 Rm: SE12-416 SE12-417 ***Clinical Sites:*** Brenda Rosenau Connie Johnston Jeff Dyck Jody Little Judi Campbell Lynn Johnston Merry Vander Gracht Susan McKenzie	**NURS 1019 Assessment Skills Testing** • testing with volunteer patients in lab — 30 minutes per student with one instructor • scenarios will include abdominal assessment, neurological assessment, heart and neck vessels assessment, thorax and lungs assessment, mental status assessment	