A POLYTECHNIC INSTITUTION

Course Outline

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

NURS 2030
Nursing Practicum 2

Start Date:	August, 2007			**End Date:**	December, 2007		
Total Hours:	224	**Total Weeks:**	16	**Term/Level:**	2	**Course Credits:**	9
Hours/Week:		**Lecture:**		**Clinical Experience:**	14	**Seminar:**	**Other:**

Prerequisites

Course No.	Course Name
NURS 1000	Nursing and Health Issues 1
NURS 1020	Clinical Techniques 1
NURS 1030	Nursing Practicum 1
NURS 1040	Professional Practice 1

Corequisites

NURS 2020	Clinical Techniques 2 — Laboratory

NURS 2030 is a Prerequisite for:

Course No.	Course Name
NURS 3034	Nursing of Families Practicum
NURS 3038	Mental Health Nursing Practicum
NURS 1060	Pharmacology
NURS 3000	Applied Nursing Science 3
NURS 3032	Family Nursing Theory
Current CPR	
Current CRNBC Membership	

■ Course Description

In this course students will be expected to provide knowledgeable and safe nursing care to patients in hospitals. The scope of nursing practice includes recognition and consideration of patient health needs entering the hospital as well as health needs requiring follow-up on discharge. Context of practice: Adult Surgery.

■ Detailed Course Description

NURS 2030 is a practicum course that focuses on providing nursing care for people experiencing health problems that require hospitalization and surgery. Emphasis is placed on developing knowledge, skills, and attitudes relevant to acquiring a professional nursing identity.

■ Evaluation

- Satisfactory/Unsatisfactory standing based on instructor evaluation and on successful completion of a journal.

Comments:

- All assignments must be completed to achieve a satisfactory standing.
- Course outcomes must be met consistently for the last three (3) weeks to pass this course.
- Unforseeable circumstances may necessitate the alteration of course.

■ Course Learning Outcomes/Competencies

(based on CRNBC Professional Standards – 2007)

Upon successful completion, the student will be able to:

1. provide professional caring which is based on knowledge and skills.
2. pursue shared meaning by communicating effectively with people.
3. use systematic inquiry to:
   a. recognize the uniqueness of each patient and/or patient situation and respond with appropriate clinical judgment.
   b. raise questions about nursing practices to explore alternatives.
   c. reflect on own nursing practice.
4. monitor own practice, determine learning needs, and independently act upon identified learning needs.
5. develop collaborative partnerships with members of the health care team.
6. use creative leadership skills to manage changing patient situations.
7. implement technical skills competently with increasing confidence.

Note: The above learning outcomes are further defined by sub-outcomes that are organized according to CRNBC indicator statements. See student practicum workbook.

■ Verification

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

Authoring Instructor	Date

I verify that this course outline has been reviewed.

Program Head/Chief Instructor	Date

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean	Date

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

■ Instructor(s)

Diane Brother	Office	SE12-418	Office	604-431-6956
Angela Lam (in charge of NURS 2030)	Location:		Phone:	604-451-6948
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Janet MacDonald		individual		604-456-1140
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Valerie Murray				604-456-8073
Claudia Mynott				604-431-4975
Susan Rowe-Sleeman				604-454-2216

■ Learning Resources

Equipment:

- a uniform that complies with program policies (refer to Guidelines for Students in the Nursing Program)
- shoes that comply with program policies
- a stethoscope
- a pen and notebook
- a penlight
- bandage scissors
- a watch with a second hand
- a lock may be required if you use a hospital locker to store coats, etc. while at the hospital

Textbooks/pamphlets:

Required:

College of Registered Nurses of British Columbia. (2006). *Scope of practice for registered nurses: Standards, limits, conditions.* Vancouver: Author. Retrieved on May 17, 2007 from http://www.crnbc.ca/downloads/433-scope.pdf

College of Registered Nurses of British Columbia. (2005). *The practice standards.* Vancouver, BC. Retrieved on May 17, 2007 from http://www.crnbc.ca/NursingPractice/Requirements/PracticeStandards.aspx

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

Nursing Program. *Guidelines for students in the nursing program.* Burnaby, BC, Canada: BCIT. http://www.bcit.ca/files/health/nursing/pdf/student_policies_august_2006.pdf

Ross-Kerr, J.R., & Wood, M. (Eds.) (2006). *Canadian fundamentals of nursing* (3rd ed.). Toronto, ON: Elsevier Canada.

Recommended:

- Black, J.M., & Hawks, H. (2005). *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.). Philadelphia: W.B. Saunders.

Dictionary:

- Taber, C.W. (2005). *Taber's cyclopedic medical dictionary* (20th ed.). Philadelphia: F.A. Davis.

Diagnostic textbook:

- Pagna, K.D., & Pagna, T.J. (2006). *Mosby's manual of diagnostic and laboratory tests* (3rd ed.). St. Louis, MO: Mosby-Yearbook.

Drug handbooks:

- Spratto, G.R., & Woods, A.L. (2006). *PDR nurse's drug handbook.* New York: Thomson Delmar Learning.
- College of Registered Nurses of British Columbia. (2005). *Administration of medications*. Vancouver, BC: CRNBC. Retrieved on May 17, 2007 from http://www.crnbc.ca/downloads/408.pdf

Math for meds textbook:

- Boyer, M.J. (2006). *Math for nurses: A pocket guide dosage calculation and drug preparation* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Clinical skills textbook:

Required:

- Perry, A.G., & Potter, P.A. (2006). *Clinical nursing skills and techniques* (6th ed.). St. Louis, MO: Mosby-Yearbook Inc.

Recommended:

Care planning textbook:

- Gulanick, M., et al. (2003). *Nursing care plans: Nursing diagnosis and intervention* (5th ed.). St. Louis, MO: Mosby.

■ Information for Students

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.

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. After an illness of three or more consecutive days, students must arrange to have a BCIT medical certificate sent to the department. Excessive absence may result in failure or immediate withdrawal from the course or program. .

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 and may receive a Zero (0) or Unsatisfactory (U) in the course, and the Associate Dean will recommend to the BCIT Vice-President, Education and/or President, that the student be expelled from the program.

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."

Accommodation: Any student who may require accommodation from BCIT because of a physical or mental disability should refer to BCIT's Policy on Accommodation 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.

■ Learning Process Threads

Professionalism: Students develop an understanding of the professional nurse's role within the surgical context of practice. They develop an understanding of nursing care that is required for safe practice. Students are accountable and responsible to follow through with work they have been assigned. They recognize the various contexts in which people live. Students use assessment knowledge to guide care with patients in acute surgical units. They analyze data and develop care plans to resolve patient issues and promote comfort. With assistance, students incorporate health promotion, illness/injury prevention, and rehabilitation into nursing care and begin to consider planning for discharge. Students implement sterile techniques associated with basic surgical nursing care. They make clinical judgments and act on those judgments. They evaluate their care according to standards and incorporate a code of ethics consistent with professional practice.

Communication: Students thoughtfully discuss practicum experiences verbally and in writing. They dialogue with colleagues and teachers in the process of learning. Students develop interpersonal awareness to identify the context of interactions and verbal and non-verbal attitudes and skills that facilitate or block shared meaning for self and others. They commit to the essential nature of communication in professional nursing. Students establish relationships with clients based on shared meaning and partnership. They anticipate concerns regarding surgery and apply knowledge to teach patients about the surgical experience, technical skills, and the plans for discharge. Students validate health issues with patients and discuss care with the health care team. They are independent with documentation and reporting of patient assessment and nursing care.

Systematic Inquiry: Students reason critically about data, patient concerns, and care. They clarify direction and practices to advocate for the patient and investigate alternate approaches to patient care. Students appreciate multiple perspectives that can be taken about patient issues. They think and reflect about technical skills by appreciating the research base, recognizing real and potential risks associated with the skills, and making judgments about the skill considering the context.

Professional Growth: Students take responsibility for their learning and for preparing information for practicum that is accurate and relevant. They take responsibility for attaining and maintaining a safe level of skill performance. Students are responsible and accountable for their actions. They begin to consider individual learning styles when preparing teaching materials for patients. They assess a variety of health professionals in hospitals. Students reflect on their values, beliefs, and assumptions about growth and development, ethnicity, health promotion, health/illness, and nursing concepts. They incorporate professional interpersonal skills into their ways of being. Students reflect on their experiences, recognizing their limitations and seeking assistance. They value discussions of own performance and self-evaluate and act on learning needs. Students share knowledge and experience with the group and take responsibility of debriefing sessions.

Creative Leadership: Students identify agency policies prior to acting. They describe the continuum of care as it relates to specific patients. Students begin to establish relationships with members of the health care team. They are generally assertive with colleagues as they work with health situations. Students explain their role and abilities and discuss patient care issues and concerns with health professionals. They are organized to care for two acute surgical patients including setting appropriate priorities for care. They are becoming confident at the bedside and are able to set limits on some inappropriate requests. Students intervene when patient safety is jeopardized. They are beginning to understand where their context of practice fits in the health care system; therefore, they are beginning to understand nursing leadership within this context of practice.

■ Learning Process Threads (cont'd.)

Technical Skills: Students continue to demonstrate correct assessment techniques during physical and psychosocial assessments and recognize normal findings and significant patterns of illness. They describe the purpose of skills and review agency policy regarding the skill. Students prepare a focused assessment of the patient related to the skills. Students anticipate skills to be performed and prepare and organize themselves to perform them. They maintain patient and own safety when performing skills and maintain patient comfort while performing selected skills. They are independent with the majority of technical skills learned this term, but may require minimal supervision with some. Students teach skills to patients and family. Specific skills include:

- surgical asepsis
- preoperative teaching and postoperative assessment
- injections — IM, SC, ID
- urinary catheter care and irrigation
- ostomy care
- intravenous therapy — maintaining, discontinuing, priming and tubing change, managing complications, IV pumps, introduction of medication to main bag and mini bag
- wound management — dressings, drains, sutures, staples.

■ Assignment Details

1. Students will be given patient information the day prior to the practicum experience. Research is required before the clinical experience so that students have a reasonable understanding of the reason for hospitalization, type of surgery and the nursing care the patient(s) might require. Students will complete written nursing care plan(s) prior to arriving at practicum.

2. Safe nursing care is required. The instructor has the responsibility to assist students to provide safe and comfortable care for the patients. Students are expected to take responsibility for errors and to document them according to agency and BCIT policy. Students whose care is unsafe may be removed from the practicum setting. (See Guidelines for Students in the Nursing Program.)

3. Students can expect to attend a weekly practicum conference. Students and the instructor have a joint responsibility to see that these conferences are meaningful. They will decide when the conferences will be scheduled each week and how the conference will be structured. A one hour a week conference is suggested.

4. Students will complete a written midterm and final evaluation that shows evidence that course outcomes are being met.

■ Reflective Thinking Activity

1. Students will keep a journal during this course. The reflective journal must demonstrate sufficient thoroughness and thought in order to be accepted.

2. The student's journal will be confidential between the student and the teacher. Sharing of any part of the student's writing will only occur when both student and teacher have given written permission.

■ Course Notes

1. Students have the right and the responsibility to evaluate the course. An end-of-year review is aimed at modifying the course for subsequent students.

2. Students are responsible to identify their own learning needs and to consult with the instructor about how they might meet these needs. Students will meet with their instructors at the beginning of the term to discuss their learning needs and to prepare a learning plan. The students will update their learning plans as the term progresses.

3. A learning partnership is essential for successful completion of this course. Both student and instructor will communicate openly, will demonstrate respect in the relationship, and will work to maintain a reasonable balance of power in the relationship. This can be achieved by:

   - discussing the course outcomes to achieve shared understanding of them.
   - identifying the evidence required to demonstrate achievement of the outcomes.
   - dialoging regularly throughout the course.

BCIT

NURSING 2030

LEVEL II

STUDENT PRACTICUM WORKBOOK

September, 2007

Phone Chain

Instructor:_____

Instructor office phone:_____Home Phone:_____Cell:_____

Office:_____

Students	Phone number	Orientation Manual number	CPR/ CRNBC
1._____	_____	___	_____
2._____	_____	___	_____
3._____	_____	___	_____
4._____	_____	___	_____
5._____	_____	___	_____
6._____	_____	___	_____
7._____	_____	___	_____
8._____	_____	___	_____

***Contact Person_____

BCIT NURSING
GUIDE TO THE USE OF THE LEARNING PLAN
FOR STUDENTS AND INSTRUCTORS

Students must start each practicum experience (with the exception of Level 1) with a professional learning plan completed. The expectation is that students will identify specific sub-outcomes that need work and then act on the strategies identified. Students are recommended to keep their learning plans in a portfolio that they can take from term to term. (Curriculum Review Committee, May 14, 2001)

Students and instructors will adopt the "3R" approach (**review, revise, roll over**) to learning plans.

Every student is responsible to complete and update (review and revise) a learning plan. Students need to take ownership of their learning plans.

Each student's learning plan should be reviewed by the instructor at the beginning (with the exception of Level 1), midterm, and at the completion of the semester as well as on a prn basis (review). The final learning plan for the semester should be brought forward (rolled over) by the student to the next level.

It is important for students to "carry through" or "roll over" their learning plans into each and all levels and in Level 3 students should "roll over" their learning plans into each specialty.

Learning plans **will not** be placed in students files. Students should keep **all** their learning plans throughout the program. Keeping all learning plans together in a file folder, duo tang, portfolio is a good thing!

The learning plan contains three sections:

1. Learning needs. This section should contain identified sub-outcomes that students and/or instructors determine that the student needs to work on. Use your outcomes and sub-outcomes for each level as a guide to identifying these areas to work on or learning needs.
2. Strategies. Identify strategies or specific ways that you can meet your identified sub-outcomes. You should have several strategies identified for each learning need that you have identified. Reflect on your strengths and incorporate your strengths (where possible) in creating workable strategies.
3. Progress. In this section you will comment on your progress toward meeting your identified sub-outcomes. You may find that some learning needs are ongoing throughout the semesters of the program. Date each of your comments in order to be able to look back and reflect upon your progress.

Note: The "3R's" were created by L. Barratt. May 2002

Name of Student: **Course:** **Date:**

Learning Needs	Strategies	Progress (Date of Comments)

Name of Student: **Course:** **Date:**

Learning Needs	Strategies	Progress (Date of Comments)
1. Improve my ability to pronounce correctly various medical terms and names of medications.	1a. Ask instructor, fellow students or other healthcare processionals for clarification. 1b. Repeat new words once learned to reinforce the correct pronunciation. 1c. Use computer medication program that sounds out the proper pronunciation of medications.	1. Expanding vocabulary daily Nov. 27, 2003
2. Continue to improve accurate and concise reporting of patient's changing condition to appropriate heal care providers.	2a. Collect and organize pertinent data before approaching and reporting. 2b. Continue to use homemade tool for collecting and reporting data.	2. Feel strong at reporting now Nov. 27, 2003
3. Remain open and interested in activities involving other patients on the unit, while still ensuring that assigned tasks are completed in a timely and thorough fashion.	3a. Remain focused on patient's daily task and complete these tasks prior to getting too involved in the care of other patients and to chart more frequently so that I'm not rushing to complete tasks at the end of the shift.	3. Improving weekly especially when I make a conscious effort. Able to say "no" to other students and nurses when I am unable to help them out when I am too busy. Nov 27, 2003

STANDARD 1: Responsibility and Accountability

Maintains standards of nursing practice and professional conduct determined by CRNBC and the practice setting.

- Takes action to promote the provision of safe and appropriate care to clients.
  - Diplomatically and tactfully questions the health care team when unsure of the rationale behind nursing practices.
- Follows BCIT and agency policies and procedures. (www.bcit.ca)
- Is accountable and takes responsibility for own nursing actions and professional conduct.
  - Takes charge of patient care rather than just following directions.

STANDARD 2: Specialized Body of Knowledge

Bases practice on the best evidence from nursing science and other sciences and humanities.

- Knows how and where to find needed information to support safe, appropriate and ethical client care.
  - Prepares for the clinical experience and is able to discuss potential post-operative problems, the diagnosis and priority nursing care.
- Uses knowledge of communication theory and appropriate professional boundaries to communicate effectively.
  - Demonstrates respect to patients, family members, staff, instructor and fellow students.
  - Able to establish relationships with patients, instructor, fellow students and health care team.
    - Able to move from a social to a therapeutic interaction with the focus on the patient.
    - Demonstrates a focus on the patient during interactions.
    - Demonstrates active listening, e.g., paraphrasing, reflection and clarification.
    - Responds to non-verbal communication.
  - Demonstrates the use of basic interviewing skills to elicit information.
    - Able to focus on the patient during interview.
    - Demonstrates active listening.
    - Responds to non-verbal communication.
    - Ability to ask pertinent or relevant questions and clarify answers.
  - Gains patient's trust.
  - Is confident at the bedside.
- Interprets and uses current evidence from credible sources to make practice decisions.
  - Teaches patients and/or family pre-operatively and in preparation for discharge.

- Performs appropriate teaching before, during and after a technical skill to the patient and family members.
- Asks about and researches alternative approaches to patient problems.

- Anticipates, prepares and organizes self to perform skills.

STANDARD 3: Competent Application of Knowledge

Makes decisions about actual or potential problems and strengths, plans and performs interventions, and evaluates outcomes.

- Collects information on client status from a variety of sources using skills of observation communication and physical assessment.
  - Performs a focused, thorough, and ongoing assessment and relates nursing action to assessed data.
  - Demonstrates an understanding of the patient's situation and context through the use of communication skills.
  - Attempts to understand situations from a variety of viewpoints.
- Designs plans of care that include data about assessments, planned interventions and evaluation criteria for client outcomes.
  - Plans, implements and evaluates safe, individualized nursing care.
  - Involves the patient in planning care and encourages the patient to take charge of his/her health care.
  - Individualizes patient care and responds to patient input.
- Sets priorities when organizing, planning and giving care.
- Identifies, analyzes and uses relevant and valid information when determining client status and reporting client outcomes.
  - Thinks through nursing situations before coming to conclusions, and clarifies conclusions when necessary.
  - Articulates the thinking behind nursing actions and judgment.
  - Recognizes and reports promptly to RN and/or instructor when the patient's condition changes.
- Documents timely and accurate reports of assessments, plans interventions and client outcomes.
  - Records in a professional manner.
    - Clear and concise.
    - Accurate and relevant with correct spelling.
    - Timely.
    - Legally, according to agency guidelines.
  - Reports and records observations assessed pre, during and post skill and interprets observations.
- Communicates client status, using verifiable information, in terminology used in the practice setting.

- Reports, in a clear and timely manner, about patient care and progress to appropriate team members.

- Carries out interventions in accordance with policies, procedures and care standards.
  - Intervenes when the patient's safety is in jeopardy.
  - Maintains patient and own safety and comfort when performing skills.
  - Uses resources to perform skills safely.
  - Practices surgical asepsis.
  - Demonstrates reasonable manual dexterity.
  - Communicates appropriately with patients and family members during technical skills.
  - Maintains a tidy work area at the patient's bedside.
- Initiates, maintains and terminates professional relationships in a manner appropriate to the setting.
  - Establishes an effective rapport with RN.

STANDARD 4: Code of Ethics

Adheres to the ethical standards of nursing profession.

- Maintains confidentiality when discussing patient specific nursing practices.
- Acts as a patient advocate when the situation arises.
- Knows and upholds the values contained in the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses, namely:
  - Safe competent and ethical care.
  - Health and well-being.
  - Choice.
  - Dignity.
  - Confidentiality.
  - Justice.
  - Accountability.
  - Quality practice environments.

STANDARD 5: Provision of Service in the Public Interest

Provides nursing services and collaborates with other members of the health care team in providing health care services.

- Communicates, collaborates and consults with other members of the health care team about the clients' care.
  - Introduces self to team members and explains role and abilities.
  - Addresses and solves a communication problem that may occur.
  - Follows up on patient issues with other health care professionals.
- Assigns appropriately to other members of the health care team.
  - Spontaneously helps team members.

- Advocates and participates in changes to improve client care and nursing practice.
  - Attempts to take on a leadership role when appropriate.
- Assists clients to learn about the health care system and access appropriate health care services.

STANDARD 6: Self-Regulation

Assumes primary responsibility for maintaining competence and fitness to practice.

- Maintains current registration.
- Practices within own level of competence.
  - Recognizes limitations and seeks help from appropriate sources.
  - Seeks assistance when limitations are exceeded.
- Meets the requirements for continuing competence, including investing own time, effort or other resources to meet identified learning goals.
  - Writes weekly reflective journals about practicum experiences.
  - Celebrates personal and professional growth.
  - Accepts feedback in an open manner.
  - Takes charge of own learning.
  - Develops and participates in a learning partnership with instructor.
    - Is willing to self-disclose about clinical performance with instructor.
    - Acts to improve clinical performance.
    - Sets goals and strategies for action.
    - Plans, implements and evaluates improvement strategies.
  - Evaluates own progress.
- Maintains own physical, psychological and emotional fitness to practice.
  - Demonstrates a fitness to practice in the clinical setting by:
    - Effective coping strategies to deal with anxiety and psychological issues.
    - A support system to help with financial, time management and emotional issues.

BCIT
Nursing Program
Level 2

JOURNALING

Journaling is a reflective activity. Reflection fosters personal and professional growth through contemplation of our experiences, knowledge, attitudes, and feelings. It enables us to find meaning from our experience — to learn.

In Level 2 we want you to keep a journal about your experience as you become a nurse. We thought you might title the journal "Becoming a Nurse." You may have other ideas about what to title it. If so, feel free to give it a different title.

The type of journal we want you to write is called a dialogue journal. It is designed to form a dialogue between you and your instructor. It is written in the style of a friendly letter. The writing of your journal will help you with your understanding of your experiences — both through the process of writing down your thoughts [Writing is one way to develop thinking skills] and through the opportunity to share your thinking with your instructor. Choose from your readings, your classroom and clinical experiences, and your personal experiences to focus your writing.

There are many ways to write about your thinking. One way is to use the elements of the reflective process. To do this you recall the experience that you wish to reflect upon and re-evaluate it considering the following elements:

- ***association*** — link the knowledge, attitudes, and feelings arising from the experience to that which you already know.

- ***integration*** — try to find relationships among old and new knowledge, attitudes, and feelings.

- ***validation*** — determine the rightness, certainty, and adequacy of the new ideas and feelings that have resulted for you and your purposes.

- ***appropriation*** — take the new knowledge, attitudes, and feelings as your own.

Note that each experience you reflect upon can be examined for new learning about knowledge, attitudes, and feelings. The context in which the experience happened is a significant fact to consider. The elements of the reflective process do not have to be addressed in sequence. There is some overlap between them at times. The eventual outcome of reflection is change in perspective and/or in behavior.

Features of reflective, non-reflective, and critically reflective thinkers are attached (Appendix A) to enable you to self-evaluate your level of reflection in order to aim for the highest level — a critically reflective thinker.

Try to make entries in your journal regularly.

Your journal is to be handed in to your instructor every week. Please use a light-weight book for your journal.

Your journal is confidential between you and your instructor.

The journal must be completed to achieve a satisfactory standing in this course. The reflections must show sufficient thoroughness and thought in order to be accepted.

For those of you who prefer things in point form, here is a summary:

1. Keep a journal as one of the requirements for the nursing course.
2. Write in your journal at regular intervals.
3. Hand your journal in to your instructor every week.
4. Your journal is confidential between you and your instructor.
5. Use the elements of the reflective process as a way to examine your experiences and develop your thinking skills.
6. Use a light weight book for your journal.

Appendix A

Features of Non-Reflectors

Very descriptive in their papers. They tend to report on the happening, rather than re-visiting the experience and analyzing it. They make no inference or analysis of the experience.

Tend to make assumptions without trying to test them for their validity. View is usually presented without supportive evidence nor specific referencing to the experience.

Tend to adopt a relatively straightforward way of viewing the situation. There is little awareness of the contextual factors. The thinking tends to be concrete, "as-a-matter-of -fact," and there is minimal evidence of abstract thinking.

Write reflective papers like any other academic paper. Those papers appear to be rather impersonal. They describe ideas substantiated with references, as if they have never gone through the experience.

Features of Reflectors

Demonstrate reflection but only at one or more of the first two levels, i.e., association and integration. Are able to relate their experiences and turn them into new learning opportunities.

They can identify relationships between prior knowledge and/or feelings with new knowledge and/or feelings.

They do not demonstrate effort in validating assumptions, signs of making knowledge one's own, nor transformation in perspectives.

Features of Critical Reflectors

Attain reflection at the level of validation, appropriation, and/or outcome of reflection.

Always return to the experience in the discussion. Continually examine the experience and themselves in a critical manner.

Are able to frame the experience in context.

Adopt a wide and multi-dimensional perspective in dealing with the issue at hand.

Draw on a number of resources, including prior knowledge, existing information and the literature.

Tend to be courageous in trying out different methods, and are amenable to change.

Decline practicing by habit and do not take things for granted.

The information in this appendix is taken from the article by Wong et al.

Bibliography

Heinrich, K.T. (1992). The intimate dialogue: Journal writing by students. *Nurse Educator, 17*(6), 17–21.

Paterson, B.L. (1995). *Developing and maintaining reflection in clinical journals.* Manuscript submitted for publication.

Wong, F.K.Y., Kember, D., Chung, L.Y.F., & Yan, L. (1995). Assessing the level of student reflection from reflective journals. *Journal of Advanced Nursing, 22*, 48–57.

The journal that students keep in Level 2 will provide students opportunity to:

1. **apply relevant content and concepts to specific practice situations.**

2. **dialogue about clinical and personal experiences in relation to reflection and/or course discussions.**

Questions or direction that assists the student to apply relevant content and concepts to specific practice situations:

- Describe the type of surgery and anesthetic one of your patients had. How did your knowledge of this content help you decide upon the assessment criteria that were relevant in the situation? What pertinent cues from your nursing assessment did you pay attention to? Explain why these cues were significant physiologically. What action did you take on the basis of these cues?

- Describe a clinical experience in which you established a partnership with a patient. What is your understanding of the meaning the surgical situation has for this patient? What does this situation represent to the patient in his/her own context? Discuss how open communication, mutual respect and cooperation contributed to the development of the partnership.

- Reflect on the work of nurses on a surgical unit. Describe an example from your experience in which you observed and/or assisted in nursing care that promoted or restored health. How did the nurse or you enhance the patient's coping abilities?

- Based on your experience working on a surgical unit consider how technology influences practice. Discuss specific examples to support claims that technology influences practice and that practice should influence technology.

- Describe your patient's relevant health history and the surgery done. Explain how the dependent and independent nursing interventions you carried out related to your patient's health status.

- Focus on a particular clinical day, describe specific leadership skills you used to manage changing patient situations on the unit. What leadership strengths have you become aware of? What leadership skills do you wish you had?

- Reflect on your awareness of professional caring by discussing rational, technical and emotive elements. Discuss specific examples that demonstrate your unique ability to demonstrate professional caring.

Questions or direction that help students dialogue about clinical experience and their reflections in relation to that experience:

- Recall a particular clinical experience in which you recall experiencing negative feelings. Describe this experience. Reflect on what triggered the negative feelings and identify possible reasons. What assumptions were you taking into consideration? How did you manage so that nursing care was not compromised? If you think your nursing care might have been compromised what might assist you in a similar situation?

- Reflect on yourexperiences working on a surgical unit. What experiences have been the most difficult to cope with? What might contribute to this difficulty? What have you found helps you cope in the situation?

- Reflect on feedback a patient gave you in relation to some aspect of your nursing care. How has that feedback made a difference to your nursing experience? How should nurses be accountable to the public they serve?

- Describe a patient situation that you believe is a significant event in that person's life. How did you know this was significant? How did you individualize nursing care to meet this person's needs? Describe your unique way of being with that person.

- Describe a particular nurse patient relationship in which you were engaged. What contributed to that engagement? How is it possible to be engaged with some patients and not with others? What meaning might the patient obtain from this kind of relationship?

- Nurses often perform clinical techniques that cause pain for the patient. Reflect on an experience you had as a student nurse in which the patient experienced pain as a result of a nursing intervention you carried out. What was this experience like for you? How did you assist the patient to cope with the experience? How did you cope with this experience? What did you learn that might be helpful in a similar situation?

Guidelines for the completion of BCIT Unusual Incident reports (specific to medication errors):

- late administration without sound rationale (e.g., new order—med. not available at designated time—pt. not on ward—SN could not have planned in advance), would include:
  - no attempt made to look up info. re. drug in advance of time due.
  - SN very slow in preparation and admin. of med.
- not completing seven rights and three checks during preparation of med.
- incorrect calculation of fractional dose (once student has been successful in related math test).
- incorrect dose poured due to: misinterpretation of order, misreading label, unfamiliarity with route, etc.
- patient with allergy given offending drug without due consideration and discussion with instructor/RN.
- outdated drug poured.
- drug past stop order date (see individual agency policy).
- incorrect time.
- incorrect route.
- wrong patient.
- dose omitted.
- improper patient identification:
  - not checking name band prior to administration.
  - name band checked but not carefully enough resulting in attempt/actual admin. of med. to wrong patient.
- prn meds. not charted immediately.
- meds. not signed for in appropriate manner, e.g., wrong route, omitting route, wrong dose, incorrect spelling.
- not taking pulse or BP prior to administration of drug (as required in relation to specific medications).
- failure to check compatibility chart prior to mixing meds. in syringe or IV medications.
- failure to follow BCIT's Policy re: medications.
- giving a med. whose order (MAR/card) is unchecked by RN

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY
NURSING PROGRAM

RECORD OF UNUSUAL INCIDENT IN THE CLINICAL AREA

Student: _____ Student #: _____ Level: ____
print

Student Signature: _____ Date: _____

Date of Incident: _____ Hospital incident filed: yes / no
day / month / year

Facility where incident occurred: _____

1. Briefly describe the incident. If medication-related write out order.

2. Identify actual and/or potential effect on patient.

3. Briefly describe the agency system (procedure, policies, etc.) related to this incident.

over

4. Briefly outline steps you (student) will take to prevent reoccurrence.

5. Which Standard(s) for Nursing Practice in British Columbia relates to this incident? Explain the relationship between the incident and the Standard(s).

Preceptor's / instructor's comments:

Preceptor/Instructor Signature: _____ Date: _____

Course instructor notified: yes / no Date notified: _____

Course instructor's comments:

Course Instructor's Signature: _____ Date: _____

BURNABY CAMPUS
3700 Willingdon Avenue
Burnaby, B.C.
Canada V5G 3H2

Student Medical Certificate

Student Number: _____

A. To be completed by student:

I, _____, hereby authorize the physician named below to provide the following information to BCIT and, if required, to supply additional information relating to my petition for special academic consideration.

_____ _____
Signature Date

B. To be completed by physician:

I hereby certify that I provided medical services to _____, a student at BCIT. On the basis of the care provided, I am submitting the following information for use by BCIT in assessing what special consideration, if any, should be given to this student with respect to missed or affected classes, labs, assignments, tests or examinations.

1. Date(s) patient seen: _____
2. Is this an acute or chronic problem?: _____
3. Date of onset of problem (or acute episode if problem is chronic):_____
4. Expected duration of the problem and treatment: _____
5. The immediate and/or ongoing impact of this problem and/or the treatment on the student's ability to meet academic commitments (such as attending classes, completing assignments, preparing for and/or writing tests and examinations, completing courses, etc.) is as follows:

_____

_____

_____

_____

6. Diagnosis or nature of health problem: **(Not required)**
(Please do not complete this section unless the student has specifically requested you to do so.)

_____

_____

_____

Office address stamp:

Signature:_____

Name (Please print):_____

Date:_____

Please retain copy for the patient's chart
Note: Any cost for this certificate must be paid by the patient

Rev 2002-03-15

When you arrive on the ward...

- Make sure that your assigned patient is on the ward. The patient might be in a different room.
- Find out the name of the RN/LPN working with your patients.
- Check the chart for doctor's orders—new and current, OR sheet re: what surgery was done, last 24 hours of nurses' notes, doctor's history.
- Check the MAR for medications and times.
- Go to report. Listen and take notes about your patients. Let the RN know which patients you have and what you can't do.
- Assess all of your patients.
- Provide required care.

Before you leave the ward...

- Be sure:
  - your patients are comfortable,
  - the bed is low,
  - bedrails are up as required,
  - bedside is tidy,
  - call bell and over-bed table are within reach,
  - drinking water is fresh and in reach.
- Empty anything which needs emptying.
- Be sure intake and output have been recorded.
- Check for doctor's orders that have not been processed.
- Chart:
  - nurses' notes,
  - flowsheet,
  - graphics,
  - signature page.
- Check that you have given all the meds on the MAR.
- Fill in the Kardex infomation.
- Report off to the RN/LPN.

POSTOPERATIVE ASSESSMENT

- Obtain a summary report from a PACU nurse.
- Check the postoperative doctors orders on the chart.
- Assist PACU personnel to transfer the patient to bed.
- Observe the patient's respiratory pattern and auscultate the lungs.
- Check oxygen saturation using a pulse oximeter.
- Administer oxygen if the oxygen saturation is less than 90% or if prescribed by the physician.
- Note the patient's level of consciousness and response to stimulation.
- Orient the patient and instruct him or her to take several deep breaths, as taught preoperatively.
- Check vital signs.
- Repeat vital sign assessments at least every 15 minutes until they are stable, then take them every hour to every 4 hours, depending on the patient's condition, medical orders, or ward routines.
- Check the incisional area and the dressing for drainage.
- Inspect all tubes, insertion sites, and connections.
- Check the type of intravenous fluid, the rate of administration, and the volume that remains.
- Monitor urination; report failure to void within 8 hours of surgery.
- Auscultate bowel sounds.
- Assess the patient's level of pain and its location and characteristics.
- Administer analgesic drugs according to prescribed medical orders, if safe to do so.
- Remind the patient to perform leg exercises.
- Use a side-lying position if the patient is lethargic or unresponsive.
- Raise the side rails unless providing direct care.
- Fasten the call light within the patient's reach.

SAMPLE CHARTING-RETURN TO WARD FROM PACU

1310 Returned to ward from PACU. Drowsy but responds to stimuli. Oriented in three spheres. Respirations clear to bases bilaterally at 14/min. BP 110/65. P. 76. Colour pale, lips pale, nail beds pink. Abdominal dressing dry and intact. Scant medium red loss per vagina. Urethral catheter draining clear amber urine; 150 mls. in bag. IV 2/3-1/3 with 20 mEq KCL infusing at 125 ml per hour into left forearm. 700 ml. TBA. IV site free of redness and swelling. Moving side to side spontaneously. Complaining of moderate discomfort (4 out of 10) in surgical site.

----------M. Green BCIT SN

NOTE:

Do admission charting within 30 minutes of the patient's arrival back to ward.

Chart patient's voiding status at the end of your shift.

Chart the initial postoperative vital signs on the vital sign sheet as well as in the nurses' notes.

Check hospital policy regarding frequency of postoperative vital signs checking.

Check vital signs 15 minutes after first analgesic that is given after the patient returns to the ward.

room *to prevent disorganization at the time of the patient's arrival.*

PROCEDURE FOR THE IMMEDIATE CARE OF A POSTOPERATIVE PATIENT

You can use this general approach to care for any postoperative patient being received from the PACU. It can be modified as appropriate for the needs of a specific patient.

1. Receive the patient from the PACU nurse. Move the patient carefully from the stretcher to the postoperative bed. *Rough or precipitous handling can contribute to sudden changes in pulse and blood pressure.* Use of a device, such as a sliding board, can make the move safer and more comfortable for the nurse and patient. You may also wish to review Module 20, Transfer. Leave in place the blanket that covered the patient en route to the unit *to help prevent chilling.*

Assessment

2. Receive the report from the PACU nurse. *This report gives you information about the patient's stay there and is a baseline for your own assessment.* In some facilities, PACU personnel telephone a status report to the nursing unit before the patient leaves the PACU to assist the nurse in preparing for the arrival of the patient.
3. Make the following initial observations:
   a. Time of arrival on unit
   b. Responsiveness (to what the patient responds and how he or she responds, for example, to name call)
   c. Vital signs:
      (1) Temperature
      (2) Pulse
      (3) Respirations
      (4) Blood pressure
   d. Skin:
      (1) Color
      (2) Temperature (warmth or coolness)
      (3) Condition (dryness or moisture)
   e. Dressing:
      (1) Clean
      (2) Dry
      (3) Intact
   f. Look and feel under patient to detect pooling of blood.
   g. Presence of an intravenous infusion:
      (1) Type of solution
      (2) Amount left in bottle
      (3) Drip rate
   h. Presence of urinary bladder catheter:
      (1) Unclamped
      (2) Connected to drainage bag or bottle
      (3) Freely draining
      (4) Characteristics and amount of urine
   i. Presence of other drainage tubes:
      (1) Unclamped
      (2) Attached appropriately to bottle or suction
      (3) Tubes not kinked or under patient
      (4) Characteristics and amount of drainage
   j. Safety and comfort:
      (1) Presence of pain, nausea, or vomiting
      (2) Position appropriate for surgical procedure
      (3) Side rails up, bed in low position, and call light within reach
4. Check the chart for the following information (some of which may have been included in the report from the PACU nurse):
   a. Surgical procedure or length of surgery
   b. Postoperative diagnosis
   c. Anesthetic agents used or length of anesthesia
   d. Estimated blood loss
   e. Blood or fluid replacement given during surgery and PACU stay
   f. Type and location of drains
   g. Vital signs when patient left PACU (for use as a baseline)
   h. Medications administered in the PACU:
      (1) Time
      (2) Type
      (3) Amount
      (4) Response of the patient
   i. Output:
      (1) Urine
      (2) Other drainage
      (3) Vomitus
   j. Physician's orders:[2]
      (1) Frequency of vital signs
      (2) Diet
      (3) Activity
      (4) Intravenous orders
      (5) Medications (amount and frequency of pain and other medications)
      (6) Laboratory or respiratory therapy orders
      (7) Orders specific to type of surgery or other problems of patient

   Some institutions use a PACU nursing record, which can be very helpful to the nurse who is taking over the care of the patient on the nursing unit (Fig. 45–1).

In most facilities, postoperative orders automatically cancel all previous written orders. Previous orders must be reordered by the physician after surgery if still wanted.

A Checklist For Better Discharge Planning

Here's a checklist for discharge planning that not only reminds you what to *teach* the patient but also documents what he's *learned.*

BY E. JANE MEZZANOTTE, RN, MSN
Assistant Professor
School of Nursing
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Milwaukee, Wisconsin

SOMETIMES a patient's discharge from the hospital comes as a surprise to both you and the patient. For instance, when the patient recovers more rapidly than the doctor had expected. Or when you find out the patient has an excellent support system at home. Or when the patient hadn't been aware of the trend toward shorter hospital stays.

Whatever the reason, the patient may find himself overwhelmed by the pressures of scurrying to leave the hospital. As a result, his anxiety level rises. And with time so limited, he (and his family) leave with less than complete information to continue a satisfactory recovery.

Here's where you—and a checklist—can make a difference. By basing your discharge planning on *outcome criteria* (what the patient has demonstrated he can do) rather than on *process criteria* (what you tell the patient), you can better prepare him to continue his care after discharge. And by checking off what he demonstrates he can do, you can document what's been taught and what he's learned.

The lack of discharge planning is especially a problem with the "average" patient, the one who's hospitalized only a few days, who doesn't have any unusual complaints or complications, who appears to be adjusting and recovering well, and who's anxious to leave the hospital. Yet he needs to be prepared for discharge, as much as a long-term patient does. This checklist, based on outcome criteria, helps ensure he will be.

Although many outcome criteria apply to patients with specific medical diagnoses or specific nursing problems, this checklist can be applied to almost all patients. You can tailor it to your patient by deleting criteria that don't apply to him and adding any criteria you feel are necessary.

To help reduce your patient's anxiety about leaving the hospital, you can adapt the checklist to a patient handout. List the same eight items (only the headings) on a sheet of paper, leaving space beneath each one for notes. Then, as you complete your checklist with the patient, he, a family member, or you can write the appropriate information under the item on his handout. This will help reassure the patient (and you) that he's thoroughly prepared to continue his recovery after discharge from the hospital. NT

CHECKLIST OF OUTCOME CRITERIA FOR HOSPITAL DISCHARGE

1. Appointments/When to call the doctor or nurse
_____ schedules appointment with his doctor, or
_____ states when he should make an appointment
_____ has appointment with other health care worker (nurse, physical therapist, occupational therapist) if needed
_____ states reasons for calling his doctor or nurse before the scheduled appointment (for bleeding, swelling, increased pain, or other complications)

2. Diet/Fluids
_____ states the diet he must follow after discharge
_____ has copy of his diet
_____ explains his diet
_____ states who to call with questions about his diet
_____ explains suggestions/restrictions regarding fluid intake—what he should drink and how much

3. Medications
States for each medication he must take
_____ its name
_____ the proper dose
_____ how often he takes it
_____ when he takes it (before or after meals)
_____ why he takes it
_____ special precautions and side effects to watch for
_____ when to call the doctor concerning the medications
_____ has prescription(s) if needed

4. Treatments/Procedures/Dressings
_____ demonstrates he, a family member, or friend can perform any necessary treatments, procedures, and dressing changes
_____ has literature if needed
_____ has the necessary equipment, supplies, and dressings, or
_____ states where to obtain these items
_____ explains alternatives (disposable vs permanent; purchase vs rental; small vs large sizes)
_____ explains the equipment's use in the treatment or procedure
_____ explains how to dispose of soiled dressings

5. Activities/Special restrictions
_____ states recommendations (such as, increase walking to 1 mile within 2 weeks)
_____ states limitations regarding positioning, weight-bearing, lifting, stair-climbing
_____ demonstrates prescribed exercises

6. Assistance at home
_____ has referral to home-care services if needed
_____ lists community resources available to him (American Cancer Society chapter, stroke, laryngectomy or ostomy club, hot lines, support groups); has printed information about appropriate community resources

7. Clothing for leaving the hospital
_____ has appropriate clothing, including footwear, for the season and for his altered physical condition

8. Checking out of the hospital
states check-out time
_____ explains how the bill will be handled, and
_____ states who will go to the billing office
explains how he will leave (by car, cab, ambulance)

Encore

Here's a second look at an especially important article from one of our past issues. This one appeared in the November issue of *Nursing80*. Its authors have updated and revised wherever indicated and reaffirmed its validity for nursing today.

Some questions you should be able to answer following your OR experience:

- How and by whom is the patient identified?
- Who looks at the consent form?
- How is the amount of anesthesia given to the patient determined?
- How is the airway kept patent during the surgery?
- How is the patient monitored during the surgery?
- How might the position of the patient was in during surgery affect him/her postoperatively?
- When does the anesthetist's responsibility for the patient end?
- How is an OR scrub done?
- How is gowning and gloving done?
- Who of the people in the OR must scrub, gown and glove?
- How is the patient's skin prepared?
- Who drapes and how?
- How are the principles of asepsis applied in the OR?
- Does this differ from their application on the ward?
- How many sponge and instrument counts are done?
- When are these done?
- What safety precautions are important when caring for immediate postoperative patients?
- How do the nurses in PARR stimulate the patient as he regains consciousness?
- What was the patient's reaction to the preanesthetic time spent in OR?
- What responses did you observe in the patient while he/she was under anesthesia?
- How did your patient behave as he/she regained consciousness?

Overall Objective

The student will observe the preoperative, operative, and postoperative care of a surgical patient.

Contributing Objectives

- The student will observe the following:
  - administration of the anesthetic.
  - operative procedure.
  - patient responses before and during the operative procedure.
  - nursing care of patients.
  - role of OR nurses.
- Accompany the patient, as directed by staff, to the post-anesthetic recovery room and observe:
  - patient's responses when recovering from anesthesia and operative procedure.
  - nursing care of patients.
  - role of PARR nurse.
- Identify safety precautions to protect patient from risk associated with surgical procedures.
- Be prepared to present during a post-conference your answers to the questions on the assignment for OR experience.

Under the supervision of the registered nurse in charge of day care surgery, the student will:

- admit preoperative patients to the day care surgery unit.
- prepare patients for the operating room.
- admit patients to the day care unit from the operating or recovery room.
- discharge patients from the unit.
- observe diagnostic procedures as available.

POSSIBLE POST OPERATIVE PROBLEMS
BCIT PRACTICUM LEVEL 2

POTENTIAL PROBLEM	THERAPEUTIC MEASURES
Risk for ineffective breathing pattern related to any of the following: • **Atelectasis** • **Pneumonia** • **Respiratory depression** • **Anxiety** • **Hx of smoking** • **Underlying respiratory disease** • **Pain** • **Pulmonary embolism**	• **Deep breathe and cough q1h.** • **Elevate head of bed as is appropriate.** • **Change position hourly and position patient appropriately.** • **Assess past and current respiratory status.** • **Auscultate breath sounds.** • **Mobilize ASAP.** • **Assist with use of respiratory aids such as incentive spirometers.** • **Stay with patient and provide comfort in a quiet and calm manner.** • **Administer supplemental O2 as required.** • **Keep patient well hydrated.** • **Maintain pain control.** • **Assess patient for shortness of breath, anxiety, mild or sharp stabbing pain in the chest, diaphoresis, cyanosis, rapid irregular pulse.** • **Administer heparin infusion, O2, and other treatments as ordered.**
Risk for fatigue/exercise intolerance related to any of the following: • **Anemia** • **Restricted nutritional intake** • **vomiting** • **hypovolemia** • **Disturbed sleep pattern** • **Pmhx of cardiac disease**	• **Identify source of fatigue (ie: inadequate sleep, CHF, anxiety….).** • **Monitor blood work such as hgb, hct….** • **Monitor intake/output.** • **Assess for signs/symptoms of dehydration.** • **Report abnormal blood work, start Fe supplement as per physician's order.** • **Assess patient's usual nutritional intake and compare to present.** • **Assess for nausea and vomiting.** • **Assess whether patient is**

	receiving adequate sleep/rest in hospital. • Encourage patient to alternate periods of rest with activity.
Risk for deficient fluid volume related to any of the following: • Excessive drainage from tubes/drains/dressings • Insufficient fluid intake • Restricted fluid intake • Nausea and vomiting • Hemorrhage • Medications (diuretics)	• Measure and record intake and output, including drains and tubes. • Carefully monitor urinary output. • Monitor vital signs noting changes in BP, pulse, and respirations. • Assess for cause of nausea and vomiting (i.e.: narcotic induced vs. motion induced) and administer appropriate antiemetic. • Resume oral intake gradually. • Inspect dressings, drains at regular intervals for excess bleeding and assess wound for swelling. • Assess skin colour, temperature, and moisture. • Monitor lab tests such as hemoglobin, hematocrit and electrolytes. • Administer parenteral fluids, blood products and/or plasma expanders as needed. • Shock positioning, patient flat with legs elevated. • Administer O2.
Risk for acute pain related to any of the following: • Disruption of skin, tissue and muscle integrity • Trauma • Tubes/drains • Anxiety • Abdominal distention	• Administer medications, narcotics and non-narcotics as indicated. • Medicate freely (q3-4h) during the first 24-48 hours. • Monitor effectiveness of PCA or local anesthetics such as epidural block or infusion. • Evaluate pain regularly (q2h X12) noting characteristics, location, and intensity. Use 0-10 scale. Emphasize patient's responsibility for reporting pain/relief of pain completely. • Assess vital signs for tachycardia, hypertension, and increased respiration. • Assess causes of possible discomfort other than operative procedure.

	• Encourage early ambulation. • Reposition as indicated. • Provide additional comfort measures. • Support all tubes/drains by pinning on patient to avoid tugging or pulling. • Encourage use of relaxation techniques. • Document effectiveness and side/adverse effects of analgesia.
Risk for excess fluid volume related to any of the following: • Excess IV fluids • Pre-existing cardiac condition	• Assess for symptoms of fluid overload (increased BP, crackles in lung bases…). • Titrate IV infusion correctly. • Monitor electrolyte levels, vital signs, and urine output.
Risk for ineffective tissue perfusion related to any of the following: • Deep vein thrombosis • Interrupted arterial/venous flow • Hemorrhage • Hypovolemia • Pre-existing cardiac condition	• Assist with range of motion exercises, active leg and ankle exercises. • Encourage early ambulation. • Raise HOB one to two minutes before getting patient out of bed. • Perform lying/standing B/P and monitor for significant B/P changes. • Teach patient to keep eyes open and breathe deeply and slowly when ambulating. • If patient faints then assist to the floor. • Avoid use of knee gatch/pillow under knees. Have patient avoid crossing legs or sitting with legs in dependent position for long periods. • Assess lower extremities for erythema, edema, and calf tenderness. • Monitor vital signs, palpate peripheral pulses. • Assess for signs/symptoms of dehydration. • Patient may require antiembolic stockings, sequential compression devices (SCDS). • Patient may receive low dose heparin therapy.

	• Assess for cardiac hx (ie: CHF, HTN, Afib…).
Risk for infection related to any of the following: • Mechanical disruption of skin/tissue • Drains, tubes • Stasis of body fluids • Stress response • Dehiscence • Hx of diabetes	• Assess incision carefully and report purulent drainage, increase drainage, and continued bleeding from incision. • Assess wound edges for approximation. • Notify surgeon of excessive or abnormal drainage from incision or VS change (increased temperature). • Surgical asepsis with dressing changes. • Maintain dependent gravity drainage of indwelling catheters, tubes. • Assess for changes in patients orientation (elderly can become confused with UTI's). • Obtain specimens for culture as requested. • Splint abdominal and chest incisions with a pillow or pad during coughing/movement. • Use abdominal binder if indicated. • If wound eviscerates stay calm, get help, cover protruding intestine with wet sterile normal saline dressings, monitor vital signs, reassure patient, and prepare patient for the OR for resuturing. • Push oral fluids if appropriate. • Administer prescribed anti microbials. • Monitor blood glucose.
Risk for urinary retention related to any of the following: • Difficulty urinating using bedpan/urinal in recumbent position • Anesthetic agents • Bladder spasms • Narcotics	• Provide voiding assistance measures as needed. For example, privacy, sitting position (female) and standing position (male), running water in sink, pouring warm water over perineum. • Ambulate to bath room. • Assess bladder fullness using bladder scanner. • Administer antispasmodic for bladder as per physician's order.

	• Observe for retention overflow. • Assess for residual volume using bladder scanner. • Catheterize in 8-12 hours.
Risk of nausea related to any of the following: • Anesthetic agents • Inflation of stomach • Ingestion of food/fluids before peristalsis returns • Bowel obstruction • Constipation	• NPO till bowel sounds return. • Start with clear fluids with IV still running and if tolerated remove IV and advance diet as tolerated. • Frequent mouth care. • Symptomatic therapy for nausea (cold cloth to head, dim lights, restful environment). • Assess for cause(s) of nausea (i.e.: narcotic induced vs. motion induced) and administer appropriate antiemetic. • If patient nauseated with NG tube then assess patency of NG tube. • Assess for bowel sounds regularly. • Assess patient's usual bowel habits and date of last BM.
Constipation related to any of the following: • Narcotics • Decrease mobility • Decrease oral intake • Irritation and trauma to bowel	• Assess patient's usual bowel habits and date of last BM. • Assess and monitor for abdominal distention and bowel sounds regularly until return of normal bowel function. • Encourage early and frequent ambulation. • Assess patient's dietary needs and refer to dietitian PRN. • Stool softener/laxative as ordered.
Risk of altered thought processes related to any of the following: • Medication/narcotics • Anesthetic agents • Hypoxia • Lack of or excessive stimuli • Excessive ETOH usage • Physiological stress	• Reorient patient on a regular basis • Speak in a normal, clear voice. • Explain procedures even if patient does not seem aware. • Maintain quiet, calm environment. • Assess for etiology of sensory changes. • Observe for hallucinations, delusions, depression, or and excited state. • Assess O2 saturation. • Secure parenteral lines, catheters if

	present and check for patency. • Assess for pmhx of ETOH usage.
Fear and/or anxiety related to any of the following: • **Change in health status** • **Unfamiliar environment** • **Separation from support system**	• **Provide adequate support (listen and talk to patient, explain and reassure, encourage significant others to attend and assist).** • **Validate source of fear: provide accurate factual information.** • **Observe for abnormal excessive reactions to stress.** • **Report unusual or disturbed behaviour STAT.** • **Referral to pastoral care, psychiatric counseling….** • **Assess patient's past coping behaviors.** • **Reunite patient with support systems ASAP.** • **Administer ordered anti-anxiety medications.**
Risk for impaired urinary elimination related to any of the following: • **Fluid volume deficit** • **Hypotension** • **Accidental surgical intervention**	• **Monitor intake and output on a regular basis.** • **Maintain IV at an ordered rate.** • **Encourage PO fluids as tolerated.** • **Notify doctor if urinary output is less than 30 ml per hour.** • **Monitor colour and clarity of urine.** • **Monitor for hypotension (especially if patient has an epidural).**
Impaired skin/tissue integrity related to any of the following: • **Mechanical interruption of skin/tissue** • **Drains/tubes** • **Altered circulation** • **Accumulation of drainage** • **Altered metabolic rate**	• **Inspect incision regularly noting skin integrity and wound approximation.** • **Note patients at risk for delayed wound healing (COPD, anemic, obese, malnourished, diabetic…).** • **Maintain patency of drainage tubes and prevent reflux of drainage.** • **Splint abdominal and chest incisions with a pillow or pad during coughing/movement.** • **Change dressings whenever they are wet/soiled.**

mlh/May 2001
Revised al/June 2004

BCIT Level 2 Nursing Care Plan

Date: Patient: Room: Age: Date of Surgery: Type of Surgery:	Diagnosis: PMHx: Diet: Activity:	Treatments: Medications: PRN Medications:

Potential Problems What are the anticipated problems for this patient and what is potentially causing these problems. (due to or related to)	**VALIDATION PROCESS** **ASSESSMENT** Wednesday PM – How will I assess each problem?	**EVIDENCE** Thursday PM – Data collected to indicate a valid problem	**INTERVENTIONS** Wednesday PM – What will I do for each of the potential problems – both nursing interventions and medical interventions?	**EVALUATION/FOLLOW UP** Thursday PM – What will I do Friday for each valid problem