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 13, 2009 **End Date:** February 20, 2009

Total Hours: 70 **Total Weeks:** 6 **Term/Level:** 1 **Course Credits:** 3.55 **(1.44 + 2.11 cr)**

Theory Hours: 31.5 **2.11 cr** **Lecture:** 2 hrs. **0.14 cr** **Seminar**: 22 hrs. **1.47 cr**

Simulation Lab: 7.5h / 0.5 cr

Clinical Agency: 36 hrs**(1.44 cr)**

NURS 1019 is a pre-requisite for: NURS 1030 Nursing Clinical Practice 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 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.
This is a six week course that begins with on-line course material, accessible through BCIT's web platform. The on-line content is divided into 5 weekly units. Opportunity to practice learned skills is provided in small group, simulation lab, and clinical settings.

Evaluation	weight:	Dates / Due Dates:
1. Completion and **presentation** of Assignment 1	30%	Due date week 6, per instructor.
2. Final Exam (multiple choice & short answer)	40%	Wed, Feb 11. time TBA (wk 5).
3.Demonstration of Assessment Skills	30%	Thursday, Feb. 19, time TBA (wk 6)
TOTAL	100%	

The written assignment (handout for oral presentation) 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 three evaluation components for the course: Assignment 1, 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 in physical assessment.
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 — 5 January 2009. Date

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — December 18, 2008 Date

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — January 5, 2009 Date

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	Tammy Lail
	Office Hrs.: See posted hours at instructor's office	Connie Johnston 451-7189
		Cristina Durana
		Mina Amiraslany 432-8788
		Corrine Schneider 454-2217
		Judi Campbell 451-6957
		Merry van der Gracht 454-2214
		Karen Tautz

Learning Resources

On-line course materials

Pre-reading and weekly units with learning activities are provided on the BCIT web platform.

Required Texts:

Assessment

Jarvis, C. (2008). *Physical Examination and Health Assessment* (5th ed.). Philadelphia: W.B. Saunders.
*Elsevier assessment on-line course package is optional

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

6. **Pathophysiology**

Porth, C. M. (2005). *Pathophysiology: concepts of altered health states* (7th ed.) Philadelphia: Lippincott Williams and Wilkins

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.
- 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** 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 the classroom, lab, and clinical settings (Acute and Subacute Medicine). In these settings, students will work in small groups (approximately eight students with one nursing instructor).

3. In the classroom and lab, students will participate in a variety of structured learning activities aimed at developing assessment knowledge and skills. During clinical 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 clinical setting.

4. This course is of short duration. Therefore, students **must complete some 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 details

- 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, Assignment 1 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.
- Clinical instructors will ask you 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 writing narrative accounts of assessments performed 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, and vital signs.
- The goal of analysis / synthesis of patient data is to identify patient problems and Nursing interventions (**how you will care for the patient**). Nursing care plans are addressed in NURS1030.

Patient Presentation (Assignment 1): 30 marks. Week 6.
(Refer to the criteria for Patient Presentation, p. 10). This criteria is also the marking guide.

The student will verbally articulate assessment and research findings of an assigned patient. The length of time for each presentation will be between 10 to 15 minutes. Provide a 1 page summary of your patient assessment (word processed).

Below are the areas that need to be addressed in this presentation.

- Provide the initials of the patient (rather than full name – to respect patient confidentiality), 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.
- Briefly give the details of your patient's admission to hospital. Provide **relevant** details of your patient's treatment & response to treatment since admission.
- Describe your assessment findings (ABC's, head to toe, and focused assessments).
- Report the patient's vital signs and relate them to the health problem. What do these vital signs tell you about this patient?
- Conclude by identifying two actual, and one potential **patient problems. Provide validation for problems identified (What data [subjective / objective]do you have to support your problem statements?)**

When assessing a patient in the clinical setting, the process nurses follow is systematic & patient centered. When doing written assessments, or verbal reports, to other members of the Health Care Team, consider:

- When researching a patient's health problem, did any information signal you to take a course of action?

Some examples might be:

- Your patient reports pain of 8/10; your course of action might be to check to see when analgesia was last given to the patient.
- If your patient was admitted with a history of "**falls**," think about what might be causing the patient to fall. How will you assess your patient's safety?
- If "**shortness of breath**" is a problem, provide reasons / possible explanations for the cause of a patient's **dyspnea** (shortness of breath).

Also consider:

➢ What additional data would you obtain (or would you like to obtain) to try to validate the problem you have identified? What further information do you need to collect? These are the kinds of questions you will explore in Nursing 1019.

The written portion of your patient presentation assignment will consist of a one page, point form handout that you will prepare, and distribute to your classmates and teacher, in conjunction with your presentation. This handout will be an outline of your presentation, and will include:

- Brief definition of your patient's diagnosis and relevant medical history.
- Description of patient's admission and course of treatment.
- Your assessment of your patient (including ABC's, head to toe & focused) and vital signs.
- Patient problem identification.

Assessment Skills Evaluation: Date: Thursday, February 19, 2009 (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(s) 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 a grade of 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 submit (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.

Assignment 1:
Patient Presentation (week 6): articulation of patient assessment.
(assignment criteria & marking guide)

Introduce your patient by giving his / her initials (rather than full name), age, sex. (1 mark)

Admission to hospital: Give brief details of your patient's admission and course of treatment (hospital stay). Present research findings on admitting diagnosis (**s**ummarize definitions). Include patient's medical history if significant. (5 marks)

How did you establish that your patient's ABC's were stable? 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. (10 marks)

Give the patient's vital signs. Are they within normal range? What does this data tell you about the patient? (5 marks)

List **two** actual patient problems & **one** potential patient problem. Prioritize these problems (put them in order of importance (4 marks)

Provide a one-page, point-form, word-processed handout to go with your presentation. This handout should be an outline of your presentation, and provide highlights of your assessment findings. It should be **no longer** than one page. (3 marks)

Present your patient assessment verbally to your Clinical group. You will present the patient you were assigned in Week 5 or Week 6. Take 10 – 15 minutes to do this. Your presentation should be succinct and clear. (2 marks)