A POLYTECHNIC INSTITUTION

School of Health Sciences
Program: Bachelor of Science in Nursing

Course Outline

NURS 1019
Clinical Techniques — Introduction to Assessment

Start Date: January 9, 2007 **End Date:** February 15, 2007

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.Completion & Submission of Assignment 1 & 2	10%	Written assignments must be submitted using **word processing**. and must be **completed** and **submitted** in order to achieve a passing grade in NURS 1019. **Marks for three assignments must total 50% in order to pass this course.**
2.Demonstration of Assessment Skills	30%	
3.Patient Presentation	30%	
4.Final Exam (short answer)	30%	
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: Dec. 11/06

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — Date: DECEMBER 11, 2006

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — Date: Dec. 11/06

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
			Terri Karapita	431-4975
			Jody Little	456-1140
			Jeff Dyck	432-8411
			Judi Campbell	456-8073
			Merry Van der Gracht	454-2214

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.

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

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.

1. **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*

2. **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.

Cheating, Fabrication, plagiarism, and/or dishonesty:
First Offense: Any student in the School of Health Sciences involved in an initial act of Academic Misconduct – **cheating, fabrication, plagiarism and/or dishonesty** will receive a zero (0) or unsatisfactory(U) on the particular assignment and may receive a zero (0) or unsatisfactory (U) in the course, at the discretion of the Associate Dean.
Second Offense: Any student in the School of Health Sciences involved in a second act of Academic Misconduct – **cheating, fabrication, plagiarism and/or dishonesty** will receive a zero (0) or unsatisfactory (U) on the particular assignment, a zero (0) or unsatisfactory (U) in that course and the Associate Dean will recommend to the BCIT Vice-President, Education and/or President, expulsion from the program.
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. **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, January 26 at 0830
	Assignment #2	Friday, February 2 at 0830
	Patient Presentation	Week 5 & 6 in clinical areas

Weekly Assignments: Weeks 3 & 4

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 making appropriate clinical judgements. It is also part of the assessment phase of the nursing process.
There are **two written assignments** done in weeks 3 and 4 that are based on assessments completed on assigned patients in practicum areas for these weeks.

Purpose of Written Assignments:
The purpose of this assignment is to assist students to develop knowledge and skill in their ability to take information (patient's information) and analyze and synthesize it. Out of this process, nurses make some decisions regarding what action they will take in the care of this patient (interventions).

How to do these assignments: Refer to the Criteria for Written Assignments as a guide.

Preamble:

- The process of analysis and synthesis of patient data **(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 to help nursing students walk through the process of diagnostic reasoning. In these assignments, you will analyze patient data.
- The analysis of patient data is a recurring and **ongoing** process performed by nurses during the assessment of patients.
- The two assignments are designed to help you **develop** knowledge and skill in the You may work in collaboration with classmates, instructors and other health care professionals to assist you in this learning process. You must complete & submit both of these assignments to receive 10% of your total grade
- Your instructor will provide detailed feedback on these assignments.
- As part of your feedback, 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.
- By performing written assessments on patients, nurses learn to gather relevant data, make connections (links) between researched data & patient data and perform assessments based on that data.

  These include: researched data, physical assessments, vital signs, medication information, lab values and identification of patient problems.
- The goal of diagnostic reasoning is to identify interventions **(how you will care for the patient)**.

Oral Presentation: 30 marks
Weeks 5 & 6

You will give a presentation in the debriefing sessions at your clinical site for your clinical instructor and clinical group. It will be a verbal report about a patient that you were assigned by your instructor. The goal of this assignment is to provide the student with experience in giving information verbally to others concerning a specific patient. It will include information similar to that provided in the written assignments but in a more condensed form. The length of time for each presentation should be no longer than 15 minutes.
Below are the areas that need to be addressed in this presentation.

- Provide the initials of the patient, age and admitting diagnosis. Include relevant social history such as marital status, living situation etc. Using the assessment, Medical Surgical Nursing textbooks and any other pertinent references including the internet, provide a brief description of the patient's healthy problem (definition or description of the disease or illness). Include any contributing factors to this diagnosis.
- Based on the information you have received and researched on this patient's health problems, how did you anticipate this patient **might** have appeared? Describe how the patient currently looks. State what assessments would be performed or what ones you performed on this patient.
- Provide information on this patient's medications, why they were prescribed & how they relate to the patient's health problems. Include any nursing implications (potential implications for the patient taking the medication).
- Report the patient's vital signs and if relevant, relate them to the health problem. What do these vital signs tell you about this patient?

- Conclude with a list of three- five ***potential patient problems*** this patient has or may have and give the rationale for the problem.

When assessing a patient in the clinical setting, the process that nurses follow is systematic & patient centered. The following should be considered when doing written assessments as well as oral reports to other members of the Health Care Team:

- When researching a patient's health problems, did any information signal you to take a course of action? (e.g. patient was found to be having pain 8/10;course of action might be to check to see if any analgesic/pain medication was administered)
- 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 might 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? Is there something making the patient dizzy so falling has become a problem? Is the patient taking medications properly? This is an example of critically thinking patient situations and is a necessary component of nursing assessment.
- What additional data would you obtain or would you like to have obtained to try and validate the problem. What further information do you need to collector ask the patient about? e.g. Checking to find out if blood sugar levels were within normal range.

Patient problems (nursing diagnosis)

Patient problems are those problems that affect the patient. They may also be referred to as a **Nursing Diagnosis**. They differ from a medical diagnosis because the medical diagnosis is the statement of what has been diagnosed by the medical personnel (physicians). An example of a medical diagnosis is "pneumonia".
The **nursing diagnosis or patient problems** that may be associated with pneumonia can be varied and usually reflect what the patient is experiencing. Examples of these are "shortness of breath", "fever", "cough".
Patient problems may be expressed as actual or potential (at risk) problems. Risk for falls, shortness of breath or abdominal pain can be actual or potential patient problems.

Journalling(see journaling handout)

At the end of each week, reflect on your hospital or clinical experience and your learning. In a half to one page (word processed preferred) 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 **per your instructor's direction**.

Assessment Skills Evaluation:

Date: Thursday, February 15, 2007 – 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 will perform the assessment appropriate for this patient with an instructor observing. You will receive more information and the scenarios later in the term and opportunities to practice your assessments in coming weeks.

The four scenarios used for testing are: **neurological, abdominal, respiratory and cardiovascular.**

At the end of your skill testing scenario, you will be asked some critical thinking questions relating to your assessment findings.

Demonstration of assessment skill is worth 30% of your final grade. Your demonstration of specific skills will be graded according to the checklist criteria that you will see prior to the test. If you meet all criteria, you will receive a satisfactory grade and 30/30 marks. 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 15/30. 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 four evaluation components of the course**: Assignments 1 & 2, patient presentation, final exam and skill testing demonstration. **You must obtain 50% or greater and complete and submit all components in order to pass NURS1019.**

Date and Location	Material Covered	Readings
	WEEK 1	
Tuesday **January 9, 2007** 0830–1030 Common Hours Rm: Willingdon Church - Chapel	Introduction to NURS 1019 • overview • course outline **What nurses do** Assessment for Health and Illness • what is assessment? • types of assessment What are Patient Problems (nursing diagnosis)? Critical thinking & problem solving ***Break***	**Jarvis:** Ch. 1 Course Outline Handouts –Week 1 notes
1030–1230 Willingdon Church Terri Room -118 Connie – 110A Jeff- 308 Jody- 110B Judi - 309 Lynn - 109 Merry - 307 Susan - 117	Meet with Clinical Instructor and Group Introductions Partnerships ABC's & Pain Assessments Head to Toe (general survey) Assessments Emergency, Focused, Ongoing Assessments	**Jarvis:** Ch. 4 Ch. 10 Handouts
Wednesday **January 10, 2007** 0830–1030 Common Hours Willingdon Church - Chapel	Introduction to Basic Interviewing Skills Communication Skills- Role Play Interview What is a Functional Assessment? Documentation/charting • what is charting? • why is it done? • template reviews ***Break***	**Jarvis:** Ch. 6 Ch. 7
1030–1530 **Same rooms as previous class** Connie Jeff Jody Judi Lynn Merry Susan	Complete Health History -review & discuss • cultural considerations • developmental tasks Assessment of Skin, Hair, Nails *Bring stethoscope to class next week.	**Jarvis:** Ch. 2, 3 Ch. 7, 8 Ch. 12

Date and Location	Material Covered	Readings
	WEEK 2	
Tuesday **January 16, 2007** 0830–1030 Willingdon Church - Chapel 1030–1430 **Same rooms as previous week** Terri Connie Jeff Jody Judi Lynn Susan	Introduction to Physical Assessment • inspection, palpation, percussion, auscultation Peripheral Vascular Assessment • arteries & veins • venous flow, pulses • lymphatics • vital signs – blood pressure, pulse, respirations, oxygen saturation ***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 Week 2 notes
Wednesday **January 17, 2007** Terri - MSJ 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 • 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/Charting • initiate charting formats using template	

Date and Location	Material Covered	Readings
	WEEK 3	
Tuesday **January 23, 2007** 0830–1030 Willingdon Church Chapel	Heart and Neck • the cardiac cycle • the vessels • cardiac output • coronary blood supply Thorax and Lungs • ventilation • respiration • oxygen exchange • the "triad" (O2 sat, resp. rate, lung sounds) • abnormal adventitious) sounds, crackles, and wheezes) ***Break*** Assessment of Heart and Neck Vessels • landmarking & auscultation apical pulse Assessment of Thorax and Lungs • landmarking and listening for air entry • quality of breath sounds • practice charting assessments	**Jarvis:** Ch. 18 Ch. 19 Week 3 notes
1030–1430 Same rooms as previous week		
Wednesday **January 24, 2007** 0800–1330/1330–1800 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 partnerships • assessment of thorax and lungs • assessment of heart and neck vessels • practice vital signs • practice charting	
Friday **February 2, 2007**	**Assignment #1 due at 0830**	See Course Outline

Date and Location	Material Covered	Readings
	WEEK 4	
Tuesday **January 30, 2007** 0830–1030 Common Hours Willingdon Church Chapel Same rooms as previous weeks	Assessment of Abdomen (urinary) (Include nutritional assessment questions) • bowel sounds — landmarking & auscultation • bladder — landmarking & palpation • major organs Neurological Assessment/Mental Status • level of consciousness • pupillary responses • movement and sensation • Glasgow Coma Scale Break Review Musculoskeletal Assessment Practice Abdominal and Genitourinary Assessment Practice Neurological/Mental status Assessment	**Jarvis:** Ch. 21 pp. 562–565 pp. 566–586 pp. 589–600 Ch. 23 Ch. 20 Week 4 notes
Wednesday **January 31, 2007** 0800–1330/1330–1800 Connie – LGH Jeff – BGH Jody – LGH Judi – BGH Lynn – MSJ Merry – BGH Susan – LGH	**Practicum** Patient Assignment: Goals • establishment of partnerships • Abdominal assessment • Neurological (mental status)Assessment • Musculoskeletal Assessment • vital signs	**Jarvis:** Ch. 22
Friday **February 2, 2007**	**Assignment #2 due at 0830**	See Course Outline

Date and Location	Material Covered	Readings
	WEEK 5	
Tuesday & Wednesday **February 6&7, 2007** 5.5 hr – Tuesday 6.5 hr – Wednesday ***Clinical Sites:*** Terri -MSJ 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 **Tuesday & Wednesday -Patient Presentations** – graded 30 marks	Patient Assignment from Instructor

Date and Location	Material Covered	Readings
	WEEK 6	
Tuesday **February 13, 2006** ***Clinical Sites:*** Terri -MSJ 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) Tuesday & Wednesday - **Patient Presentations** – graded 30 marks	**Jarvis:** selected chapters Weekly handouts Lecture content Marking criteria
Thursday **February 15, 2007** Set J: 0900–1130 Set K: 1230–1500 Rm: SE12-416 SE12-417 **Testers:** Terri Karapita 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** • See handouts	