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 14, 2007 **End Date:** September 21, 2007

Total Hours: 70 **Total Weeks:** 6 **Term/Level:** 1 **Course Credits:** 3.5 **(1.66 + 1.86 cr)**

Theory Hours: 29 **Lecture:** 10 **Seminar:** 19 hrs.
1.86 cr **0.6 cr** **1.26 cr**

Clinical Agency: 41 hrs**(1.66 cr)**

NURS 1019 is a pre-requisite for: NURS 1030 Nursing Practicum 1.

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

Course Description

This course presents essential skills for conducting psychosocial and physical assessment. It includes techniques for taking a health history in order to identify health needs, & perform assessments, physical assessments. Opportunity is provided 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		Dates / Due Dates:
1.Completion & Submission of Assignment 1	5%	Friday, August 31 at 0830 (wk 3).
Completion & Submission of Assignment 2	5%	Friday, Sept. 7 at 0830 (wk 4).
2. Completion and **presentation** of Assignment 3	30%	Week 5 **OR** 6, as per instructor
3. Final Exam (multiple choice & short answer)	30%	Tues, Sept. 11, time TBA (wk 5).
4.Demonstration of Assessment Skills	30%	Thursday, Sept. 20, time TBA (wk 6)
TOTAL	100%	

Written assignments must be submitted using **word processing**, and must be **completed** and **submitted** in order to achieve a passing grade in NURS 1019

Your final mark in NURS 1019 is out of 100% and will be calculated by adding your marks obtained in the five evaluation components for the course: Assignments 1, 2, & 3, final written exam, and demonstration of assessment skills.

Course Learning Outcomes/Competencies

Upon successful completion of **NURS 1019**, the student will be able to:

1. appropriately use the general (head to toe) and focused assessments.
2. demonstrate correct assessment techniques during physical and psychosocial assessment, recognizing normal findings.
3. recognize abnormal findings.
4. report abnormal findings to RN & instructor.
5. recognize (with instructor guidance) significant patterns of patient behaviour based on evidence solicited.
6. recognize (with instructor guidance) actual and potential patient problems.
7. begin to plan and implement individualized nursing interventions, with instructor guidance.
8. communicate assessment findings systematically to other health professionals.

Verification

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

Authoring Instructor — Date: 30 May 2007.

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — Date: May 30, 2007

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — Date: May. 30/07

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:	Kathy Martin	TBA
	Office Hrs.: See posted hours at instructor's office		Connie Johnston	451-7189
			Connie Evans	432-8687
			Peggy Wyatt	432 -8782
			Terri Karapita	431-4975
			Corrine Schneider	TBA
			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 Textbooks:**

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. (2008) PDR Nurses Drug Handbook. New York: Thompson Delmar Learning.

4. **Nursing Care Planning texbook**

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

Gulanick, M. et al. (2003) *Nursing Care Plans: Nursing Diagnosis and Intervention* (6th ed.). Mosby.

5. **Med Math**

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

The following statements are in accordance with the BCIT Student Regulations Policy 5002. To review the full policy, please refer to: http://www.bcit.ca/~presoff/5002.pdf.

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, that the student be expelled 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/Illness:
In case of illness or other unavoidable cause of absence, the student must communicate as soon as possible with his/her instructor or Program Head or Chief Instructor, indicating the reason for the absence. Prolonged illness of three or more consecutive days must have a BCIT medical certificate sent to the department. Excessive absence may result in failure or immediate withdrawal from the course or program.

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:
BCIT Nursing Program Student Guidelines, Policies and Procedures which are located online at http://www.bcit.ca/health/nursing state: Applicants 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." Applicants who have any combination of two instances of withdrawal or failure in any Nursing Practicum course(s) for academic or performance reasons, will not be readmitted to the program.

Accomodation:
Any student who may require accommodation from BCIT because of a physical or mental disability should refer to BCIT's Policy on Accomodation for Students with Disabilities (Policy # 4501), and contact BCIT's Disability Resource Centre (SW1-2300, 604 451 6963) at the earliest possible time. Requests for accommodation must be made to the Disability Resource Centre, and should not be made to a course instructor or Program area.

Any student who needs special assistance in the event of a medical emergency or building evacuation (either because of a disability or for any other reason) should also promptly inform their course instructor(s) and the Disability Resource Centre of their personal circumstances.

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

Introduction to Assessment: Course Information Package

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.

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.

Assignment 1 (due week 3) & assignment 2 (due week 4):

Purpose of Written Assignments:
The purpose of these assignments is to assist students to develop knowledge and skill in their ability to analyze and synthesize patient information. From this process, nurses make 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 (p. 9).
This criteria is also the marking guide.

- The process of analysis and synthesis of patient data 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 assessment and analysis of patient data.
- The analysis of patient data is an **ongoing** process performed by nurses during the assessment of patients.
- You may work in collaboration with classmates, instructors, and other health professionals to assist you in this learning process.
- 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 develop your critical thinking 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, students learn to gather relevant data, make connections
  (links) between researched data & patient data, and perform assessments based on that data. These data include: researched data, physical assessments, vital signs, medication information, and laboratory values.
- The goal of analysis / synthesis of patient data is to identify patient problems and Nursing interventions **(how you will care for the patient)**.

Oral Presentation: 30 marks. Week 5 or 6.
(Refer to the criteria for Patient Presentation, p. 10). This criteria is also the marking guide.

The student will verballt articulate assessment and research findings of an assigned patient. The length of time for each presentation will be no longer than 15 mintues.

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, provide a brief description of the patient's health problem (definition or description of the disease or illness). Include any contributing factors to this diagnosis. Include pertinent medical history.
- Describe your assessment findings (head to toe, and focused assessments).
- Provide information on the patient's prescribed medications, why they were prescribed & how they relate to the patient's health problems.
- Report the patient's vital signs and relate them to the health problem. What do these vital signs tell you about this patient?
- Report lab values, and describe the relevance of the results to the patient's health problem.
- Conclude with a list of three- five ***actual or high risk patient problems.***

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 reported pain of 8/10; course of action might be to check to see when analgesia was last administered).

- After reviewing your data, look to see if some of the 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 problem, consider what might be causing these falls. Or, if **"chest pain"** is a problem, provide reasons / possible explanations for the cause of a patient's chest pain.
- What additional data would you obtain (or would you like to obtain) to try to validate the problem. What further information do you need to collect? Is there any lab data you would like to know? For example, what is the patient's blood glucose level? Hemoglobin? (within normal range?).

Assessment Skills Evaluation: Date: Thursday, September 20, 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 simulated patient. You will be given a short scenario (case study) to read. You will perform the assessment appropriate for this patient with an instructor observing.

As well as being tested on the "head to toe" assessment, you will also be required to assess one of the following systems: **neurological, abdominal, respiratory, OR cardiovascular.**

At the end of your skill testing scenario, you will be asked some critical thinking questions related to your assessment findings. For example, the instructor will ask you, "What patient problem can you identify from your assessment of this patient?" and "What is your rationale for identifying this problem?"

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 a mark of 30/30. 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.

Glossary of Terms:

- Actual problem: any health condition that requires diagnostic, therapeutic, or educational action.
- Potential problem: A potential problem describes a risk the patient may face due to a health condition; or side effect of therapeutic treatment. These potential risks may be designated as high risk (requiring immediate action or frequent assessment) or low risk, requiring preventive interventions and periodic assessment.

Journals:

- Please hand in (or email) your journals each week **per your instructor's direction.** Begin writing your journal entries at the end of week 2 (your first week in the Clinical setting). Please refer to the handout titled "Journaling" for detailed information.

Learning Plans:

- Throughout the term, you will find certain parts of the course material and learning objectives challenging. A Learning Plan is an effective way to identify and address your own learning needs, and develop and achieve objectives for the term. Consider this at about midterm (week 3). Discuss your learning plan with your clinical instructor.

NURS 1019 Assignments 1 & 2
(assignment criteria & marking guide)

1. Research of Diagnoses: Research done on admitting diagnosis as well as medical history of patient – information is relevant, thorough. Information provides brief but complete summary of definitions, etiology, pathophysiology, symptoms, treatment, and patient care.

2. Assumptions based on data provided: What would you assume this patient might look like / what behaviours might you observe? What might you expect to see?

3. Based on the information you received for this patient, what assessments would you perform and how would you prioritize these?

4. Provide information on each of the medications prescribed for this patient. Why were they prescribed, and how do they relate to the patient's health problem?

5. Interpret the patient's vital signs and lab values. Are they within normal range? What do these vital signs tell you about the patient?

6. List **two** priority patient problems you were able to identify from your assessment/ data collection.

Assignment 3:
Patient Presentation (week 5 **OR** 6): articulation of patient assessment.
(assignment criteria & marking guide)

Research of Diagnosis: Present research findings on admitting diagnosis as well as medical & social history of patient. Include relevant information only. Give summaries of definitions, considering etiology, pathophysiology, symptoms, treatment, and patient care.

Provide information on each prescribed medication for this patient. Why were they prescribed ? How do they relate to the patient's health problem / history ?

Interpret the patient's vital signs and lab values. Are they within normal range? What does this data tell you about the patient?

Based on the information for this patient, what assessments did you perform? What were your assessment findings? Please use a systematic way of articulating your findings.

List **three – five** actual or high risk patient problems. Prioritize these problems (put them in order of priority).

note: "assumptions" section is missing from this assignment criteria.