# BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

# NURSING PROGRAM

# NURSING 2040---PROFESSIONAL PRACTICE 2

**INSTRUCTORS:**
**Ivy O'Flynn**
**Kathy Quee**

# Table of Contents

*BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY* *Course Outline* ***Part A***

**School of school of health**

*Program: nursing*
*Option:*

***NURS 2040***
***Professional Practice 2***

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|---|---|---|---|---|---|
| **Hours/Week** | 2 | **Total Hours:** | 34 | **Term/Level:** | 4 |
| **Lecture:** | | **Total Weeks:** | 17 | **Credits:** | 2 |
| **Lab:** | | | | | |
| **Other:** | seminar | | | | |

**Prerequisites**

| Course No. | Course Name: |
|---|---|
| NURS 1040 | Professional Practice 1 |
| NURS 2030 | Practicum 2 |

**is a Prerequisite for:**

| Course No. | Course Name: |
|---|---|
| NURS 4530 | Practicum Level 5 |
| " | |

**Course Goals**

Professional Practice Seminar 2 continues to facilitate student understanding of the professional practice of nursing

**Course Description**

This seminar course extends the concepts of specialization, technology-as-practice, research/evidence based practice, ethics, legality, primary health care, health promotion in acute care settings and role of professional associations and unions so that students will continue to develop a professional role perspective. The concepts of nursing theory, collaborative practice, change/transition/ risk taking and partnerships will be introduced. Computer work, projects, written assignments, clinical assignments, and discussion with other students, peers, health care team and faculty are part of the course.

**Evaluation**

- Exploration of an ethical situation
- Clinical application/validation of an identified nursing issue

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|---|---|
| Assignment #1 Exploration of an ethical situation | 40% |
| Assignment #2 Clinical application/validation of an identified nursing issue | 40% |
| Assignment #3 Facilitate class discussion of an issue. | 20% |
| TOTAL | 100% |

**Course Outcomes and Sub-Outcomes**

The student will:

1. Understand the evolution of specialization and impact on nursing.
2. Appreciate the impact of technology on the nursing workplace and patients.
3. Discuss the tools to promote research/evidenced-based practice and their relationship to better patient outcomes.
4. Consider ethical principles when working with ethical dilemmas in nursing.
5. Use an ethical framework to analyze an ethical dilemma.
6. Discuss the legal implications and responsibilities of the professional nursing role.
7. Discuss nursing models as examples of "nursing theory" noting their contribution to the development of the profession.
8. Discuss the nurse's role in a collaborative approach to patient care and appreciate the value of partnerships within this team.
9. Appreciate the goals, mandates and roles of professional associations and unions
10. Value the role of the nurse in health promotion in acute care settings.
11. Understand the impact of change and appreciate how people cope with change.
12. Value reflective skepticism in nursing practice.
14. Identify and explore a variety of resources related to issues in nursing.

**Process Threads relevant to this content:**

- Leadership- looking at what collaboration and partnerships mean. Discussing transition/change characteristics and planning for positive responses to changes.
- Communication - continuing to use class discussion and evaluation criteria to help the students appreciate the standards for communication in nursing. Interviewing of members of health care team and lay personnel.
- Systematic inquiry - using questioning in class/clinical area and student feedback to help students think critically and reflect on their thinking; looking at evidence-based practice, nursing models/theories, and analyzing ethical and legal issues.
- Professionalism - taught directly in class and emphasized in considering class conduct rules; looking at professional associations and unions and health promotion in acute care settings.

**Course Record**

Developed by: Ivy O'Flynn Nursing Date: Dec 16/97
Instructor Name and Department (signature)

Revised by: Ivy O'Flynn Nursing Date: May 20/99.
Instructor Name and Department (signature)

Approved by: Kathy Lane Nursing Start Date: May 20/99
Instructor Name and Department (signature)

*BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY* *Course Outline* ***Part B***

**School of school of health**

*Program: nursing*
*Option:*

***NURS 2040***
***Professional Practice 2***

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**Effective Date**
August 1999

**Instructor(s)**

| | | |
|---|---|---|
| Ivy O'Flynn | Office No.: SE12 418 | Phone: 432-8911 |
| Kathy Quee | Office No.: SE12 439 | Phone: 432-8411 |

**Text(s) and Equipment**

Required:

Canadian Nurses Association (1997). *Code of Ethics for Registered Nurses.* Ottawa: Author
Registered Nurses Association of British Columbia (1992) *Standards of Nursing Practice in British Columbia.* Vancouver: Author
RNABC Membership – cost approximately $38 per year.

Recommended:

Medical-Surgical textbook of your choice
American Psychological Association. (1994). *Publication Manual of the American Psychological Association.* (4th ed.). Washington , D.C. Author.
A Medical dictionary

**Course Notes (Policies and Procedures)**

- Students are encouraged to identify individual learning needs that may be met in this course. Please talk with the instructor to see how this might be accomplished.
- During the first class, evaluation methods will be discussed and the percentage of marks assigned to each will be explained.
- The reference readings (except those from required or recommended readings, booklets, etc.) are on reserve in the library. The material will be on a 2-day loan.
- Required readings are available from the instructor for photocopying. Some readings, those marked with an (*), are only available from the library or RNABC.
- Supplemental readings are not on reserve.
- All the readings are to be read by every student.
- Students will have an opportunity to participate in a verbal/written review of the course at midterm and at the end of the term. This review will include a discussion of teaching methods,

resources, and course structure. The midterm review is aimed at meeting the needs of the students currently taking the course. The end review is aimed at modifying the course for the next class.
- The group assignment will receive a group mark.

Participation/ Attendance
- Refer to "Student guidelines, policies and procedures in the BCIT nursing program" and the BCIT Calendar
- Attendance is required in this course because of the importance of dialogue in thinking and learning. The different viewpoints shared during the seminar will help expand the thinking of all participants.
- People must participate so that all can develop their critical thinking about the subject being discussed. Participation includes doing the reading and answering the questions prior to attending class and then talking actively within the group. People will be called randomly to share their thoughts.
- All assignments must be completed to pass the course

**ASSIGNMENT DETAILS:**
**ASSIGNMENT #1 ETHICS PRESENTATION (40%)**
Introduction
The purpose of this presentation is for the group to explore an ethical dilemma using an ethical decision-making framework. Each group will select one of the scenarios and go through the process of ethical decision making. Then, to expand upon your perspective of the dilemma, the group will consult with people in the health care field and lay persons to gain their perspective of the dilemma. This assignment will give you an opportunity to work through an ethical decision making framework and apply ethical principles and the C.N.A. code of ethics.
- Sign up for one of the scenarios (see appendix B) Each group will sign up for a different scenario.. Also indicate if you have a time preference for presentation. **Sign up no later than week 3.**
- Each group will have 30 minutes for their presentation (this also includes discussion time).
- 50 marks will be allotted for this presentation. See presentation details for the allotment of marks.

Presentation (50 marks)
- The presentation is due on the assigned date

/10 the presentation in class is marked on speaking style, quality of presentation and extra effort (handouts, overheads, posters, dramatizations, other).
/20 content
- /1 What is the dilemma?
- /1 What are the nurses moral obligations?
- /10 Use the C.N.A. Code of Ethics for Nurses and ethical principles to support the group's thoughts on the dilemma. Identify 2-3 indicators under each applicable value of the C.N.A. code of ethics and state how indicators influenced your decision-making.
- /5 Identify how you would use the ethical principles to support your decisions in your case.
- /2 State any assumptions the group made about the scenario
- /1 Look at the decision-makers: are they competent? Do they have sufficient information to make decisions? Are they in a legal or ethical position to make the decision.
- /2 outcome—report on the opinions

- /5 how could the information you have gathered regarding this scenario impact on nursing practice
- /5 conclusion summarizes the presentation
- /3 the presentation adheres to time parameters
- /5 the group stimulated class discussion

*****At the end of the presentation please hand in all the content portion of the group's presentation—readable rough notes, overheads, posters etc. are acceptable.**

**ASSIGNMENT #2 CLINICAL APPLICATION/VALIDATION OF AN IDENTIFIED NURSING ISSUE (40%)**
**THIS ASSIGNMENT IS DUE ON OR BEFORE WEEK 13**

Introduction
The purpose of this paper is for you to look for evidence to support or not support an issue that you have come across in your nursing practice or readings. This assignment will also broaden you understanding of an issue. You will need to explore the literature, develop a ***short*** questionnaire based on your reading and gather a variety of opinions from 3 nurses (RN, LPN, RPN) ask the nurse to complete the questionnaire either verbally or in the written form. You will then compare the answers of the completed questionnaire with the literature. **If you are taking this questionnaire into the clinical area please let your instructor know what you are doing. Let the unit manager know what you are doing and that you are just validating your reading you are not evaluating the staff or doing research.**

Written (50 marks)

General Guidelines for Written Assignments

- Written assignment must be word processed and in a folder.
- The purpose of the written assignment is to help students apply their ability to reason and reflect. Students may request assistance with the written assignment as they need it and as faculty are able to assist. There is no penalty for this assistance.
- Marks will be assigned according to following criteria: content of the paper, structure or organization of the paper, and mechanics of the writing. See below for description of assignment and specific details.
- The paper is no longer than 8 pages (not including the completed questionnaires)
- **Twenty-four hour extensions can be negotiated with the instructor without a penalty. If the assignment is late the mark will drop by 5%/day. This assignment is due at 1630 on the due date.**

**Content** of the paper refers to the thinking demonstrated
/2 introduces content of paper and identified issue
/10 literature reviewed that supports each question on the questionnaire. Questions must relate to the issue
/5 designs a short questionnaire to validate the issue related to the topic. The method is not time consuming for the participants (5 minutes). Please submit completed questionnaire as an appendix.
/2 describe information collected
/5 compare the information you collected with your supporting literature
/5 how could the information you collected impact on nursing practice
/4 generate further relevant questions based on the information you collected
/3 conclusion summarizes the content presented in the paper

**Structure:** (10 marks)

- The tone or style of the paper is appropriate to the audience. Professional papers avoid slang language, use specific words and clearly describe ideas. The style clearly indicates that the thoughts are written for professional purposes, not for a casual discussion with friends.
- A central idea organizes the paper and paragraph form units of thought.
- Paragraphs include a topic sentence and details that support the topic sentence.
- The links between paragraphs provide smooth transition.
- APA writing style is followed e.g. writing style is incorporated into the paper as well as spacing, margins, title page, font size etc. Note that reporting is usually in the past tense.
- Content is referenced—refer to APA guidelines and BCIT policy for plagiarism.
- A bibliography that reflects the references used in the text and is in appropriate APA format is included.

**Mechanics** of writing the paper refers to:
/2 sentence structure and flow
/2 grammar and verb tense.

**FOR ASSIGNMENT #3 YOUR GROUP IS TO FACILITATION A CLASS DISUCSSION ON AN ISSUES COVERED IN THE CLASS OR ANOTHER ISSUES OF YOUR CHOICE. (20%)**

The purpose of this assignment is for you to apply the process threads of leadership, communication, systematic inquiry and professionalism in the professional practice class. As a group you will be addressing the process threads by introducing a topic, developing clinically focused questions related to the topic, facilitating each of the groups and reporting back the group responses to you questions.

Each group will select and sign up for one of the issues covered in class or an issue of their own interest.

**Please sign up by week 5**
Please keep to your allotted time of **25 minutes**
Please submit a copy of your questions to the instructor.
Those groups facilitating an issue that is covered in class will conduct the class discussion at the beginning of the class on the day that class is to be held. Those choosing an issue not covered in this course the date will need to be negotiated. Only one group will be facilitating per class day as there is content that needs to be covered.

**Marking**
/5 Introduces the topic identifying key points in the readings (approximately 5 minutes).
/4 Develops one question for each individual group that focuses on clinical application of the key points identified in the readings. You will need to develop discussion questions that are not already covered in your course outline.
/3 Each group member facilitates an individual group (approximately 10 minutes)
/3 Reports back in an organized fashion the information from the individual groups (approximately 10 minutes 2min/group).
/2 Adheres to time limit of 25 minutes.
/3 Represents a group effort.

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY
NURSING PROGRAM
NURS 2040
PROFESSIONAL PRACTICE SEMINAR
CLASS SCHEDULE

**LOCATION: SE 12 412**

| DATE | ACTIVITY |
|---|---|
| 1. August 17, 1999 | Introduction to Nursing 2040 |
| 2. August 24, 1999 | Legal issues |
| 3. August 31, 1999 | Legal issues<br>**Sign up for ethics presentation** |
| 4. September 7, 1999 | Ethical issues |
| 5. September 14, 1999 | Standards for Nursing practice |
| 6. September 21, 1999 | **Ethics presentation** |
| 7.September 28, 1999 | **Ethics presentation** |
| 8. October 5, 1999 | Health promotion |
| 9. October 12, 1999 | Technology |
| 10 October 19, 1999 | Nursing theory |
| 11. October 26, 1999 | Evidence based practice |
| 12. November 2, 1999 | Partnerships |
| 13. November 9, 1999 | Transition/change |
| 14. November 16, 1999 | Professional associations and unions |
| 15. November 23, 1999 | Specialization |
| 16. November 30, 1999 | Specialization—**Guest speaker** from Specialty nursing at BCIT |
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| WEEK | ISSUES/INFORMATION TO BE COVERED | REQUIRED AND SUPPLEMENTAL READINGS |
|---|---|---|
| Week 1 | **Introduction**<br>Overview of the course<br>Assignments<br>Evaluation Methods<br>Discussion of readings<br>How Nursing competencies and skills of the new graduate will be used in this course<br>Class norms<br>Prep for next week | |

## TECHNOLOGY AS PRACTICE

To prepare for this section of the course please review the definition of Technology as practice as outlined in the BCIT Nursing Program Curriculum Overview (appendix C of this course). In this course technology as practice covers the following issues: legal, ethics, standards for nursing practice, nursing theories and models, research/evidence-based practice and technology.

## LEGAL RESPONSIBILITIES OF THE NURSE

In 1998 the National Nursing Competency Project information document and the RNABC "Competencies required of the new graduate" (RNABC 1998) list the following legal and ethical responsibilities of the nurse. We will be addressing some of these competencies in the readings and situations under legal and ethical responsibilities.

To fulfill our legal responsibilities in nursing we must promote the client's rights and responsibilities. To do this we act as an **advocate** for clients, especially when the client is unable to advocate for him/herself. Nurses perform the role of **advocate** when they assist clients to select choices, which will support positive changes in their affect, cognition and behavior. **Advocacy** also involves: challenging and taking action on questionable actions, orders or decisions made by other health team members, protecting clients by using appropriate technology and principles to perform safe, effective and efficient nursing interventions and reporting situations which are potentially unsafe for clients. For clients experiencing difficulty protecting themselves, the nurse provides support and protection. When advocating on behalf of clients the nurse shares only appropriate information about clients' care while respecting confidentiality.

Nurses also practice in a manner consistent with: **professional standards** of the regulatory body, **scope** of practice within nursing and **provincial and federal legislation.**

Nurses are responsible for **assessing**, on a continuing basis, his/ her **own competencies** related to: **knowledge, skill, attitudes and judgment**. Nurses must **recognize limitations** of his/ her own competence and seek assistance when necessary.

Nurse must keep up to date by recognizing, assessing and implementing **changes in the health care system** that effect own practice and client care.

Nurse also have a responsibility to keep accurate and timely records regarding their patients conditions.

| | **LEGAL ISSUES** | |
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| Week 2 | **Class preparation**<br>How does the RNABC define the practice of nursing?<br>Using a dictionary, define risk-taking.<br>How does risk-taking relate to the definition of the practice of nursing?<br>A nurse is considered competent if s/he meets the "standard of care". What does "standard of care" mean and how is it determined?<br>What is a nurses' "legal duty of care"?<br>When is a nurse considered negligent?<br>When is a nurse considered incompetent?<br>What legal protection is there for the R.N.?<br>In what situations is it acceptable for an RN to withdraw or refuse to provide care?<br>Read the scenarios and be prepared to discuss them in class.<br><br>**Class discussion**<br>**Situations**<br>1. A 55-year-old diabetic was admitted to the coronary care unit with a myocardial infarction. Soon after admission and for the next 24 hours, his nurses documented that one of his toes was cool, pale and painful. Two days later, the toe had to be amputated due to gangrene. Were the nurses negligent? If so, Why? (Nursing life, September/October 1982, pp 36-37)<br><br>2. A nurse is giving out a medication that s/he was not familiar with. S/he talked to two nursing colleagues and then gave the medication after they told her the dose | RNABC (1998) Publication "Overview of nurses registered act, rules and RNABC constitution and bylaws"<br><br>---Why nurses get into trouble. RNABC NEWS, January/February, 1987, pp. 24-25<br><br>**RNABC Publication "Negligence, suits and the nurse" (1993)<br><br>RNABC publication "Duty to Provide Care"<br><br>**RNABC Publication "Negligence, suits and the nurse" (1993)<br><br>RNABC Standards for Nursing Practice (1998) pp 26 & 39<br><br>RNABC Publication (1998) "Overview of legislation relevant to nursing practice"<br><br>RNABC Capture Insurance Corporation. Liability insurance for the registered nurse pp. 1-4. |

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| | "wasn't out of line". The patient died as a result of the medication. Is the nurse negligent? If so, Why? (Nursing life, September/October 1982, pp 36-37)<br><br>3. Nurses working on the unit routinely turn off the audible patient call system at night and rely on the light to alert the nurse if a patient needs assistance. One of the patients was 4 days post abdominal-perineal resection. He got up and went to the bathroom around 0200 and started to hemorrhage rectally. He pulled the signal cord but no one responded for about 10 minutes. The patient suffered some brain damage due to cerebral anoxia from hemorrhaging. Are the nurses who turned off the alarm liable for the injuries he suffered? If so, why? | |
| Week 3 | **Class preparation**<br>What does informed consent mean?<br>What is the role of the substitute decision-maker?<br><br>What does the Infant's Act state regarding competency and what does this mean for health care workers?<br><br>How does the Freedom of information and privacy act relate to nursing?<br><br>Are nurses legally required to stop at the scene of an accident and render help? (see good samiratan act)<br>How does one determine competency?<br><br>What is the difference between assault and battery?<br>Who determines the boundaries of patient confidentiality?<br>What is the nurses' responsibility when delegating tasks or procedures?<br><br>Go to Appendix D. In that section there are 2 case studies on the legal aspects of charting from the RNABC. Review the case | Mass, H. (1995). On getting consent: how do recent legislative changes on consent affect you. Nursing B.C, March/April, pp. 9&11.<br><br>RNABC Publication (1998) "Overview of legislation relevant to nursing practice".<br><br>RNABC (1998) Nursing practice guidelines: Freedom of information and protection of privacy act.<br><br>Ellis, J., & Stone, S. (1996). Confidentiality and the police. Nursing B.C. August/September, pp. 13-14.<br><br>**RNABC Publication "Delegating nursing tasks and procedures" (1994). |

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| | studies and state what the nurse should have charted and the rationale behind your statements.<br><br>What factors need to be considered when delegating tasks or procedures?<br><br>**Class discussion**<br>When working in a hospital/institution who determines what is told to the media/police?<br><br>4. If one did not get either verbal or written consent and went ahead with a procedure what could one be charged with? Also give an example of when a nurse might (or did) go ahead without consent and do a procedure for a patient. In your situation could the nurse be charged?<br>5. A competent patient refused to get out of bed, so the nurse asked for the physiotherapists assistance. Together, they got the patient up, carefully walked him, and then returned him to bed. The patient later sued for assault and battery. What grounds would the patient have to file a lawsuit? What do you think of this? (Nursing life, September/October 1982, pp 36-37).<br>6. Your patient has dementia and refuses medications. The nurse mixes the medications in with the cereal or jam and gives it to the patient. What would the patient/family's legal position be if they tried to sue for assault and battery?<br>7. A patient's boss called to ask about his employee's condition. The nurse mentioned that the patient was being treated for narcotic addiction. What is the nurse liable for if the employee is fired? (Nursing life, September/October 1982, pp 36-37).<br>8. You are about to delegate the shortening of a penrose drain to an LPN on your unit. What do you need to consider before delegating the procedure?<br>9. Your patient Mrs. M. is to be discharged in 3 days. She was admitted with a CVA that has left her with some cognitive (memory) and physical impairment. She is 65 years old and on TPN at home. She has been managing her TPN at home for the past | RNABC Standards for Nursing Practice (1998) p 39.<br><br>Sibbald, B. (1997). Delegating away patient safety. Canadian nurse February, pp 22-26.<br><br>Sibbald, B. (1997). A right to be heard. Canadian Nurse November, pp 22-30.<br><br>RNABC (1998). Nursing practice guidelines: documentation<br><br>**SUPPLEMENTAL READINGS**<br><br>Eskreis, T.R. (1998). Seven common legal pitfalls in nursing. AJN April pp34-41.<br><br>Mass, H. (1998) When can you call yourself a nurse. Nursing BC. March-April pp27-28.<br><br>Caleff, B. (1994) Seven things you should never chart. Nursing '94, p43.<br><br>Phillips, P. (1994). Accountability, responsibility, liability. Canadian nurse April pp 51-52.<br><br>Tapp, A. (1994). Negligence. Canadian Nurse June, p. 51. |

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| | 3 years. She lives in Hazelton (small town) with her son who is schizophrenic. She refuses to live in a nursing home. What direction would "Delegating nursing tasks and procedures" give you regarding Mrs. M's discharge.<br>After reading the article by Sibbald "A right to be heard" why do you think nobody listened to the nurses?<br>Could the nurses have done anything differently to achieve the outcome. | Ellis, J. (1997) The client's right to know versus the nurse's right to be protected from harm. Nursing BC, November-December 1997. pp 11-12. |

## ETHICS

In nursing our primary commitment is to the patient. Nurses act as liaisons between clients and other health care team members to ensure that client's rights are honored and that clients know and understand their options.

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| | **ETHICAL ISSUES** | |
| Week 4 | **Class preparation**<br>What is the relationship between law and ethics?<br>Why do we have a "Code of Ethics" for nurses? | RNABC Standards for Nursing Practice (1998) Appendix 3, pp 30-35. |
| | According to Kerr and MacPhail in Canadian Nursing issues and prespectives (1991) they identify the following 8 concepts related to ethics: personhood, autonomy, veracity, peternalism, confidentiality, beneficence, nonmalifence and justice.<br>Describe these concepts **and** identify where each concept is reflected in the code of ethics. | Use your med-surge text or an ethics book from the llibrary or a dictionary to define the concepts. |
| | What is the difference between active and passive euthanasia? | Sanchez-Sweatman, L. (1994). Euthansia. Canadian Nurse, January, pp51-52. |
| | **Class Discussion**<br>Nurses are also accountable to physicians, other health team members and the institutions for which they work. **What does this mean to you? Can you see any problems with the nurse being accountable to physicians, other health team members and institutions?** | Erickson, J., Rodney, P. and Strazomski R. (1995) When is it right to die? Canadian Nurse, September, pp 29-33. |
| | Give an example, from your observations/practice in the clinical area, related to the 8 concepts described by Kerr and MacPhail. | **SUPPLEMENTAL READINGS**<br>Van Weel, H. (1995). Euthanasia: mercy, morals |

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| | Discuss the difference between active voluntary, active involuntary, passive voluntary and passive involuntary euthanasia.<br>Discuss example of each type of euthanasia?<br>Which type of euthanasia is legal? | and medicine. Canadian Nurse, September, pp35-40. (the Sue Rodriguez story<br>Ramsey, G.C. (1998). Nursing and ethical issues. Imprint April-May pp 43-45.<br><br>Savage T. & Bosek, M.S. (1998) Moments of courage, reconciling the real and the ideal in the clinical practicum. Imprint April-May 1998 pp 31-34. |

**STANDARDS OF NURSING PRACTICE**

National nursing competency project of1998, states that the nurse needs to use the Standards of Practice to highlight own learning needs by: identifying gaps in knowledge and skills, evaluating own nursing practice and taking action to update own competencies.

| | **STANDARDS FOR NURSING PRACTICE** | |
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| Week 5 | **Class preparation**<br>What is the purpose of the standards for nursing practice?<br>Review Standards for "Clinical Practice for the Clinical Practitioner"<br>Read the article by H. Griffiths and Standards for Nursing Practice--Appendix 1(Guidelines for resolving professional practice problems).<br>Review case studies of past few weeks in relation to violation of standards for nursing practice and the code of ethics.<br>**Class discussion**<br>Both the legal and ethical components of nursing practice are reflected in the RNABC Standards for Nursing Practice. Review the indicators of one of the standards for the clinical practitioner. State whether each indicator reflects an ethical or legal component.<br>Discuss how the nurses (in the Griffiths article) went about resolving a clinical practice problem. | Griffiths, H. (1995). Standards in action: ensuring safe nursing practice. Nursing B.C. May/June, pp16-18.<br><br>RNABC Publication: Standards for Nursing Practice in B.C. (1998).<br><br>**SUPPLEMENTAL READINGS**<br>Wells, B. (1998) Taking charge of your practice. Nursing BC. January/February pp 16-17. |

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| Week 6 and 7 | **Presentation of an Exploration of an ethical issue.**<br>Review Assignment #1 details | See Appendix A and B<br><br>**SUPPLEMENTAL READING**<br>Canadian Nurses Association (1998) Everyday ethics: Putting the code into practice. ( 3 copies are on reserve in the library). |

## HEALTH PROMOTION

Health promotion is a key role for nursing whether at the bedside or in the community. The RNABC "Competencies required by the new graduate" (1998) state that the new graduate: supports clients to draw upon own assets and resources for self-care and health promotion (practicing independently); provides general health-related information to individuals, families and populations (practicing independently) and to groups (under direction) and supports professional efforts in nursing to achieve a healthier society (lobbying, health fairs, promoting principles of the Canadian Health Act). In this section we will be looking at describing health promotion, values and principles of health promotion and the role of the acute care nurse in health promotion.

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| Week 8 | **Class preparation**<br>Describe health promotion.<br>Describe the values related to health promotion.<br>Describe the principles related to health promotion.<br>Complete the questionnaire in appendix E "role of hospital nurses in health promotion: RNABC 1993 pp 24-33.<br>Describe the enabling factors related to health promotion (role of the hospital nurses in health promotion p32)<br><br>**Class discussion**<br>The first half of the class may be needed to sum up the Ethics presentations.<br><br>Discuss your responses to the questionnaire, and compare to research.<br>What health promotion activities do you do with/for your patients?<br>Discuss the enabling factors as they relate to your unit. | RNABC (1993). Role of the hospital nurse in health promotion. Appendix E pp 24-33 (attached).<br><br>Canadian Nurses Association Position Statement (1992). Health Promotion.Ottawa:Author<br><br>Canadian Public Health Assocation (1996). Action statement for health promotion in Canada p2 Ottawa:Author.<br><br>**SUPPLEMENTAL READING**<br>Stone, S. (1998). Where is primary health care in |

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| | **Midterm evaluation of the course** | health care reform? Nursing BC January/February pp29-31. |

## TECHNOLOGY

In this section we will look at expanding your knowledge of the concept Technology-as-practice. The RNABC (1998) Competencies required by the new graduate requires that that the new graduate be able to select (with peer consultation) and use (independently) appropriate technology to perform efficient and effective nursing interventions. After reading the required readings come to class prepared to discuss your understanding of technology-as-practice and give examples to support your view.

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| Week 9 | **TECHNOLOGY**<br>**Class preparation**<br>Review BCIT curriculum definition of "Technology-as-practice"<br><br>**Berry** et al discusses some of the patient responses to invasive technology. Describe these responses.<br><br>Review the questions on pages 159-161 of the **Axford** et al article and describe how you might use the questions in you clinical area to address technology other than computers?<br><br>In the **Jacox et al** article review the chart on page 82 that provides a classification of nursing technology.<br><br>In the **Locin** article on page 201 there are some assumptions made about the nurse-patient relationship. Describe the assumptions.<br><br>**Class discussion**<br>What reactions might patients have to some of the technologies in your clinical area?<br>What interventions might be useful to reduce the negative impact of technology on patients in your clinical area?<br>What is the impact of new technology on | BCIT Curriculum: definition of "Technology-as-practice" (appendix C—NURS 2040).<br><br>Berry, T. & Baas, I. (1996). Medical devices and attachment: holistic healing in the age of invasive technology. Issues in mental health nursing. Vol 17, pp233-243.<br><br>Axford, R.L. & Carter, B.E.L. (1996). Impact of clinical information systems on nursing practice: nurses perspective. Computers in nursing 14(3), pp156-163.<br><br>Jacox, A., Pillar, B. & Redman, B.K. (1990). A classification of nursing technology. Nursing Outlook. 38(2), pp81-85.<br><br>Locin, R.C. (1995). Machine technology and |

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| | nursing staff?<br>How would you validate the assumptions re impact of technology on the nurse-patient-family relationship?<br>In a group of 4 choose a technology used on one of your units and state what questions your group might use to assess the impact of the technology on patients and on the nurses workload. | caring in nursing. Image: Journal of nursing scholarship. 27 (3), pp201-203.<br><br>**SUPPLEMENTAL READINGS**<br>Pillar, B., Jacox, A. and Redman, B.K. (1990). Technology, its assessment and nursing. Nursing Outlook 38 (1), pp16-19.<br><br>Wichoski, H.C. & Kubsch, S. (1995). How nurses react to and cope with uncertainty of unfamiliar technology: validation for continuing education. Journal of continuing education in nursing. 26(4), pp174-178. |

## NURSING THEORY

Nursing is moving away from the medical model and developing its own theory base. In this section we will be looking at conceptual frameworks and theories as they relate to nursing, There are many conceptual frameworks or nursing models to choose from. Selection of a nursing model is based upon your values and beliefs related to the 4 central concepts of nursing. We will look at the 4 central concepts of nursing theory and how it relates to nursing practice, education and research. You will be developing part of a model and identify some of the potential outcomes.

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| Week 10 | **NURSING MODELS/CONCEPTUAL FRAMEWORKS**<br><br>**Class preparation**<br>Describe the purpose of nursing models/conceptual frameworks.<br>Describe the 4 basic concepts in nursing?<br>Describe how the BCIT Curriculum framework addresses the 4 central | BCIT Curriculum Framework (Part C of Nursing 2040).<br><br>Belanger, P. (1991). Nursing models—a major step towards professional autonomy. AARN 47(8) p13. |

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| | concepts of nursing?<br>Describe how nursing conceptual frameworks provide direction to practice, education and research.<br>**Class Discussion**<br>Please bring the BCIT framework in appendix C to class.<br>Discuss how the BCIT Framework directs the curriculum.<br>In class you will be drafting a definition of one of the 4 central concepts of nursing. Then use your definition to describe how it directs nursing practice, education and research. | Kozier, B., Erb, G & Blais, K. (1997). Nursing theories and conceptual frameworks. In Professional nursing practice concepts and perspectives, 3rd ed. pp28-30. Addison-Wesley: California.<br><br>Scherubel, J.C. (1987). Nursing theory: the basis of nursing knowledge. In W.B. Young (Ed.), Introduction to nursing concepts. pp 10-11 Appleton & Lange: Norwalk, Connectucut.<br><br>**SUPPLEMENTAL READINGS**<br>Wesley R.L.(1995) Nursing Theories and Models, 2nd Ed. Chapter 1.<br><br>Adam E. (1987). Nursing Theory: What it is and what it is not. Nursing Papers 19(1), pp5-14.<br><br>Herbert, M. (1988). The value of nursing models. Canadian nurse. December, pp 32-34. |

## EVIDENCE-BASED PRACTICE (RESEARCH-BASED PRACTICE)

In this section we will be addressing evidence-based practice. Throughout your readings you will note that it is also called research-based practice. The "Competencies required of the new graduate" (1998, RNABC) state that the new graduate: integrates research findings from nursing, health sciences and related disciplines into own nursing practice (with peer consultation); engages in conducting health or nursing research by identifying researchable questions and collecting or assembling research data (under direction); and uses evidence-based knowledge from nursing, health sciences and related disciplines to select and individualize nursing interventions (practicing independently). We will be looking at evidence-based practice in more detail and exploring how it is integrated into clinical practice.

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| Week 11<br><br>First hour | **EVIDENCE/RESEARCH BASED PRACTICE**<br>**Class preparation**<br>Define research/evidence-based practice.<br>Describe the goals of nursing research according to the RNABC position statement.<br>What is the purpose of research based practice?<br>What are the barriers to nursing research?<br>What are some examples of research/evidence based clinical practice tools?<br><br>**Class discussion**<br>Identify research studies that would fulfill the goals of nursing research.<br>Discuss the role nurses can play in relation to nursing research?<br>What role can you assume as student nurses?<br>Discuss solutions to breaking down the barriers to research.<br>How can clinical paths be a source of nursing research studies?<br>Review selected research studies in class and identify:<br>a) the purpose of the study.<br>b) potential impact on patient outcomes.<br>c) the goal it achieves in relation to the goals of nursing research. | RNABC position statement on Nursing Research.<br><br>RNABC Standard for Nursing Practice (1998) P39.<br><br>Simpson, B. (1996). Evidence-based nursing practice: state of the art. Canadian Nurse, November, pp22-25.<br><br>RNABC: Integrating evidence-based practice clinical tools with practice (1996). |

## PARTNERSHIPS

The BCIT Curriculum defines partnerships as being a supportive relationship among students, nurses, clients, teachers, and other members of the health care system that is built upon three essential components: open communication, mutual respect and cooperation. Mutually established goals and reciprocal learning characterize partnerships.

In order to accomplish a partnership, the nurse/teacher must understand the **meaning** of the situation/event of another human being. This understanding is referred to as "shared meaning". In this definition, meaning refers to a human being's **interpretation** of an event, including the significance the event holds and what the event may symbolize or represent within the person's context. Such context-specific meaning and interpretation have an impact on how the individual views health and illness.

Bonnie Wesorick (1995) elaborates on partnerships when she states that the quality of each person's care rests on the ability of the many people who provide the services they need to come together as partners synchronized on the mission to help them reach their ultimate health. Every nurse must be a master of partnership. **Why?** The nurse is the only continuous provider of care for the person needing health care. The nurse is the link between the person/significant others and their physician, occupational therapist, respiratory therapist, dietitian, laboratory technician, social worker, radiologist, and physical therapist. For the person to get the kind of care they need, the nurse must have a partnering relationship with the person and every other provider who cares for the person. We must learn to be partners. Once we learn to be partners with other members of the health care team, we can reach out across disciplines and settings to create partnerships that link us with whomever is necessary to meet the patient's needs. To create this partnership relationship there needs to be a change in the hierarchical structure of the hospital. **How can this hierarchical structure interfere with partnerships across disciplines/departments?** (Wesorick, B. Presentation to Lions Gate Hospital October 31 and November 1, 1995 on Clinical Practice Model.).

In the RNABC Standards for Nursing Practice (1998) on page 5, the RNABC states that "the therapeutic relationship established between the registered nurse and clients receiving their services is based on a recognition that people are able to make decisions about their own lives and are, therefore, partners in the decision-making process (RNABC, 1994)".

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| Week 12 | **PARTNERSHIPS**<br>**Class preparation**<br>Review the "Skills and Competencies" below and **come prepared to class to discuss** how you have/will achieve each competency.<br>Review of the old and new paradigms of thinking and how they effect partnerships across disciplines/departments.<br><br>**Class discussion**<br>1. Discuss the old and new paradigms of thinking and how they effect partnerships across | Wesorick, B. (1997) Partnering: the invisible field of hope, potential and discovery for the work setting. Creative Nursing: a journal of values, issues, experience and collaboration. Vol 1,pp 3-10. |

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| | disciplines/departments.<br>2. In the "Skills and Competencies for the new graduate—1998" the following competencies are related to partnerships and are identified as essential for the new graduate. For each of the following competencies identified give an example of how you have/will achieve that competency:<br>1. Demonstrates attitudes which contribute to effective partnerships with clients:<br>Respect.<br>Empathy.<br>Honesty.<br>2. Supports clients while coming to decisions about their health, then supports their decisions.<br>3. Understands the overall organization of health care at the: (look at organizational charts)<br>Unit level.<br>Agency level.<br>4. Collaborates with clients to perform a holistic assessment of needs.<br>5.Collaborates with clients to identify their health problems and issues.<br>6. Collaborates with clients to develop a plan of care by:<br>a. Identifying expected outcomes.<br>b. Questioning and offering suggestions regarding approaches to care.<br>c. Reducing complex health problems into systematically manageable components.<br>d. Developing a range of possible alternatives and approaches to care.<br>e. Establishing priorities of nursing care<br>f. Seeking information from relevant nursing research, experts and literature.<br>7. Negotiates with clients to determine when consultation is required with other health team | |

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| | members or other health related sectors.<br>8. Makes formal referrals to other health team members and other health related sectors for clients who require consultation.<br>9. Includes the family in clients care delivery (with client's consent).<br>10. Forms partnerships with clients to achieve mutually agreed-upon health outcomes.<br>11. Coordinates health team members to ensure continuity of health services for clients.<br>12. Participates in quality assurance and improvement activities to enhance client care and nursing practice.<br>13. Collaborates as a member of the interdisciplinary health team.<br>14. Develops partnerships with nursing and health team members based on respect for the unique competencies of each team member.<br>15. Uses established communication protocols within agencies and across agencies. | |

## TRANSITION/CHANGE

Throughout your career and throughout you life you will and have encountered change. Change is the end product of the transition you go through to achieve the change. During that process you may need to take risks with your behavior to achieve the change. In this section we will look at transition as a process and the psychological aspects associated with transition. We will also be looking at a variety of barriers associated with change/transition such as role strain and stress and how to cope with transition/change in a positive manner.

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| Week 13 | **TRANSITION/CHANGE**<br>**Class preparation**<br>Define change and transition.<br>Define risk-taking<br>What is the relationship between change and risk-taking?<br>Describe the ten stages of change according to BCNU? | BCNU (1995). The ten stages of change. <u>BCNU Update</u>. June p.5.<br><br>Blanchard, K. (1992) The seven Dynamics of Change. <u>Inside Guide</u>, |

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| | Describe the seven dynamics of change?<br>Describe some of the barriers (resistance) associated with transition/change.<br>Describe some of the coping mechanisms used in the transition phase.<br><br>**Class discussion**<br>1. In class you will be given an article to discuss the following issues:<br>Describe the change the nurse encountered?<br>Relate this change to the ten stages of change.<br>Describe the stresses s/he went through during the transition phase.<br>Were there any barriers s/he encountered during the transition phase?<br>Describe the behaviors that helped her/him through the transition?<br>2. Describe how organizational change might effect patient care and team work?<br>3. Describe what strategies the team might use to facilitate transition. | September/October pp 11-12.<br><br>http://www.demon.co.uk/mindtool/plreschn.html Mind tools—helping you to think your way to an excellent life: resistance to change.<br><br>Davidhizar, R. (1994) Coping with difficult changes. Today's OR nurse. May/June pp 53-54.<br><br>Thomas, D.O. (1997). Change—be part of it. RN. March p 80.<br><br>**SUPPLEMENTAL READINGS**<br>King, S.K. (1982). Coping with organizational change. Topics in clinical nursing. July, pp 66-73. |

## PROFESSIONAL ASSOCIATIONS, UNIONS AND POLITICS

The professional association and the union are integral parts of the nurses work life. Each has different mandates to guide and protect the nurse in the daily care of patients and self. One of the avenues that the professional association, union and nurses use to protect the patient is political action. After reading the articles in the bibliography come prepared to discuss the questions in the outline and prepare questions for the guest speakers.

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| Week 14 | **PROFESSIONAL ASSOCIATIONS, UNIONS AND POLITICS**<br><br>**Class preparation**<br>Describe the goals/mandates of unions and professional associations. What are the similarities and differences?<br>Prepare questions for guest speakers.<br>**Class discussion**<br>Guest speakers from RNABC and BCNU | Downe-Wamboldt, B. (1997). Associations or unions. C.N.A. Today, 7(2), pp 4-5.<br>Guest speaker from RNABC and BCNU (come with prepared questions for the guest speakers) A |

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| | | good source for your questions might be Nursing BC and BCNU Update in relation to what issues have been raised in the last few months. (BCNU Update magazines are available from the instructor). |

**SPECIALIZATION**

To prepare for this section of the course please review the definition of specialization as outlined in the BCIT Nursing Program Curriculum Overview. In this course specialization refers to specialization in nursing. A member of the specialty nursing group of BCIT will explain what specialties are available at BCIT and how you, as a BCIT nursing student, can access the programs.

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| Week 15 | **Specialization**<br>**Class Preparation**<br>Review BCIT definition of specialty nursing.<br>What factors/trends influence specialization in nursing?<br>Think about the pros and cons of specializing in nursing? Why would you want to specialize, in what area would you want to be a specialist?<br>How does a nurse become a specialist?<br><br>**Class Discussion**<br>What is the impact of specialization on nursing, hospitals and other health team members?<br>What might be the future of specialization?<br>How does a CNS differ from other nurse specialists, such as, a nurse clinician, nurse educator, nurse administrator? | Review definition of Specialty Nursing in the BCIT Nursing program curriculum overview (appendix C).<br><br>Caukin, J. (1992) Canadian nursing faces the future. In Baumgart, A & Larson, J. (Eds.). Specialization issues, chapter 17. pp 327-340.<br><br>RNABC (1994) Position statement: clinical nurse specialist. |
| Week 16 | First hour<br>Guest speaker from specialty nursing to discuss transition of BCIT nursing students into the specialty nursing course—prerequisits etc.<br><br>Second hour<br>Course and instructor evaluation | |

## APPENDIX A

### SITUATION #1

Mrs. F. is a patient on your ward. She was admitted 2 weeks ago and had her fractured hip repaired. She also has a diagnosis of probable Alzheimer's disease. She is disoriented to time and place. She frequently does not recognize family members who visit regularly. She wanders into other patient's rooms and requires direction for all her ADL's. She seems unhappy in hospital and her mobility has deteriorated due to the hip fracture. She needs a walker to safely ambulate, however, she has poor safety awareness and frequently tries to walk without assistance. She has had 3 falls in the past two weeks. They were not witnessed but she was found on the bathroom floor once and twice on the floor beside her bed. She has recently become incontinent of urine and appears more confused.

She has a past medical history of intermittent atrial fibrillation. Her hypertension is currently stable and she is off medications.

Prior to admission she had filled out an advanced directive in which she requested only intravenous therapy but no major interventions. Her family is aware of this document and had assisted her in completing it. They were satisfied that this was an accurate reflection of her wishes.

She is now experiencing orthostatic hypotension. An ECG shows second degree heart block with a ventricular rate of 36-40. The attending physician recommends that a pacemaker be inserted to prevent further syncopy which may have led to her falls.

The family is very involved and is known to be very caring toward the patient. They express concern that, on the one hand, this is a life saving procedure and on the other hand feel that her advanced directive rejects any major procedures. The physician recognizes their concern but explains that while this may or may not be lifesaving it will impact considerably on her quality of life and to not have the procedure places her at great risk of further falls and fractures.

Mrs. F. has a pacemaker inserted. The day following the procedure she is found to have had a stroke. She has a dense right-sided hemiplegia and is aphasic. She is unable to swallow safely and an intravenous is inserted for hydration. One week later she is still unable to swallow and the physician suggests that for adequate nutrition a gastrostomy tube will need to be inserted for tube feeds. The family is reluctant and confused. They describe feelings of guilt for consenting to the pacemaker, which they think, has left her worse off than before. They think that it makes no sense to allow a surgical procedure and yet do not want to deny her food and fluids. Their major concern is that she not suffer and they are very worried about her starving to death. They acknowledge that a gastrostomy tube does constitute a life preserving intervention.(RNABC presentation on Ethics for Nurses by Janet Erickson: Permission granted December 10, 1997)

### SITUATION #2

Paul, RN, has cared for Sarah for several months in a 40-bed medical nursing unit of an acute care community hospital. Sarah is a 48 year-old mother of two teenagers. She has advanced metastases from breast cancer. She is emaciated, requiring hourly turning and skin care. Sarah eats only a few bites of every meal and takes

sips of fluid. The family visits briefly every day, but she speaks very little while they are there.

Sarah calls for pain medication often, complaining of pain in her back , hips and legs. Because she is so thin and seldom seems alert, some of the nurses believe she is being overmedicated with the 3-4 hourly prn oral morphine. They think that it is wrong to give her so much morphine, for she could become addicted or it could kill her. Some of the nurses delay giving the medication.

Paul finds that Sarah seems to know how frequently the morphine has been ordered that she asks for it regularly. Paul worries about what the other nurse's say and wonder if he is hastening Sarah's death by giving the drug every three hours.

One night about an hour after having last seen his client to give the medication and do skin care, Paul finds that Sarah is breathing stertorously and not responding. After calling the family and physician, Paul sits with Sarah while she is dying and wonders if he has assisted in something that is immoral and maybe illegal. What will the family think? What will his colleagues think? Has he done the right thing? (Canadian Nurses Association, A question of respect: nurses and the end-of-life treatment dilemmas. October 1994: Permission granted by N. LaLonde CNA on December 9, 1997)

**SITUATION #3**

Christie is a 3-year-old child, mature beyond her years owing to her suffering. She is dying of lymphosarcoma. For three months, she has been in and out of the hospital—and this trip is the last one. Everyone knows that she is dying: her physician, her parents and her nurses. Christy's mom stays with her all day, every day, and her dad usually spends the night with her.

One night about 12:30 a.m., I went into her room. She was resting quietly, but her mother had had about all she could take. Tears of exhaustion, pain and grief were sliding down her cheeks. I sat down next to her and we stayed together for a few minutes until her husband arrived. The floor was fairly quiet that night, so I suggested that both of them go down for the cup of coffee and a little time together. I promised that I would not leave Christy's room until they returned.

About ten minutes after they left, Christy awoke. She was much worse and appeared to be very frightened. I called the practical nurse and told her to call the doctor, the supervisor, and the chaplain and to send an aide down to the coffee shop stat to get her patents. Christy was struggling to breathe and there was fear in her eyes. Suddenly, I remembered what the mother had told her when Christy asked what it would be like to die? Her mother said it would be like when she fell asleep downstairs and daddy would prick you up and carry you upstairs and everything would be all right. When you die, God picks you up and then everything will be fine. So, gently I leaned over and picked her up and held her in my arms. She seemed to relax as she laid her head against my shoulder. She died like that---quietly in my arms. I do not know how long I stood there holding Christy. It seemed like an eternity but it could not have been more than a few minutes.

Her parents rushed into the room, I looked at them—and they knew that Christy had died. As we were tucking her into bed, a young resident physician entered the room. He took one look at Christy and said, "My God, why didn't you call a code?" He started to pound on Christy's chest, but her father stopped him. I

turned to Christy's mom and said, "I'm so sorry." She started to cry and so did I. I held her in my arms and she held me. In a few minutes I was able to tell her how Christy died. The chaplain arrived about that time and we all went to the lounge. As he talked to them, I left to get coffee from the nurse's locker room.

The priest was talking with the parents, and the other children on the floor needed my attention, so I did not stay long. I made rounds and then helped to prepare Christy's body for the morgue. I thought the incident was ended—although I knew I would never forget Christy or her patents. However, the incident was far from over. The next morning I was called to the nursing office. Why hadn't I called a code on Christy? Hospital policy required that a code be called on all patients unless there is a written no code order. Her pediatrician had not written a "No Code" order; who was I to make such a decision?
(Curtin, L. & Flaherty, M.J. (1982), Nursing Ethics, Case Study X: Cardiopulmonary resuscitation and the nurse, pp293-294: Copyright via CanCopy)

**SITUATION #4**

Mrs. A is a 75-year-old Caucasian female who sustained a cardiopulmonary arrest in the emergency room. She was comatose and responded nonpurposively to painful stimuli with her right side only. She was intubated and maintained on a respirator. The decision had been made in the emergency room that her prognosis was so poor that utilization of an intensive care bed was not warranted. Thus she was admitted to a general medical ward for her ongoing nursing care.

On the first day her "cascade of disasters" began. She was started on a nasogastric tube feeding, had an indwelling catheter placed in her bladder, and was receiving intravenous hydration. The tube feeding gave her profuse liquid diarrhea. Several attempts were made at changing the formula strength and the type of formula with minimal success at resolving the diarrhea. The incontinence resulted in the development of several large sacral decubiti which became infected. It also led to a bladder infection requiring intravenous antibiotics which resulted in impairing her renal function. Then she aspirated the tube feeding, developed pneumonia, and slipped into septic shock. The physician in charge at one o'clock in the morning decided to aggressively treat her for shock by placing her on a special intravenous medication that would maintain her blood pressure. The nursing staff were not familiar with this medication as it is only given in the intensive care unit. The following morning, the physicians were unwilling to discuss stopping the medication since it had already been started.

The family were upset about her condition, but no one had talked to them about their choices. They were Roman Catholic, and the priest had been called in to meet with the family. The purpose of this meeting was to comfort the family rather than to decide how much the health care team should intervene.

The health care team knew nothing about Mrs. A's prior wishes or goals for her life. There was no question that she was in a chronic vegetative state and that her prognosis was hopeless. The physicians had embarked on a cycle of trying to manage each new problem as it arose while not addressing her overall condition. The nursing staff were overwhelmed by the constant barrage of new problems and were concerned when treatments were being ordered that they did not feel comfortable about administering. The nursing goals for this patient included: relief of

pain and suffering, maximal preservation of limited function and enhancement of the patient's dignity.
(Jonsen, A.R., Siegler, M. & Winslade, W.J., 1982. Clinical Ethics. New York: MacMillan Publishing Company. Copyright via CanCopy)

**SITUATION #5**

William R, a recently widowed man in his late sixties, was admitted to the hospital through the emergency room with a provisional diagnosis of intestinal blockage, probably resulting from a tumor. He had no personal physician, so he was assigned to a house surgeon for care. On admission to the hospital, he was sent to a surgical oncology unit where primary nursing care is practiced. Jean, a staff nurse with 10 years experience in oncology, was assigned to care for Mr. R. She cared for him for five days prior to surgery and a good rapport developed between them.

She was scheduled for three days off starting on the day of Mr. R's surgery and did not see him again until two days after surgery. She read the surgical reports and checked with her associate nurse to determine both Mr. R's reaction to the surgery and what he had been told about his condition. Mr. R's tumor was malignant and there was evidence of wide-spread metastasis. The physician performed only a simple colostomy to relieve Mr. R's pain and closed him up. The associate nurse reported that Mr. R had asked no questions about his condition and she had not volunteered any information. There was no indication in the physician's note of what, if anything, the physician had told the patient.

Jean entered Mr.R's room not knowing what he had been told. His first few comments indicted that he did not know that his tumor was cancerous, nor that the cancer was metastasized, and he thought that the colostomy was temporary and would be closed after he had left the hospital. He did not know the seriousness of his condition, but he did ask questions indicating he was concerned. He asked Jean directly if the colostomy really was temporary; the physician had not been very clear about this matter. Mr. R also asked if Jean thought it was necessary for him to contact his son and daughter, both of whom were married and lived out of town. He did not want to worry them so he had not told them he was in hospital. However, if he was really sick, he thought they should be called. What did she think he ought to do?

Jean tried to keep the conversation general and to divert his attention to other things—without success. However, as she listened to Mr. R her concern and consternation grew. A group of surgical residents, led by Mr. R's house surgeon, entered Mr. R's room, asked him how he felt, and examined him. Mr. R said he felt "pretty good all things considered," but he did not ask the physicians any questions. They left the room, telling Mr. R that he looked fine and was doing "great".

Shortly afterward, Jean cornered the house surgeon assigned to Mr. R. She told him that she was Mr. R's nurse and that he was asking her a great many pertinent questions. She asked him how much he had told to Mr. R because she needed this information so she could be more open and supportive with him. The physician said that he had not told Mr. R anything about his cancer. When Jean asked why, he responded, "There's nothing we can do for him. He's going to die and knowing it will only increase his anxiety." Jean said, "But what about his children? He wants to call them if it's anything serious. Have you talked to them? What are you going to tell the family?" The physician assured her that he would talk to Mr. R's family but, in the meantime, she was not to answer any of the patient's

questions. The physician claimed that giving information to the patient is a physician's prerogative and any act of disclosure on her part would be considered and treated as insubordination.

Jean retreated in order to consult the head nurse. The head nurse assured her that the questions she had asked the resident were not inappropriate, but she really was not quite sure how to handle the problem. As the days passed, the relationship between Jean and Mr. R became strained. He could not understand why she would not answer his questions and he resented her evasive tactics. When she tried to teach him colostomy care, he paid little attention. Why should he? After all, the colostomy was temporary, wasn't it?

Mr. R was not recuperating rapidly. In fact, he felt terrible. He did call his son and daughter and they both came to the city to see him. They were concerned about his care and how long he would live. They knew he had cancer and they had read about the hospice concept of care for the dying. They asked Jean if there was a hospice in this city. Jean knew there was and told them about it. She again ran into trouble with the physician who told her that he would make whatever referrals he thought necessary.

Jean asked him what arrangements he thought would be necessary for Mr. R's discharge. He did not think that a hospice was a good idea because then Mr. R would know he was dying. He expressed the thought that it is very cruel to take away a person's hope. He told the same thing to Mr. R's family. In his opinion, Mr. R needed skilled care and should be discharged to a nursing home. That way his children would not have to worry about his care and he would not be alone.

When the doctor told Mr. R that he was going to discharge his to a nursing home, he was quite upset. Among other things, he asked why his colostomy was not closed and why he could not go home and take care of himself. The physician said he needed more care than he could give himself at home and that he would close his colostomy when he got stronger. Mr. R remarked, "I'm not getting stronger. I seem to be getting weaker." The doctor responded, "You'll be as good as new in no time" and walked out. Mr. R turned to Jean and said, "What's going on here? Isn't it about time someone levelled with me? What's wrong? Am I dying? Can't you say anything?"

What can or should Jean do in this situation? Should she follow the physician's lead and assure Mr. R that he is fine? If so, why? If not, why not? (Curtin, L. & Flaherty, M.J. (1982), Nursing Ethics, Case Study XIV: A Patient's Right to Know—A Nurse's Right to Tell, pp321-337 Copyright via CanCopy)

**SITUATION #6**

Anita is a nurse who has spent the past year working in various hospitals for several nursing pools, and who now works as a staff nurse on a substance abuse unit. She wonders if she should inform co-workers that David W., a recently admitted patient, has tested HIV-positive at another hospital. When she spoke with David about the matter, he acknowledged being the former patient but denied having tested HIV-positive and refuses to be tested again.

David requires assistance and care since he is bowel incontinent. Anita is worried that David might infect someone with the HIV virus. She has not read of a documented case of AIDS transmission from contact with feces, but she has read of

a nursing home worker who failed to wear gloves and became infected from caring for a man diagnosed postmortem as having AIDS.

Anita's unit manager urges her staff to protect themselves against any patient (not just HIV-positive patients) if they expect to come into contact with bodily fluids. Anita always uses gloves when exposed to David's feces. However, she has seen only a few staff members wear gloves when cleaning Davic after he has been incontinent. Should Anita tell the nursing staff that David is HIV-positive? (Benjamin, M. & Curtis, J. (1992) Ethics in Nursing. (3rd Ed.) New York: Oxford University Press. pp 75-77. Copyright via CanCopy)

**SITUATION #7**

Jolene, works on an oncology unit. She is interested in caring for the dying patients. Mrs K., a 59-year-old woman was recently admitted to the hospital in a leukemic crisis. Mrs. K was told by her physician that she was dying of myelogenous leukemia, and that her only hope of survival was chemotherapy. The physician described the possible side effects to her—nausea, hair loss, fever and bone marrow depression—and obtained her consent.

When it was time to begin chemotherapy Jolene approached the patient. The patient had been crying and, while she disclosed the side effects of the drug, she began to relate to the nurse her own beliefs about God and herself. Mrs. K had controlled her leukemia for 12 years with natural foods, and she felt God would perform a miracle on her behalf. Mrs. K was apprehensive about the drug, but gave consent because her son wanted her to take it. After some discussion of alternative forms of treatment, the patient pleaded with Jolene to return in the evening and to discuss alternative with her family. Jolene began the chemotherapy.

Although Jolene told the patient that she was not sure that it was ethical or legal to do so, she met with the family that evening. Because of Jolene's concern about the consequences of the meeting, Mrs. K asked her family not to tell her physician about the meeting. But the daughter-in-law called the physician. The physician neither interfered with the meeting nor discussed the matter with the patient or Jolene. However, he ordered the chemotherapy stopped because of the patient's change in attitude.

At the meeting Jolene discussed the treatment and its side effects, alternatives such as natural foods, herbal medicine, the need for blood transfusions, and Laetrile. Jolene indicated willingness to assist the patient in seeking alternative treatments, but she did not claim that any of the alternatives would cure her client nor did she recommend them. The conference resulted in a consensus that the patient would remain in the hospital and continue chemotherapy. Chemotherapy resumed after an hour interruption. The patient died two weeks later. The patient experienced some adverse side effects and was comatose most of the time. There was no indication or claim that Jolene's intervention hastened or caused the death of the patient.

After Mrs. K died, her son complained to the physician about Jolene's conduct. The physician complained to the hospital. The hospital fired Jolene and complained to the RNABC.

(Jameton, A. 1984. Nursing Practice: the ethical issues. Prentice-Hall Series in the Philosophy of Medicine, Englewook Cliffs, New Jersey. pp 167--)

**SITUATION #8**

Amelda is a 21 year-old, unmarried, competent female with anorexia nervosa. Her parents immigrated to Canada from the Philippines when she was a baby. Amelda's father is a successful businessman belonging to the upper-middle class. The other members of the family are Amelda's older brother and two younger sisters. Members of the family are practicing Roman Catholics. The family may accurately be described as "western" in outlook.

During the past three years Amelda has been admitted 15 times to the psychiatric unit at Fairweather Hospital. A wide range of treatment regimes have been employed, including individual psychotherapy, family therapy, antidepressant and antipsychotic drugs, electro-convulsive therapy and behavior modification.

All attempts at treatment so far have failed. All efforts at feeding have been frustrated by Amelda's self-destructive behavior. She has refused solid foods, repeatedly removed her naso-gastric tube, withdrawn nutritional supplements from her stomach with a syringe and over-dosed herself with laxatives. The only successful deterrent to this behavior has been physical restraints. Even physical restraints, however, have not prevented her from doing isometric exercises that have successfully reduced her weight.

Amelda exudes an air of sadness and describes herself as being depressed most of the time. Despite her thin, emaciated appearance—she weighs 36.5 kg (80.7 lbs)—she perceives herself as obese and is revolted by food and the sounds of mastication and swallowing.

Although her high cognitive functions are normal, Amelda's insight and judgement are poor. She objects to force-feeding. While she has expressed no desire to die, she does not believe that she needs as much food as her physicians claim in order to live. Isn't the fact that she is still alive despite all warnings proof of this?

Physicians, other health-care professionals and members of Amelda's family have reached an impasse and are now querying the wisdom of continuing to force-feed her. To stop force-feeding, however, would probably result in death. Amelda's past medical history confirms that whenever her weight falls below 35 kg (77 lbs) her blood pressure, electrolytes, and hemoglobin drop to dangerously low levels, threatening her life. If allowed to continue to lose weight, Amelda is likely to become confused, then comatose, or she would develop a cardaic arrhythmia and die. The question then to be faced is whether she should be resuscitated if she were to suffer a cardiac arrest.

Would health care professionals with the agreement of Amelda's family be morally justified in refraining from force-feeding her, and in the event of cardiac arrest resisting resuscitative measures? (Webber, P., Manville, M., Boroja, M. and McDermid R. (1994) INDE 403 Biomedical Ethics, Syllabus: Case 5.3 p43)

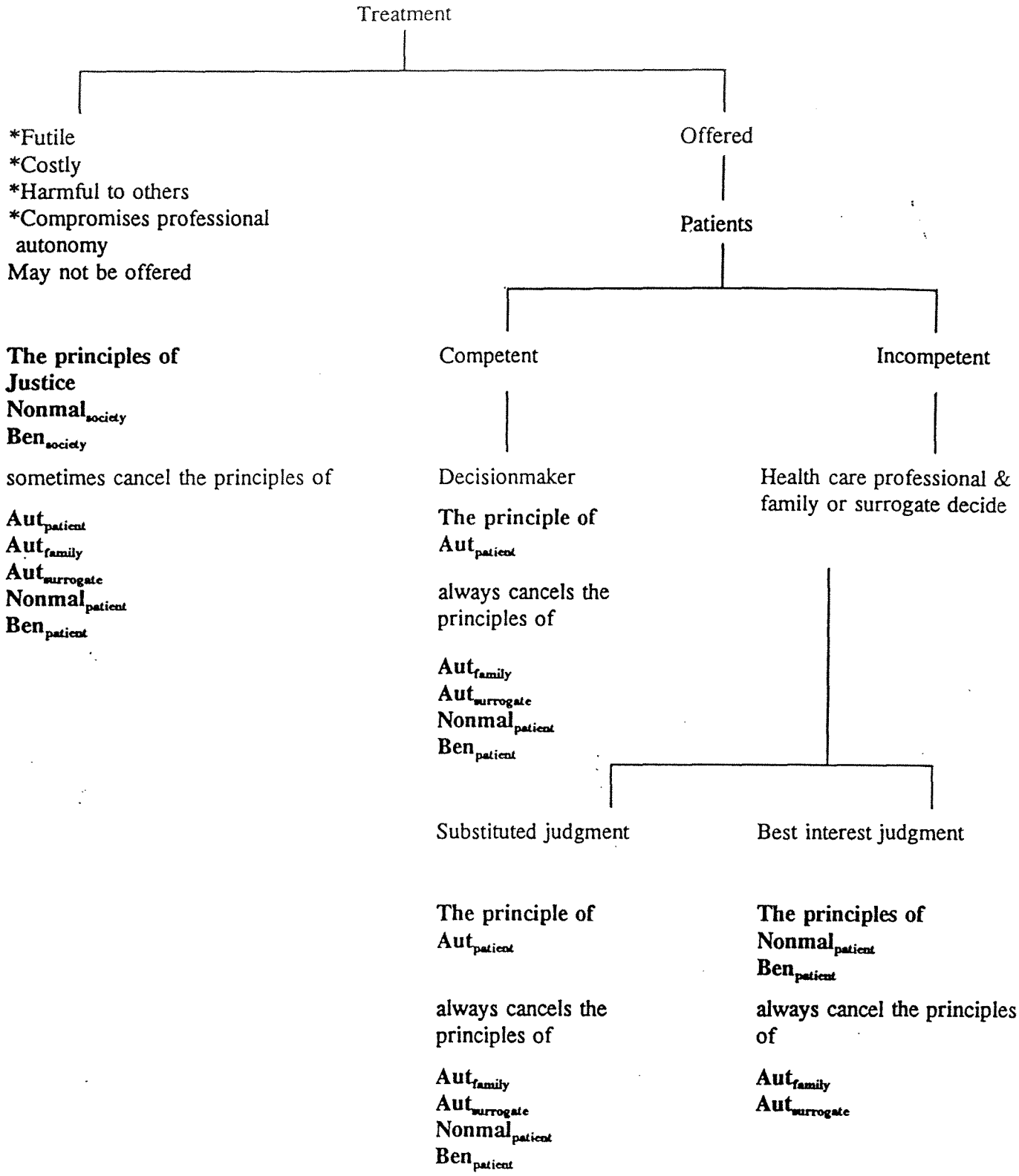
Jonsen, A., Siegler, M., & Winslade, W. (1992) Clinical Ethics (3rd Ed.). Toronto: McGraw-Hill. (Ethical Decision-making model)

## VI. Ethical Decision-making Model

Making an ethical decision involves weighing facts (assembled information) in the light of the above principles and nursing values. Sometimes this process points to a single course of action; however, other times there are conflicting values and more than one point of view on a suitable course of action. There is no recipe for arriving at the "right" ethical decision.

| **Health Care Medical Indications** | | **Patient/Surrogate Preferences** | |
|---|---|---|---|
| Facts | Principles | Facts | Principles |
| What is the patient's diagnosis/prognosis?<br><br>What are the risks/benefits of treatment?<br><br>*Value:*<br>*Health & well-being* | *Beneficence*<br><br>*Nonmaleficence* | What does the patient/surrogate want?<br><br>Is the patient competent?<br><br>Has the patient/surrogate been adequately informed?<br><br>Is consent fully voluntary?<br><br>*Values:*<br>*Accountability*<br>*Choice* | *Autonomy*<br><br>*Veracity*<br><br>*Fidelity* |
| **Quality of Life** | | **Contextual Features** | |
| Facts | Principles | Facts | Principles |
| What kind of life will the patient have with/without treatment?<br><br>*Values:*<br>*Fairness*<br>*Dignity* | *Beneficence*<br><br>*Nonmaleficence* | Whose other interests are affected?<br><br>What costs are involved?<br><br>What does the law say?<br><br>Belief system of the care provider.<br><br>*Values:*<br>*Fairness*<br>*Accountability*<br>*Practice environments* | *Justice* |

## Prioritization of principles (preferred decision-making goes from left to right)






**Substituted Judgement:** surrogate has knowledge of preferences, or at least knows values of the individual. What the person would choose if competent

**Best interest Judgement** Preferences unknown or are unclear. Surrogate's decisions promote the welfare of the individual—reasonable person in a similar circumstance would likely choose.

## How the principles apply to the topics

MEDICAL INDICATIONS

Relevant principles:
*Nonmaleficence* applied to patients
*Beneficence* applied to patients

If Tx is $\text{Harmful}_{\text{patient}}$, then withhold Tx
If Tx is $\text{Beneficial}_{\text{patient}}$, then deliver Tx
Tx

PATIENT/SURROGATE PREFERENCES

Relevant principle:
*Autonomy*

If Pat/Fam/Sur wants Tx, then deliver Tx
If Pat/Fam/Sur does not want Tx, withhold

QUALITY OF LIFE

Same as for Medical Indications

CONTEXTUAL FEATURES

Relevant principles:
*Nonmaleficence* applied to society
*Beneficence* applied to society
*Justice*

If Tx is $\text{Harmful}_{\text{society}}$, then withhold Tx
If Tx is $\text{Beneficial}_{\text{society}}$, then deliver Tx
If Tx shows partiality, then withhold Tx

## Moral problems

Moral problems persist only if the Facts are unclear or the Principles conflict. Principles can conflict in a number of ways. For example:

Ben (patient) vs Nonmal (society)
Aut (patient) vs Aut (family)
Aut (patient) vs Justice
Ben (patient) vs Aut (patient)

## NOTES ON THE FRAMEWORK

These are some of the notes I have made from different sources on the framework outlined in this appendix. At the end of this section the references are cited if you are unclear re the notes made. There are many ethics books in the library for you to use to clarify some of the principles and concepts.

### MEDICAL INDICATIONS

Whether treatment will do the patient any good.
Is the treatment appropriate for the problem the patient has?
Need pt diagnosis, prognosis and risks and benefits of treatment

What is the patient's diagnosis/prognosis?
What are the risks/benefits of treatment
What can the treatment accomplish for this patient
what are the goals of treatment—care, cure, cope
what are the probabilities of success
How can this patient be benefited by medical and nursing care and harm avoided

**Value:**

**health and well being:** Nurse value health and well being and assist persons to achieve their optimum level of health in situation of normal health, illness, injury or in the process of dying.

**Principles:**

**What treatments will do the patient good**
**Beneficence**—we ought to promote good/well being. If treatment will benefit the patient we ought to treat. Contribute to the good health and welfare of patients. In beneficence the issue of balancing the benefits and costs, and determining whether the benefits outweigh the costs. Prevent harm, remove harm, promote good/well being
Protecting and defending the rights of others; preventing harm from occurring to others; removing conditions that will cause harm to others; helping persons with disabilities; rescuing persons from danger

**Nonmaleficence**: we ought not to do anything which will harm patients. If treatment will harm the patient we ought not to treat. Sometimes our actions as nurses may temporarily cause hurt or harm, for example, when administering a vaccine or changing a dressing. The temporary harm is justified, as long as, the principle of autonomy is upheld. Occasionally, in the therapeutic setting, doing something good may lead to secondary harmful effects (principle of double effect)

**Concepts:**

**Double effect** May be helpful and harmful at the same time. One of the outcomes is desired; the other is not intended. It is moral to act for the benefit of the patient

and allow the second, harmful effect, provided the harm is not the means to the good end and provided the harm is not directly intended.

**Futility** When interventions are not likely to preserve life, restore health, or relieve suffering they are considered futile.

**PATIENT PREFERENCE**

What is the patient's preference, based upon the patient's own values and his or her personal assessment of the benefits and burdens?
Whether the patient is competent—if not who has the authority to decide on behalf of the patient?
Preferences of surrogate decision-makers?
Whether the patient and those parties have been adequately informed
Whether the consent was fully voluntary

**Values:**

**Accountability:** Nurses act in a manner consistent with their professional responsibilities and standards of practice

**Choice** Nurses respect and promote the autonomy of clients and help them to express their health needs and values, and to obtain appropriate information and services

**Principles:**

**Autonomy:** We ought to honor the preferences of the patient or surrogate decision maker
Promoting independent choices, self-determination and freedom of action as long as actions do not infringe upon action of others. May involve risk to the patient and we may consider that action to be foolish.
The individual determines own course of action in accordance with a plan chosen by him/herself.
Three elements:

1. One must have the freedom to decide—in order to do this one needs to know all the facts available;
2. One must have the freedom to act—free power of choice without duress or constraint (informed consent; right to refuse treatment; responsibility of others to assist a helpless person in implementing autonomous decision)
3. One must acknowledge and respect the dignity and autonomy of others. (paternalism if not respected→restrict patient choices. Beneficence overrides autonomy)

**Veracity:** To be truthful. To Tell the truth and not to lie or deceive others. Central to informed consent. We must disclose all information that a reasonable person would want to know when making a decision. Deceiving a patient is coercive in that the client has limited or incorrect information on which to base a decision.

**Fidelity** Have primary loyalty to the patient Being faithful to those who have been entrusted to us for care.

**Concepts:** **Informed consent:** a process of shared decision making and mutual respect and participation

**QUALITY OF LIFE**

This information overlaps with that provided under Medical Indications
Not important under which topic the info is collected, as long as it is collected somewhere
Is or will the quality of life be satisfying?
Can the quality of life be improved?

**Value:** **Fairness:** Nurses apply and promote principles of equity and fairness to assist clients in receiving unbiased treatment and a share of health services and resources proportionate to their needs.
**Dignity:** Nurses value and advocate the dignity and self-respect of human beings

**Principles** **What outcomes would be good or bad for the client**
**Beneficence and Nonmaleficence**

**Concepts** **Scantity of life:** human life is so valuable that it must be preserved at all costs, under any conditions, for as long as possible.

**CONTEXTUAL FACTORS**

Refers to persons, institutions, and financial and social arrangements
Record the interests of any other parties which may be affected by treatment or non-treatment
Are there provider (family, physicians and nurses) issues that might influence treatment decisions? E.g. values, beliefs, religion, culture etc
Whether applying or withholding treatment to a patient will be unfair to anyone else
Costs of treatment in terms of money, time and/or administration of treatment
What are legal implications of treatment decisions?
Benefits and burdens to others—finance, family situations, availability and use of resources, pressures from family or friends, and organizational or public policy.
Is the use of resources justifiable

**Values:** Fairness

Accountability

**Practice environments:** Nurses advocate practice environments that have the organizational and human support systems, and the resource allocations necessary for safe, competent and ethical nursing care.

**Principles**

**Justice** To promote fair treatment. We ought to be fair, and treat equals equally. Fair and equitable distributions of burdens and benefits within a community.
Several theories have been suggested each leads to a different method of allocating scarce resources:
Each person should be treated in proportion to his or her need
Everyone has an equal right to health care. Allocating decision may be based on lottery or on a first-come-first-serve basis
Each person should be treated according to his/her previous effort or work. In health care this might be interpreted as health care first for those who are employed taxpayers. The infant or the indigent would take second place.
People should be selected for treatment on the basis of their actual or potential contribution to society. The Nobel prize winner would then receive priority over the ditchdigger
People should be selected for treatment on the basis of merit. If a drunken driver and the innocent victim s/he ran down on the street are brought into emergency the innocent victim would receive priority over the driver
Health care should be based on the ability to pay

**References:**

Craven and Hurnle, Chapter 3
Jonsen, A.R., Siegler, M. and Winslade, W.J. (1992). Clinical Ethics (3rd Ed.). McGraw-Hill Inc., New York (available at RNABC Library)
Canadian Nurses Association (1998) Everyday Ethics: putting the code into practice

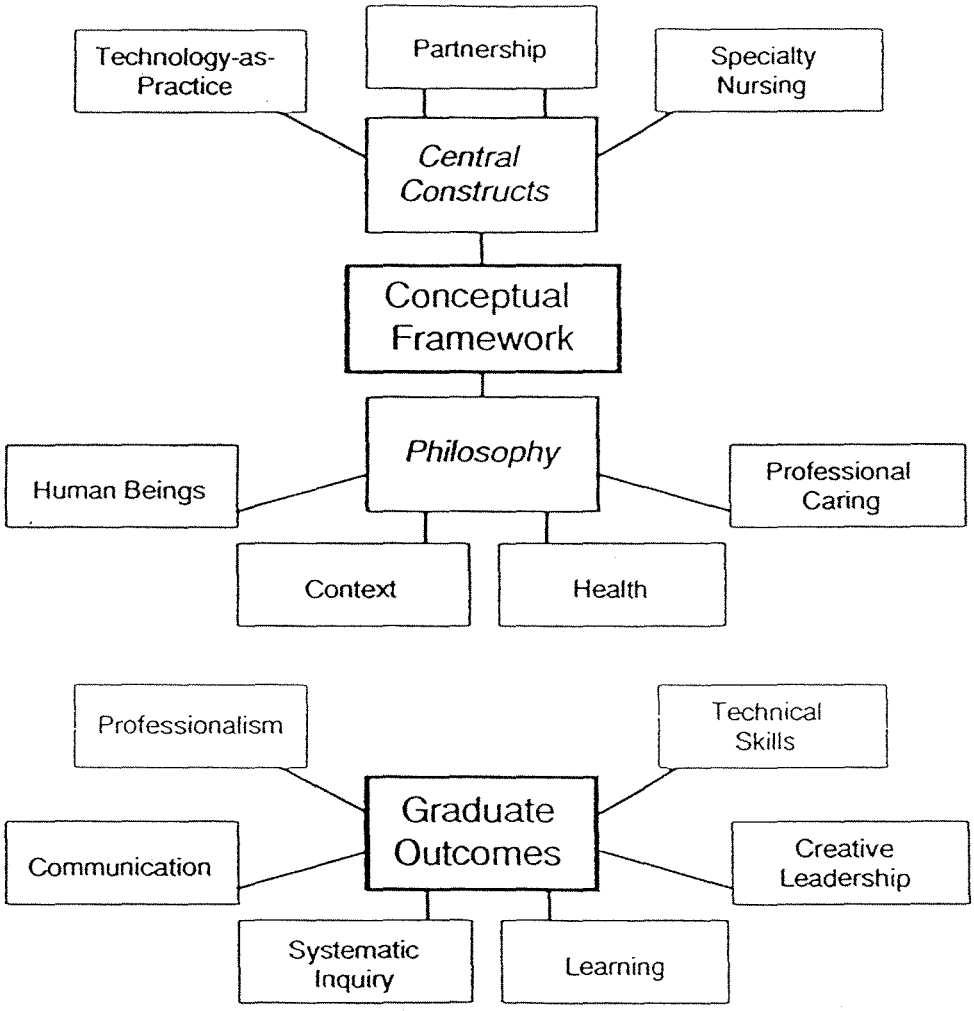
At the end of this section, if there is a treatment involved, look at "prioritization of principles" .

# NURSING PROGRAM

# CURRICULUM

# OVERVIEW

# CURRICULUM FRAMEWORK



# PROGRAM PURPOSE

The purpose of the BCIT Nursing Program is to prepare diploma graduates who will work in health care institutions as beginning nurses. Students in the Program will be introduced to specialty nursing practice through a variety of practicum experiences and through discourse with nurses who work in specialty areas. This exposure aims to assist students who are interested in choosing a clinical focus in their degree completion.

# CURRICULUM FRAMEWORK

The curriculum was developed using the educative paradigm. The partnerships between people in this educative learning model are characterized by respect, participation and egalitarianism.[1&2] Self-directed, small-group, and problem-based learning are central to acquiring an integrated body of knowledge and the graduate outcomes in this curriculum.

*Self-directed learning* — *Self-directed learning is a method of learning that: "encourages students to identify their own goals and learning needs, allows students to suggest strategies to meet those learning needs and assumes an interest in evaluating one's own progress towards the achievement of goals. The course objectives provide a framework within which the student's goals are identified."*[3]

*Small-group learning* — *Small-group learning is an approach to learning in which the discussion among students and tutors facilitates the development of communication, thinking, learning, leadership and team work skills.*

*Problem-based learning* — *Problem based learning is an approach to teaching and learning in which a 'problem' is presented as a starting point for learning. It has two purposes: the development of "an integrated body of knowledge related to the problem and relevant for future problems, and the development or application of problem solving skills."*[3]

# *CENTRAL CONSTRUCTS*

The curriculum has been developed within the central constructs of **specialty nursing, partnership, and technology-as-practice**. The curriculum focuses on the development of nursing practice within institutions to prepare for a clinical focus, the development of partnerships with people (clients, students, faculty, health professionals), and the understanding and use of technology.

## SPECIALTY NURSING

Specialty nursing provides direct nursing care to human beings in a context. Specialty nurses refer to a broad range of theories, specialty knowledge and skills. The specialty nurse's level of expertise is carried out in simple and complex care situations. Specialty nurses both provide and manage specialized care. Within partnerships, specialty nurses promote and restore health, and enhance the person's coping abilities.

## PARTNERSHIP

Supportive partnerships among students, nurses, clients, teachers, and other members of the health care system are built upon three essential components: open communication, mutual respect, and cooperation. Partnerships are characterized by mutually established goals and reciprocal learning.

In order to accomplish a partnership, the nurse/teacher must understand the ***meaning*** of a situation/event to another human being. This understanding is referred to as "shared meaning".[3] In this definition, meaning refers to a human being's ***interpretation*** of an event, including the significance the event holds and what the event may symbolize or represent within that person's context. Such context-specific meanings and interpretations have an impact on how the individual views health and illness.

## TECHNOLOGY- AS- PRACTICE

Technology- as- practice involves ways of knowing, being and doing that include a body of organized knowledge, ideas, and patterns associated with practice.[4] In specialty nursing, technology- as- practice is demonstrated through practice-based learning, professional caring, communicating, systematic inquiry, and creative leadership. Technology as practice is influenced by culture and by socially accepted practices and values and vice versa.

## *PHILOSOPHY*

The following statements reflect the faculty's beliefs about human beings, context, health, and professional caring.

### HUMAN BEINGS

Humans beings interpret. All have potential and each is unique.

We find ***meaning*** in our lives from a variety of experiences. What our lives mean to us is influenced by the ***context*** in which we live. Within that context, we may make choices regarding the ***quality*** of life.

### CONTEXT

Human beings exist within a dynamic context comprised of physical, emotional, social, cultural, economic, political and spiritual variables. Context influences the way people perceive their health and learning. Context may be modified to promote health and personal growth as well as to promote self esteem and comfort when health deteriorates and death is expected.

### HEALTH

Health is defined as being all of which one is capable in one's life situation.[3] The World Health Organization defines health as a resource for everyday life that enables human beings to realize aspirations, and to interact with a changing context. Health is a dynamic experience involving body, mind and spirit.

Because health is individually defined within contexts, a human being's view of health is influenced by personal meaning, by awareness of what influences personal health practices, and by the ability to perceive what is possible in each situation.

### PROFESSIONAL CARING

Professional caring is the unique contribution of nursing which helps ...(human beings)... identify, determine and act upon their life experiences relevant to their health.[3] The nurse is open to learning about people and understanding their perceptions and experiences so that both may discover ways to strengthen or sustain health or promote self-esteem and comfort when health deteriorates and death is expected.

The nurse draws on personal, empirical and ethical knowing to bring to life the ***artistry*** of nursing.[5] This creative activity is professional caring. It involves three elements:

* rational---use of decision making and systematic inquiry skills
* technical---competent performance of specific procedures
* emotive---interpersonal relationships that foster partnerships [3]

## *PROCESS THREADS*

These process threads give rise to the graduate outcomes.

### PROFESSIONALISM

Within a respectful and supportive context, students and teachers commit to using reason and reflection in the pursuit of shared understanding and goals. They practice in a professional manner as established in the **Standards for Nursing Practice in British Columbia.**[6] This includes but is not limited to having a depth of nursing knowledge, having skill in carrying out technical aspects of care, having skill in organizing and prioritizing care, providing humanistic care to clients, making sound clinical judgments, evaluating care, using and participating in research, incorporating a set of values and ethics, valuing self-regulation, making a commitment to providing a public service and changing practice as society requires.

Since contexts contribute to health, professional nurses have a role in working to foster contexts which promote, maintain and restore health.

### COMMUNICATION

Communication is a process by which embodied, verbal, written, emotional and spiritual messages are exchanged.[3] There is a rhythm of attachment and separation between the participants that creates a whole experience. The purpose is to establish ***shared meaning*** and ***partnership*** and, where possible, to develop the person's capacities for healing and growth. Shared meaning is also used to promote self esteem and comfort when health deteriorates and death is expected.

Communication includes the use of written, verbal, nonverbal and information technology skills.

### SYSTEMATIC INQUIRY

Systematic inquiry refers to an intellectual process which uses reasoning skills and reflective skills in relation to the ***quality*** of reasoning. This process is a guide for formulating beliefs and for taking action in nursing practice. [7,8,9] Specialty nurses use evidence from research, practical knowledge and personal experience in the pursuit of clear understanding so that decisions and judgments are sound and nursing practice is safe.

### LEARNING

Learning for the professional practice of nursing is both a process of inquiry and a skill that develops as a life long activity.

Learning is a process in which people create meaning from experiences. They do this in an integrated, whole manner. Both the learner and the teacher have the potential to learn from one another. A healthy teacher/learner partnership is collaborative, caring and mutually respectful. Human beings have different motivations and abilities to achieve

learning goals and they are responsible for their learning. The process of learning promotes personal growth with the potential for increased reasoning and reflective ability.

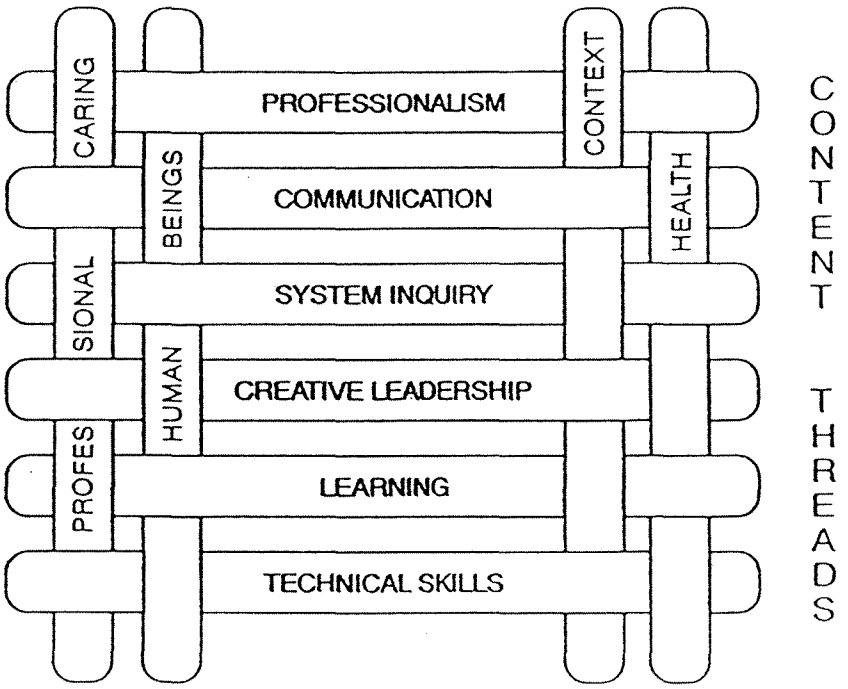
## CREATIVE LEADERSHIP

Leadership entails the use of management skills in working with human beings. Creative leadership encourages and supports the release of creative potential within human beings and provides vision and focus towards the attainment of mutually beneficial goals. This occurs through making positive assumptions about peoples' abilities, valuing individuality and encouraging self direction. In creative leadership, a greater sense of commitment to the overall goals is promoted through collaborative decision making. Continuous change is managed by stimulating and rewarding creativity and encouraging risk-taking.

## TECHNICAL SKILLS

Technical skills are the hands-on skills nurses use in their daily practice.

This diagram shows the interwoven nature of the content threads (philosophy) and the process threads (program outcomes).



Appendix D



## 3.2 KOLESAR VS. JEFFRIES

### PIKE VS. PEACE ARCH HOSPITAL

From: *Canadian Nurse*, March 1978

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**Principle:** The chart is important for both what is recorded and what is not recorded.

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### Kolesar vs. Joseph Brant Memorial Hospital 1977

A 36-year-old male underwent spinal fusion for an injury received in an auto accident. Post-operatively, he was put on a stryker frame and returned to his surgical unit. The next morning he was found dead.

The client's family sued the hospital, nurses and surgeon. All courts, including the Supreme Court of Canada, concurred in the finding of liability against the hospital and the nurse caring for the client.

One important fact was that there was no negligence found on the part of the surgeon. In fact, the Court found that the surgeon was "entitled to rely on the hospital and its staff in the management of the post-operative care of his client and that when they accepted his client they would without negligence care for him."

The chart was most significant; there was no charting from 10 p.m. until 5 a.m. the next day, when the client died. The nurse was instructed by the Assistant Director of Nursing to record the observations which she claimed to have made, but not recorded.

The trial judge made the following statement:

> ***One is always suspicious of records made after the event and if any credence is to be attached to Ex. 29 (the later-entered note), it shows that at all times the patient was quite pale, very pale, and was allowed to sleep soundly to his death.***

The client died of "pulmonary edema and hemorrhage secondary ... to the aspiration of gastric juice. His bladder was grossly distended. The client's death was held to have been caused by negligent nursing care in that he was not roused to cough, breathe deeply, or to perform simple body movements. He was given large quantities of fluids and his blood pressure, respiration, pulse and temperature were not taken nor recorded properly. The medical record was not properly kept."

The nursing notes were introduced as evidence and the absence of entries permitted the inference that: "Nothing was charted because nothing was done." The court then compared the nursing care, the deceased was alleged to have received, with the post-operative care he reasonably should have received. The absence of entries during the crucial period determined the liability of the hospital and the nurse.

One must be very clear that this case shows not only a lack of charting; it demonstrates a shocking lack of care. The condition of the client and the obvious lack of nursing assessment and intervention were the key factors. The lack of charting simply reflected the lack of care. All cases have different facts; therefore, the outcomes won't necessarily be the same. Contrast our next case, Pike vs. Peach Arch Hospital (which also shows poor charting) with the Kolesar case.

### Pike vs. Peace Arch Hospital

#### Facts

On the morning of July 2, 1981 Mrs. Anita Pike, age 39, underwent a total abdominal hysterectomy at Peace Arch District Hospital, White Rock, B.C. The next morning she complained of severe headaches and became unconscious for a time. Early that afternoon she went into a coma

and suffered respiratory cardiac arrest. Four days later she died in the Royal Columbian Hospital, New Westminster, without regaining consciousness.

Mr. Pike sued the hospital, surgeon, anaesthetist, PAR nurse and one unit nurse claiming his wife's death was due principally to inadequate oxygen supply during the surgery and in the PAR. This hypoxia was alleged to be due to carelessness on the part of the physicians and the nurses.

**Judgement**

In spite of very poor charting the judge found for the defendant hospital, nurses and physicians.

He said of the PAR nurse:

> *"Nurse C. conceded that her charting in Mrs. Pike's case was inadequate in that it failed to record several things which have since proved to be of importance." In conclusion, the judge said that he found nothing in nurse C.'s evidence, or in the manner in which it was given, to suggest that she was other than truthful in her description of normal practices (she couldn't remember Mrs. Pike specifically), of observations she has made of patients in similar circumstances or of the meaning of her notations.*
>
> **"I am unable to draw simply from admitted inadequacy in her charting any inferences that the care provided by nurse C. was below that expected of an ordinarily careful nurse of her considerable experience."*

He said of the unit nurse:

Regarding the care given when Mrs. Pike suffered the respiratory arrest, "she agreed that her charting had not been good". The judge was influenced by the observation that nurse P. was not only distressed by the ordeal of giving evidence, but embarrassed by the fact that she had only inadequate after-the-event chart notations on which to rely. "She ought not, in my view, be faulted for having ignored the chart at that point and for having devoted her attention instead by the emergency created by Mrs. Pike's condition."

**Judge's conclusions**

1. The claim that Mrs. Pike died of progressive hypoxia is not supported by the evidence.
2. Her death probably resulted from an unpredictable reaction to post-operative drugs (This hypothesis was put forward by the defendants and their expert medical witnesses).
3. The charting of vital signs and other observations was inadequate and does not meet the standard of acceptable hospital record keeping.
4. Had the proper records been kept, these would clearly have ruled out the possibility that hypoxia caused Mrs. Pike's death.
5. The plaintiff, Mr. Pike, has not shown that Mrs. Pike's death was due to negligence.

* Mr. Justice Taylor concluded his written decision by saying that the lawsuit would not have been brought had the defendants maintained complete and regular records of vital signs and other important observations in accordance with proper hospital practice. Therefore, the defendants were not awarded costs even though they won the case.

Appendix E Questionnaire

# THE ROLE OF THE HOSPITAL NURSE IN HEALTH PROMOTION

DIRECTIONS:

The statements provided below apply to the role of the hospital nurse in health promotion. Health promotion is defined by the World Health Organization as "the process of enabling people to increase control over and to improve their health."

Read each statement and **circle** the letter to the right of the statement that best indicates your role in health promotion as a hospital nurse. Try to answer every question. Although some questions may ask about situations that are not commonplace for you, answer the question as if you were called upon to respond to that situation. Please respond to the questions from your experience as a hospital nurse. The key for the responses is:

**SA - STRONGLY AGREE**
**A - AGREE**
**N - NEITHER AGREE NOR DISAGREE**
**D - DISAGREE**
**SD - STRONGLY DISAGREE**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Healthful lifestyles is an important topic for patient teaching. | SA | A | N | D | SD |
| 2. | There are potential health benefits for patients when I teach them about their medications. | SA | A | N | D | SD |
| 3. | Teaching patients how to care for themselves is an important part of a nurse's role. | SA | A | N | D | SD |
| 4. | Teaching patients about disease processes is an important part of a nurse's role in health promotion. | SA | A | N | D | SD |
| 5. | Feedback about the effectiveness of health teaching is lacking. | SA | A | N | D | SD |
| 6. | Patients expect nurses to encourage them to adopt healthy lifestyles. | SA | A | N | D | SD |
| 7. | I encourage patients facing discharge to carry on with healthful behaviours learned in the hospital. | SA | A | N | D | SD |
| 8. | There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts. | SA | A | N | D | SD |
| 9. | There are adequate resources for teaching chronically ill patients coping skills. | SA | A | N | D | SD |

| | | | | | |
|---|---|---|---|---|---|
| 10. | Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities. | SA | A | N | D |
| 11. | If the family/caregiver supports a patient's lifestyle change, a nurse's health promotion efforts are more effective. | SA | A | N | D |
| 12. | Family members/caregivers who expect a nurse to give the patient total care hinder health promotion efforts. | SA | A | N | D |
| 13. | The team approach to patient care strengthens a nurse's health promotion efforts. | SA | A | N | D |
| 14. | My hospital is supportive of health promotion activities. | SA | A | N | D |
| 15. | Societal values that are in opposition to the values of health promotion are a barrier to health promotion efforts. | SA | A | N | D |
| 16. | There are health benefits for depressed patients that result from a nurse's counselling efforts. | SA | A | N | D |
| 17. | Nursing practice includes comforting patients and their families/caregivers. | SA | A | N | D |
| 18. | Counselling patients following physical abuse is part of a nurse's role. | SA | A | N | D |
| 19. | Health promotion activities include enhancing patient's coping skills. | SA | A | N | D |
| 20. | Sometimes nurses plan activities that 'normalize' the hospital environment. | SA | A | N | D |
| 21. | Health promotion group work with patients is sometimes part of a hospital nurse's practice. | SA | A | N | D |
| 22. | I generally model healthful lifestyles for my patients. | SA | A | N | D |
| 23. | Encouraging patients to advocate for themselves is part of a nurse's role in health promotion. | SA | A | N | D |
| 24. | Encouraging patients to share experiences about procedures is part of my role in health promotion. | SA | A | N | D |

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| 25. | Health promotion in the community is part of a nurse's role as a member of the community. | SA | A | N | D | SD |
| | A nurse must assume the role of patient advocate. | SA | A | N | D | SD |
| 27. | Ensuring a healthful work environment is important to me. | SA | A | N | D | SD |
| 28. | Health promotion is an important part of my role. | SA | A | N | D | SD |
| 29. | A hospital nurse's health promotion activities are incidental rather than planned. | SA | A | N | D | SD |
| 30. | Lack of continuity of care between different hospital departments interferes with a nurse's health promotion efforts. | SA | A | N | D | SD |
| 31. | Time constraints are a barrier to nurses undertaking health promotion activities. | SA | A | N | D | SD |
| 32. | Health promotion efforts would improve if there were more time for patient conferences, inservices and bedside teaching. | SA | A | N | D | SD |
| | Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching. | SA | A | N | D | SD |
| 34. | Incomplete written records hinder a nurse's health promotion efforts. | SA | A | N | D | SD |
| 35. | I change hospital rules or routines to accommodate patients' control. | SA | A | N | D | SD |
| 36. | It is important that hospital nurses are involved in discharge planning. | SA | A | N | D | SD |
| 37. | I can refer patients to to community agencies. | SA | A | N | D | SD |
| 38. | I involve patients' families/caregivers in health promotion when appropriate. | SA | A | N | D | SD |
| 39. | Family members/caregivers are included in a hospital nurse's health promotion efforts. | SA | A | N | D | SD |
| 40. | Health promotion principles apply in caring for terminally ill patients. | SA | A | N | D | SD |
| 41. | I direct my health promotion activities to my nursing colleagues. | SA | A | N | D | SD |

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|---|---|---|---|---|---|---|
| 42. | Knowing about cultural values helps nurses in their health promotion efforts. | SA | A | N | D | SI |
| 43. | Learning more about health promotion will help me provide better patient care. | SA | A | N | D | SI |
| 44. | My experience as a nurse has taught me about health promotion. | SA | A | N | D | SI |
| 45. | In my basic nursing program, health promotion was included in the course work. | SA | A | N | D | SI |
| 46. | Since graduation I have taken courses on health promotion. | SA | A | N | D | SI |
| 47. | I am satisfied with my skills in health promotion. | SA | A | N | D | SI |
| 48. | My knowledge on self-care is adequate. | SA | A | N | D | SI |
| 49. | I am comfortable teaching patients about self-care. | SA | A | N | D | SI |
| 50. | Health promotion is an "everyday thing" for nurses. | SA | A | N | D | SI |
| 51. | I have the ability to advocate for a healthy hospital. | SA | A | N | D | |
| 52. | I have the ability to advocate for a healthy community. | SA | A | N | D | SI |
| 53. | I am involved in health promotion activities in my community. | SA | A | N | D | SI |

54. How often do you carry out health promotion activities, including hea teaching?

Once a day [ ] Once a week [ ] Once a month [ ] Never

55. How strongly do you believe that health promotion is part of a nurse's role? Place a mark on the line indicating your opinion on a scale of 0 - 10. A mark of 0 indicates that you believe that a nurse has no role in health promotion. A mark at 10 indicates that you believe that health promotion is an extremely important role for nurses.

0 (No role) 10 (Extremely important role)

56. What do you think are the most important factors (facilitators/barriers) influencing the hospital nurses' role in health promotion?

57. **Additional Comments:**

## - Subscales used in analysis

Predisposing Factors

Healthful lifestyles is an important topic for patient teaching.

There are potential health benefits for patients when I teach them about their medications.

Teaching patients how to care for themselves is an important part of a nurse's role

Teaching patients about disease processes is an important part of a nurse's role in health promotion.

Patients expect nurses to encourage them to adopt health lifestyles.

I encourage patients facing discharge to carry on with healthful behaviors learned in the hospital.

There are health benefits for depressed patients that result from a nurse's counselling efforts.

Nursing practice includes comforting patients and their families/caregivers.

Counselling patients following physical abuse is part of a nurse's role.

Health promotion activities include enhancing patients coping skills.

Sometimes nurses plan activities that 'normalize' the hospital environment.

Health promotion group work with patients is sometimes part of a hospital nurse's practice.

I generally model healthful lifestyles for my patients.

Encouraging patients to advocate for themselves is part of a nurse's role in health promotion.

Encouraging patients to share experiences about procedures is part of my role in health promotion.

Health promotion in the community is part or a nurse's role as a member of the community.

A nurse must assume the role of patient advocate.

Ensuring a healthful work environment is important to me.

Health promotion is an important part of my role.

A hospital nurse's health promotion activities are incidental rather than planned.

I changed hospital rules or routines to accommodate patients' control.

It is important that hospital nurses are involved in discharge planning.

I involve patients' families/caregivers in health promotion when appropriate.

Family members/caregivers are included in a hospital nurse's health promotion efforts.

Health promotion principles apply in caring for terminally ill patients.

I direct my health promotion activities to my nursing colleagues.

I am satisfied with my skills in health promotion.

My knowledge on self-care is adequate.

I am comfortable teaching patients about self-care.

Health promotion is an "everyday thing" for nurses.

I have the ability to advocate for a healthy hospital.
I have the ability to advocate for a healthy community.
I am involved in health promotion activities in my community.

### Enabling Factors

There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.
There are adequate resources for teaching chronically ill patients coping skills.
Hospital activities on health promotion topics support a nurse's ability to carry out health promotion activities.
The team approach to patient care strengthens a nurse's health promotion efforts.
My hospital is supportive of health promotion activities.
Lack of continuing of care between different hospital departments interferes with a nurse's health promotion efforts.
Time constraints are a barrier to nurses undertaking health promotion activities.
Health promotion efforts would improve if there were more time for patient conferences, in-services and bedside teaching.
Hospital nurses' health promotion efforts would be strengthened by consistent patient teaching.
Incomplete written records hinder a nurse's health promotion efforts.
I can refer patients to community agencies.
Knowing about cultural values helps nurses in their health promotion efforts.
Learning more about health promotion will help me provide better patient care.
My experience as a nurse has taught me about health promotion.
In my basic nursing program, health promotion was included in the course work.
Since graduation I have taken courses on health promotion.

### Reinforcing Factors

Feedback about the effectiveness of health teaching is lacking.
If the family/caregiver supports a patient's lifestyle change, a nurse's health promotion efforts are more effective.
Family members/caregivers who expect a nurse to give the patient total care hinder health promotion efforts.
Societal values that are in opposition to the values of health promotion are a barrier to health promotion efforts.

### Actual Knowledge

Knowing about cultural values helps nurses in their health promotion efforts.

My experience has a nurse has taught me about health promotion.
In my basic nursing program, health promotion was included in the course work.
Since graduation, I have taken courses on health promotion.

Perceived Knowledge

I am satisfied with my skills in health promotion.
My knowledge on self-care is adequate.
I am comfortable teaching patients about self-care.
Health promotion is an "everyday thing" for nurses.
I have the ability to advocate for a healthy hospital.
I have the ability to advocate for a healthy community.

**Promotion Activities**

I encourage patients facing discharge to carry on with healthful behaviors learned in the hospital.
I generally model healthful lifestyles for my patients.
Encouraging patients to share experiences about procedures is part of my role in health promotion.
Ensuring a healthful work environment is important to me.
I change hospital rules or routines to accommodate patients' control.
I can refer patients to community agencies.
I involve patients' families/caregiver in health promotion when appropriate.
Family members/caregivers are included in a hospital nurse's health promotion efforts.
I direct my health promotion activities to my nursing colleagues.
I am involved in health promotion activities in my community.