BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

NURSING PROGRAM

NURSING 2040---PROFESSIONAL PRACTICE 2

August, 2001

INSTRUCTORS:
Ivy O'Flynn
Lynn Field

Table of Contents

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY

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

Course Outline

NURS 2040
Professional Practice 2

Start Date: August 2001 **End Date:** December 2001

Course Credits: 2 **Term/Level:** 4

Total Hours: 34
Total Weeks: 17

Hours/Week: 2 **Lecture:** **Lab:** **Shop:** **Seminar:** x **Other:**

Prerequisites

Course No.	Course Name
NURS 1040	Professional Practice 1
NURS 2030	Nursing Practicum 2

NURS 2040 is a Prerequisite for:

Course No.	Course Name
NURS 4530 Or NURS 7030	nursing Practicum 5 Nursing Practicum 6

Course Calendar Description

This seminar course extends the concepts of specialization, technology-as-practice, research/evidence based practice, ethics, legality, primary health care and the 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.

Course Goals

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

Evaluation

Assignment # 1 Exploration of an ethical situation	40%
Assignment #2 Clinical validation of a nursing issue	40%
Assignment #3 Facilitate class discussion of a nursing issue	20%
Total	100%

Course Learning Outcomes/Competencies

At the end of this course the student will be able to:
1. describe the evolution of specialization and its 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 theory noting the implications for nursing practice.
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. describes the implications, characteristics and role of the nurse in risk taking.
11. describes the impact of change
12. describe the various ways people cope with change.
13. value reflective skepticism in nursing practice.

Process Threads relevant to this content:

- **Professionalism:** Students discuss professionalism in class and it is emphasized in considering class conduct. They further develop an understanding of the professional nursing role.

- **Communication:** Students continue to use discussion and evaluation criteria to help them appreciate the standards for communication. They interview members of the health care team and lay personnel. Discussion/feedback is thoughtful. Students improve computer literacy by using Internet course material and resources. Academic use of APA is used in essay writing.

- **Systematic Inquiry:** Students use questioning and feedback to help them think critically and reflect on their thinking. They investigate issues in nursing. Students take part in clinical validation related to nursing issues. When research finding are presented to the group, group members are responsible for questioning findings. Students develop reflective skepticism regarding nursing practice.

- **Professional Growth:** Students consult/interact with a variety of health professionals. Students evaluate sources of knowledge that are used in their practice. Students assume responsibility for learning and become self-starters. Students value continually updating knowledge. Students are responsible and accountable for actions.

- **Creative Leadership:** Students use facilitation skills within groups so they function productively. They appreciate the role of nursing in the health care system and understand the various components in their context of practice.

Course Content Verification

I verify that the content of this course outline is current, accurate, and complies with BCIT Policy.

Program Head/Chief Instructor — Date: May 22, 2001

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

Instructor(s)

Ivy O'Flynn	Office No.: SE12 418	Office Phone: 432-8911
Lynn Field	Office No: SE12 438	Off ice Phone: 451-6945

Learning Resources

Required:

Registered Nurses Association of British Columbia (1998) *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

BCIT Policy Information for Students

- 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.
- Course readings (except those handed out in class and those listed below) are on reserve in the library. The library material will be on a 2-day loan.
- Required readings are available in a binder from the instructor for photocopying. **Except** the readings marked with an (*), are only available from the library or RNABC. Another **exception** is the readings from RNABC that are available on the internet—www.rnabc.bc.ca.
- Supplemental readings are not on reserve but are in the back of the reading binder.
- All the required 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 assignments will receive a group mark.

Participation/ Attendance

- Refer to "Student guidelines, policies and procedures in the BCIT nursing program" in the BCIT Calendar or on the web site: http://www.bcit.bc.ca/~sohs/nursing/studentpolicies.htm
- 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 are encouraged to 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, apply ethical principles and the C.N.A. code of ethics.

- Sign up for one of the scenarios (see appendix A) Each group will sign up for a different scenario. Also indicate if you have a time preference for your presentation. **Sign up no later than week 3.**
- Each group will have 40 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.
- Suggestions of where to locate ethical decision making frameworks: Canadian nurses association (1998). Everyday ethics: putting the code into practice. (3 copies on reserve in the library); http://www.ethics.ubc.ca (search around at this site under Chris MacDonald publications)

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?
- /3 Uses an ethical decision making framework
- /8 Use the C.N.A. Code of Ethics for Nurses 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 **why** you used these indicators
- /4 Identify how you would use the ethical principles to support the groups thoughts on the dilemma—relate to code of ethics.

- /2 State all 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?

/20 outcome
- /2 report on the opinions you have gathered from 2 health care workers (who have been in health care for at least 2 years) and 2 lay persons.
- /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 VALIDATION OF A NURSING ISSUE (40%)
THIS ASSIGNMENT IS DUE ON OR BEFORE WEEK 7

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 (5-6 questions) based on your reading. Use this questionnaire to gather responses from 3 nurses (RN, LPN and/or RPN depending upon your issue). Ask the nurses to complete the questionnaire either verbally or in the written form. If you have gathered the information verbally you will need to document the responses on the questionnaire. You will then compare the responses of the completed questionnaires 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 of text.
- **Twenty-four hour extensions can be negotiated with the instructor, prior to the due date, without a penalty. If the assignment is late the mark will drop by 5%/day. This assignment is due at 1230 on the due date.**
- You will need a consent for the questionnaire. The following is a sample consent for you to use when distributing the questionnaire:

Sample Consent

The purpose of this questionnaire is for me to look for evidence to support or not support an issue that I have come across in my nursing practice or my readings and to broaden my understanding of the issue. The purpose is not to do research or evaluate nursing practice but to support or not

support an issue I have read about or seen in practice. I have designed a short questionnaire for you to help with this project. The questionnaire should not take more than 5 minutes of your time. If you complete the questionnaire consent is presumed. You are free to refuse to answer all or any of the questions if you do not feel comfortable with the question(s). Your name will not appear on the questionnaire and the information will only be shared with my instructor. After my instructor sees the data the questionnaire will be shredded. If you wish further information regarding this project please feel free to contact my BCIT instructor, (name of 2040 instructor) at (phone number). Thank you for participating in this project.

Content of the paper refers to the thinking demonstrated (36 marks)
/2 introduces content of paper and identified issue(s)—be specific and relate to the questions on your questionnaire
/8 literature reviewed that supports each question on the questionnaire. Questions must also relate to the issue
/2 one of at least 3 of the articles in your literature review is a research article
/5 designs a short questionnaire (5-6 questions) to validate the issue related to the topic. Consent must accompany the questionnaire (see above under Sample Consent). The questionnaire is not time consuming for the participants (5 minutes). Please submit **completed** questionnaires as an appendix.
/2 describe information collected on the questionnaires
/5 compare the information you collected on the questionnaires with your supporting literature/research
/5 how could the information you **collected on the questionnaires** impact on nursing practice
/4 generate further relevant questions based on the information you collected on the questionnaires
/3 **summarizes** the content presented in the paper (this is a summary not a conclusion)

Structure: (10 marks)
/1 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.
/1 A central idea organizes the paper (your identified issue(s)) and paragraph form units of thought.
/2 Paragraphs include a topic sentence and details that support the topic sentence. The links between paragraphs provide smooth transition.
/1 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.
/3 Content is referenced—refer to APA guidelines and BCIT policy for plagiarism.
/2 the reference list 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 FACILITATE A CLASS DISCUSSION ON AN ISSUES OF THEIR OWN INTERST THAT IS NOT COVERED IN THE COURSE (20 marks , 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 an issue of their own interest that is not covered in class.
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.
Only one group will be facilitating per class day as there is content that needs to be covered. See schedule for dates of presentation times.

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
/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.

SUGGESTIONS RE ISSUES:

Nurse abuse
Use of restraints
Use of mechanical lifts
Patient focused care
The art of nursing
Substance abuse in nursing
Future role of the RN
Role of the nurse in quality assurance
Shiftwork
Empowerment in nursing
Horizontal violence
Complementary and Alternative medicine
Telehelath
Recruitment and retention
Health professions council
Nursing Shortage
Workplace Violence
Check RNABC and C.N.A. web sites

AUGUST 2001
PART B

BRITISH COLUMBIA INSTUTUTE OF TECHNOLOGY
NURSING PROGRAM
NURS 2040 - PROFESSIONAL PRACTICE SEMINAR 2

SCHEDULE FOR PROFESSIONAL PRACTICE
LOCATION: SE 12-412 AND SW 9-122

DATE	ACTIVITY
1. August 21	Introduction to Nursing 2040
2. August 28	Legal issues
3. September 4	Legal issues **Sign up for ethics presentation**
4. September 11	Ethical issues
5. September18	Standards for Nursing practice
6. September 25	Risk taking and whistle blowing **Presentation time**
7. October 2	Evidence based practice and nursing theory **Clinical validation of a nursing issue paper due** **Presentation time**
8. October 9	Evidence based practice and nursing theory **Presentation time Midterm course evaluation**
9. October 16	**ETHICS PRESENTATIONS**
10 October 23	**ETHICS PRESENTATIONS**
11. October 30	**ETHICS PRESENTATIONS**
12. November 6	Technology **Presentation time**
13. November 13	Partnerships **Presentations time**
14. November 20	Transition/Change **Presentation time**
15. November 27	Professional associations and unions and primary health care **Guest speakers**
16. December 4	Specialization **Presentation time** **(Course and instructor evaluation)**

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

WEEK	ISSUES/INFORMATION TO BE COVERED	REQUIRED AND SUPPLEMENTAL READINGS
1	**Introduction** Overview of the course Assignments Evaluation Methods Discussion of readings How Nursing competencies and skills of the new graduate will be used in this course Class norms Professional behaviour 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 B of this course). In this course technology as practice covers the following issues: legal, ethics, standards for nursing practice, risk taking, nursing theory, 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 2000) 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 address these competencies we will use the RNABC standards for nursing practice, the code of ethics, the role of the nurse, the use of RN and LGN title and any other relevant documents.

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 or 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**. To fulfill the standards, scope and legislation nurses are responsible for **assessing,** on a continuing basis, his or her **own competencies** related to: **knowledge, skill, attitudes and judgment.** Nurses must **recognize limitations** of his or her own competence and seek assistance when necessary. Nurses are also accountable for own actions and decisions. Nurses commit to the principle that the primary purpose of the professional nurse is to serve the public.

One of the responsibilities of the nurse is to appropriately delegate. In the process of delegation the nurse must also evaluate the workload management skills to whom she delegates and exercise accountability for decisions which are delegated to others.

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

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

2	**LEGAL ISSUES** **Class preparation** How does the RNABC define the practice of nursing? Describe how nurses act as advocates in the nurse-client relationship. A nurse is considered competent if s/he meets the "standard of care". What does "standard of care" mean and how is it determined? What is a nurses' "legal duty of care"? When is a nurse considered negligent? When is a nurse considered incompetent? What legal protection is there for the R.N.? In what situations is it acceptable for an RN to withdraw or refuse to provide care? Read the scenarios and be prepared to discuss them in class. **Class discussion** **Situations** 1. A 55-year-old diabetic was admitted to the coronary care unit with a myocardial infarction. Soon after admission and for the	RNABC (1998). Nursing practice guidelines "Overview of nurses registered act, rules and RNABC constitution and bylaws" (www.rnabc.bc.ca) RNABC (2000). Nursing practice guidelines: advocacy and the registered nurse (www.rnabc.bc.ca). RNABC (1999). Practice guidelines: use of title (www.rnabc.bc.ca) ---Why nurses get into trouble. RNABC NEWS, January/February, 1987, 24-25

	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)	**RNABC Publication "Negligence, suits and the nurse" (1993)
	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 "wasn't out of line". The patient died as a result of the medication. Is the nurse negligent? Of so, Why? (Nursing life, September/October 1982, pp 36-37)	RNABC publication "Duty to Provide Care" RNABC Standards for Nursing Practice (1998) pp 26 & 39 RNABC (1999). Nursing practice guidelines "Overview of legislation relevant to nursing practice" (www.rnabc.bc.ca)
	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?	RNABC Capture Insurance Corporation. Liability insurance for the registered nurse pp 1-4 Gray, L. and Treleaven S. (2000) Liability insurance for RN's. Nursing BC, December, 25-26.
3	**Class preparation** What does informed consent mean? What is the role of the substitute decision-maker?	
	How does one determine competency? What does the Infant's Act state regarding competency and what does this mean for health care workers? How does the Freedom of information and privacy act relate to nursing? Are nurses legally required to stop at the scene of an accident and render help? (see good samiratan act)	Mass, H. (1995). On getting consent: how do recent legislative changes on consent affect you. Nursing B.C, March/April, 9&11 RNABC (1999). Nursing practice guidelines: "Overview of legislation relevant to nursing practice"

	What is the difference between assault and battery? Who determines the boundaries of patient confidentiality? What is the nurses' responsibility when delegating tasks or procedures? Go to Appendix C. In that section there are 2 case studies on the legal aspects of charting from the RNABC. Review the case studies and state what the nurse should have charted and the rationale behind your statements. What factors need to be considered when delegating tasks or procedures? **Class discussion** When working in a hospital/institution who determines what is told to the media/police? 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? 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) 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? 7. A patient's boss called to ask about his employee's condition. The nurse mentioned that the patient was being treated for	(www.rnabc.bc.ca) RNABC (1998) Nursing practice guidelines: Freedom of information and protection of privacy act, (www.rnabc.bc.ca) RNABC (1999). Position statement on informed consent. (www.rnabc.bc.ca) RNABC (2000). Nursing practice guidelines: Informed consent Steele, M. (February 2001) Confidentiality. Nursing B.C. Keatings, M. & Smith, O.B. (1999). Ethical and legal issues in Canadian nursing, 2nd ed. W.B. Saunders, Canada. pp 65-67. RNABC (2000). Position statement: nursing staff mix for safe and appropriate care (www.rnabc.bc.ca) RNABC Publication (2000). Mock coroner's inquest. Sept 18. **RNABC Publication "Delegating nursing tasks and procedures" (1994) RNABC Standards for Nursing Practice (1998) p 39

	narcotic addiction. What is the nurse liable for if the employee is fired? (Nursing life, September/October 1982, pp 36-37) 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? 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 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.	Sibbald, B. (1997). Delegating away patient safety. Canadian nurse February, 22-26. RNABC (1998). Nursing practice guidelines: documentation (www.rnabc.bc.ca) **SUPPLEMENTAL READINGS** Eskreis, T.R. (1998). Seven common legal pitfalls in nursing. AJN April pp34-41. Mass, H. (1998) When can you call yourself a nurse. Nursing BC. March-April pp27-28 Caleff, B. (1994) Seven things you should never chart. Nursing '94, p43 Phillips, P. (1994). Accountability, responsibility, liability. Canadian nurse April pp 51-52. Phillips, P. (1997). Delegation and liability. Canadian Nurse. September. 47-48. Tapp, A. (1994). Negligence. Canadian Nurse June, p. 51 Ellis, J. (1997) The client's right to know versus the nurse's right to be protected from harm. Nursing BC, November-December. pp 11-12

		Nursing B.C. (2000). Coroner's recommendations. Nursing B.C. April, 11 RNABC (2000). Position statement: Delegating tasks to unregulated care providers. (www.rnabc.bc.ca) **RNABC Publication (2000). Confidentiality for nurses. RNABC. August. Walker, D. (2000). Why do they complain about nurses? Nursing B.C. June 25-27

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. The nurse also identifies the effects of own values and assumptions in interactions with the client.

4	**ETHICAL ISSUES** **Class preparation** What is the relationship between law and ethics? Why do we have a "Code of Ethics" for nurses? Define the following ethical principles (Catalino, J.T. (1997): autonomy, justice, fidelity, beneficence, nonmaleficence, and veracity Define confidentiality—use a dictionary or an ethics book in the library. Identify where each of the above principles is reflected in the code of ethics. What is the difference between active and passive euthanasia? **Class Discussion** Nurses are also accountable to physicians,	RNABC Standards for Nursing Practice (1998) Appendix 3, pp 30-35 Catalino, J.T. (1997). Professional ethics. In R.K. Nunnery (Ed.). Advancing your career: concepts of professional nursing. (pp. 371-380) Philadelphia; F.A. Davis. Ramsey, G.C. (1998) Nursing and ethical issues. Imprint April-May pp 43-45 Sanchez-Sweatman, L.

	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?** For the following cases identify the ethical principles involved and direction you are given from the Code of Ethics: 1.The postop orders for a patient who is also a substance abuser say, "Discontinue the PCA morphine and give 2 cc of normal saline IM q4-6h for pain". On the first postop day, the patient, who has sustained massive injuries from a car accident, is already asking for something to relieve his severe pain. (RN Jan 2000 pp 21-23) 2. A 23 year-old accident victim arrives in the emergency department suffering from multiple contusions, severe lacerations, and signs and symptoms of acute brain injury. Despite impassioned pleas from the medical staff, however, he refuses treatment, insisting that it would violate his religious beliefs. (RN, March 1999 pp 27-30) 3. An 85 year-old man with mild dementia often threatens the safety of other patients when he gets out of bed. Because the facility is so short-staffed, his nurse wants to put him in restraints to prevent him from hurting himself and others. (RN, May 1999 pp27-29) 4. A 65 year –old patient is admitted with cancer of the colon. He is operated upon and the physician finds metastases to the liver and other organs. The team feels the patient should be on palliative care. The patient is aware of the metastases. The family requests that the patient be given a medication and the patient be told that the medication is a cancer chemo drug. (clinical practice)	(1994). Euthansia. Canadian Nurse, January 51-52 Seitz, T. (2000). The euthanasia debate. Canadian Nurse, March 43-44. Erickson, J., Rodney, P. and Strazomski R. (1995) When is it right to die? Canadian Nurse, September, 29-33. **SUPPLEMENTAL READINGS** Van Weel, H. (1995). Euthanasia: mercy, morals and medicine. Canadian Nurse, September, 35-40 (the Sue Rodriguez story 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 Moorhouse, A. (2001) When CPR is not an option. Canadian Nurse, January, 37-38.

	Discuss the difference between active voluntary, active involuntary, passive voluntary and passive involuntary euthanasia and give examples of each type of euthanasia? Which type of euthanasia is legal?	

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.

5	**STANDARDS FOR NURSING PRACTICE** **Class preparation** What is the purpose of the standards for nursing practice? Review Standards for nursing practice. Look at the "Clinical Practice indicators for the registered nurse" Read the article by H. Griffiths and Standards for Nursing Practice--Appendix 1(Guidelines for resolving professional practice problems). Review case studies of past few weeks in relation to violation of standards for nursing practice. **Class discussion** 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 and/or legal component. 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, 16-17 RNABC Publication: Standards for Nursing Practice in B.C. (1998) **SUPPLEMENTAL READINGS** Wells, B. (1998) Taking charge of your practice. Nursing BC. January/February pp 16-17.

RISK TAKING /WHISTLEBLOWING

Although the nursing literature suggests that nurses generally avoid risks, their willingness and ability to take risks are fundamental to professional advancement and job satisfaction. In this section we will look at the positive characteristics of risk taking and how to develop these characteristics. Whistle blowing will also be discussed in relation to risk taking. In the RNABC position statement "nursing leadership and quality care" also refers to risk taking as a component to leadership. The following RNABC competencies of the new graduate will be addressed in this section: Challenges questionable actions, orders, decisions made by other health team members; demonstrates openness to new ideas which may change, enhance or support nursing practice and attending to changes in the health system by recognizing and analyzing changes that affect own practice and client care, b) implementing changes developed by others and c) developing strategies to manage changes that affect own practice and client care.

6	**Class preparation** Define risk taking. Why does P. Wolfe think that nurses are not risk takers? What factors does P. Wolfe identify as factors that enhance risk taking? What factors does P. Wolfe identify as factors that do not facilitate risk taking? Describe whistle blowing? **Class discussion** From your experience or readings what characteristics are needed to be a risk taker? How does risk taking connect with whistle blowing? What problems and issues were the nurses concerned about in the Sibbald article? In the Sibbald article when and why did the nurses consider going outside the institution? In the Sibbald article what process did the nurses use to get their concerns recognized? What were/are the actual and potential problems for the nurses in the Sibbald article? In the Sibblald article what could the nurses have done differently to achieve the desired outcome? What were the outcomes of the inquest into the Manitoba pediatric cardiac surgery deaths? Describe situations when you might consider whistle blowing. **Midterm evaluation of the course**	RNABC (1999). Position statement: Nursing leadership and quality care (**www.rnabc.bc.ca**) Canadian Nurses Association (1999). Ethics in practice: I see and am silent/I see and speak out: the ethical dilemma of whistle blowing. November. Wolfe, P.L. (1994). Risk taking: nurses comfort zone. Holistic Nurse Practice, 8(2), 43-50 (see Nurs 1040 readings) Sibbald, B. (1997). A right to be heard. Canadian Nurse November, pp 22-30 Fletcher, M. (2001). The Manitoba pediatric cardiac surgery inquest report. Canadian nurse. February, 14-16 **SUPPLEMENTAL READING** Levine-Ariff, J. & Groh, R. (1990). Whistleblowing. Creating an ethical environment: A quarterly series, 2(1) 84-89. March. (In library on reserve)

EVIDENCE-BASED PRACTICE (RESEARCH-BASED PRACTICE) AND NURSING THEORY

In this section we will be addressing evidence-based practice and nursing theory. Throughout your readings you will note that it is also called research-based practice. Nursing research and theory are linked together. Sometimes research generates theory and sometimes research tests theory and promotes the evolution of new theories. For example, the theory of caring was generated from research. Once the theory of caring was generated it was tested to see if it is true in circumstances other than the circumstances it was generated under—e.g. other age groups, cultures etc.

The "Competencies required of the new graduate" (2000, 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). The nurse participates in analyzing, developing, implementing and evaluating nursing practice policy in the workplace. As part of the role of the nurse, the nurse participates in quality assurance and improvement activities to enhance client care and nursing practice. We will be looking at evidence-based practice and nursing theory in more detail and exploring how they are integrated into clinical practice.

7	**EVIDENCE/RESEARCH BASED PRACTICE** **Class preparation** Define research/evidence-based practice. Describe the goals of nursing research according to the RNABC position statement. What is the purpose of research based practice? What are the barriers to nursing research? What are some examples of research/evidence based clinical practice tools? **Class discussion** Identify research studies that would fulfill the goals of nursing research. Discuss the role nurses can play in relation to nursing research? What role can you assume as student nurses? Discuss solutions to breaking down	RNABC (1992). Position statement on Nursing Research (www.rnabc.bc.ca) RNABC Standard for Nursing Practice (1998) P39 Simpson, B. (1996). Evidence-based nursing practice: state of the art. Canadian Nurse, November, 22-25. RNABC (1996): Integrating evidence-based practice clinical tools with practice

	the barriers to research. How can clinical paths be a source of nursing research studies? Review selected research studies in class and identify: a) the purpose of the study b) potential impact on patient outcomes the goal it achieves in relation to the goals of nursing research	

NURSING THEORY

Nursing theory is a set of ideas, experiences, or observations regarding how and why nurses engage in certain activities and exhibit various behavioral attitudes in providing patient care. Through research, these activities and attitudes are tested for validity (Dunlop K. 1998) Theory also provides nurses with a view of client situations, a way to organize the hundreds of data bits encountered in the day-to-day care of clients, and a way to analyze and interpret the information. Theories allows the nurse to plan and implement care purposefully and proactively. When nurses practice purposefully and systematically, they are more efficient, have better control over the outcome and the care they give, and are better able to communicate with others (Raudonis, B.M. & Acton G.J., 1997). Nursing is developing its own theory base and using theories from other disciplines to provide safe and effective nursing care. In this section we will be looking at how theories are used in the care of the client. There are many theories to choose from. Selection of a nursing theory is based upon your patients needs. We will be looking at a few theories and how they apply to the clinical situation.

Dunlop, K. (1998). The practice of nursing theory in the operating room. Today's surgical nurse. September/October,18-22.
Raundonis. B.M. and Acton, G.J. (1997). Theory-based nursing practice. Journal of advanced nursing. 26(1).,138-145

8	**NURSING THEORY** **Class preparation** Define concept. Define theory. Describe the four concepts considered to be central to nursing: person, environment, health and nursing Describe the purpose of nursing theories. Describe how nursing theories are used in practice.	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

	Review the selected theories assigned to your group. **Class Discussion** Describe your assigned theory. Which of the following concepts are addressed (patient, environment, nursing, health)? What other concepts are addressed? How would this theory guide your nursing care? What assumptions are made regarding the role of the patient? What research questions are generated from this theory?	Morse, J.M., Bottoroff, J., Neander, M., and Solberg S. (1991). Comparative analysis of conceptualizations and theories of caring. Image: journal of nursing scholarship. 23(2) 119-126.
9, 10 and 11	**Presentation of an Exploration of an ethical issue.** Review Assignment #1 details	See Appendix A and B **SUPPLEMENTAL READING** Canadian Nurses Association (1998) Everyday ethics: Putting the code into practice (3 copies are on reserve in the library) MacDonald, C. A guide to moral decision making. UBC Center for Bioethics at WEB site: http:/www.ethics.ubc.ca

TECHNOLOGY

In this section we will look at expanding your knowledge of the concept Technology-as-practice. The RNABC (2000) 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 safe, efficient and effective nursing interventions. The nurse will also be able to manage the physical resources in order to provide effective and efficient care (equipment, supplies, medication, linen). In performing client assessments, the nurse will customize standard assessment tools to individualize them to the client's particular needs. The nurse will also use computerized and other health and nursing information systems to plan and coordinate client care. After reading the required readings come to class prepared to discuss your understanding of technology-as-practice and give examples to support your view.

12	**TECHNOLOGY** **Class preparation** Review BCIT curriculum definition of "Technology-as-practice" **Berry** et al discusses some of the patient responses to invasive technology. Describe these responses. 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? In the **Jacox et al** article review the chart on page 82 that provides a classification of nursing technology. In the **Locin** article on page 201 there are some assumptions made about the nurse-patient relationship. Describe the assumptions. **Class discussion** What reactions might patients have to some of the technologies in your clinical area? What interventions might be useful to reduce the negative impact of technology on patients in your clinical area? What is the impact of new technology on nursing staff? As an RN you will be asked to evaluate new technology coming to your unit. In your group choose a technology used on one of your units and state what questions your group might ask to assess the impact of the technology on patients and on the nurses workload. In the Novek article what were some of the problems with the automatic drug dispensing machine? How could some of these problems been avoided?	BCIT Curriculum: definition of "Technology-as-practice" (appendix B—NURS 2040). Berry, T. & Baas, I. (1996). Medical devices and attachment: holistic healing in the age of invasive technology. Issues in mental health nursing. Vol 17, 233-243 Axford, R.L. & Carter, B.E.L. (1996). Impact of clinical information systems on nursing practice: nurses perspective. Computers in nursing 14(3), 156-163 Jacox, A., Pillar, B. & Redman, B.K. (1990). A classification of nursing technology. Nursing Outlook. 38(2), 81-85. Locin, R.C. (1995). Machine technology and caring in nursing. Image: Journal of nursing scholarship. 27 (3), 201-203 Novek, J. and Rudnick W. (2000) Automatic drug dispensing help or hindrance? Canadian nurse. April, 29-33. **SUPPLEMENTAL READINGS** Pillar, B., Jacox, A. and Redman, B.K. (1990). Technology, its assessment and nursing.

		Nursing Outlook 38 (1), 16-19 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), 174-178.

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 are 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 each 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 care 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)"

13	**PARTNERSHIPS** **Class preparation** Review the "skills and Competencies" below and **come prepared to class to discuss** how you have/will achieve each competency. Review of the old and new paradigms of thinking and how they affect partnerships across disciplines/departments. **Class discussion** 1. Discuss the old and new paradigms of thinking and how they affect partnerships across disciplines/departments. 2. In the "Skills and Competencies for the new graduate—2000" 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: 3. Demonstrates attitudes which contribute to effective partnerships with clients: respect empathy honesty 4. Supports clients while coming to decisions about their health, then supports their decisions 5. Understands the overall organization of health care at the: • Unit level • Agency level 6. Collaborates with clients to perform a holistic assessment of needs	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, 3-8

	7.Collaborates with clients to identify their health problems and issues 8. Collaborates with clients to develop a plan of care by: identifying expected outcomes questioning and offering suggestions regarding approaches to care reducing complex health problems into systematically manageable components developing a range of possible alternatives and approaches to care establishing priorities of nursing care seeking information from relevant nursing research, experts and literature. 9. Negotiates with clients to determine when consultation is required with other health team members or other health related sectors 10. Makes formal referrals to other health team members and other health related sectors for clients who require consultation 11. Includes the family in clients care delivery (with client's consent) 12. Forms partnerships with clients to achieve mutually agreed-upon health outcomes 13. Coordinates health team members to ensure continuity of health services for clients 14. Participates in quality assurance and improvement activities to enhance client care and nursing practice 15. Collaborates as a member of the interdisciplinary health team 16. Develops partnerships with nursing and health team members based on respect for the unique competencies of each team member 17. Uses established communication protocols within agencies and across agencies.	

	18. Provides care that demonstrates sensitivity to client diversity (culture, race, age, sexual orientation, gender, beliefs, values) 19. Provides constructive feedback to colleagues about client care. 20. Selects methods of communication which are appropriate to client circumstances. 21. Verifies evaluation finding with stable clients (practicing independently), and unstable clients (with peer consultation) and other members of the health care team.	

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 and how to cope with transition/change in a positive manner. It is also important to recognize the impact of change on other health team members.

14	**TRANSITION/CHANGE** **Class preparation** Define change and transition. Define risk-taking What is the relationship between change and risk-taking? Describe the ten stages of change according to BCNU? Describe the seven dynamics of change? Describe some of the barriers (resistance) associated with transition/change. Describe some of the coping mechanisms used in the transition phase. **Class discussion** 1. In class you will be given an article to discuss the following issues: Describe the change the nurse encountered? Relate this change the ten stages of change. Describe the stresses s/he went through	BCNU (1995). The ten stages of change. BCNU Update. June p.5 Blanchard, K. (1992) The seven Dynamics of Change. Inside Guide, September/October pp 7&12. http://www.demon.co.uk/mindtool/plreschn.html Mind tools—helping you to think your way to an excellent life: resistance to change. Davidhizar, R. (1994) Coping with difficult changes. Today's OR nurse. May/June pp 53-54.

	during the transition phase. Were there any barriers s/he encountered during the transition phase? Describe the behaviors that helped her/him through the transition? 2. Describe how organizational change might effect patient care and team work? 3. Describe what strategies the team might use to facilitate transition.	Thomas, D.O. (1997). Change—be part of it. RN. March p 80. King, S.K. (1982). Coping with organizational change. Topics in clinical nursing. July, pp 66-73. RNABC (1999). Position statement: Nursing leadership and quality care. (www.rnabc.bc.ca) RNABC (1999). Position statement: Educational requirements for future nurses (www.rnabc.bc.ca)

PROFESSIONAL ASSOCIATIONS, UNIONS AND PRIMARY HEALTH CARE

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.

15	**PROFESSIONAL ASSOCIATIONS, UNIONS AND PRIMARY HEALTH CARE** **Class preparation** **BCNU** Describe the goals/mandates of unions and professional associations. What are the similarities and differences? Prepare questions for guest speakers **RNABC** **Primary Health Care and C.N.A.** Define "Primary health care" Describe the principles upon which primary health care is based Describe the role of the nurse in relation to the principles of primary health care **Class discussion** Guest speakers from RNABC and BCNU	Downe-Wamboldt, B. (1997). Associations or unions. C.N.A. Today, 7(2), 4-5. Canadian nurses association. A framework for health care delivery.

SPECIALIZATION

To prepare for this section of the covers 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.

16	**Specialization** **Class Preparation** Review BCIT definition of specialty nursing. What factors/trends influence specialization in nursing? 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? How does a nurse become a specialist? **Class Discussion** What is the impact of specialization on nursing, hospitals and other health team members? What might be the future of specialization? 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 B) Caukin, J. (1992) Canadian nursing faces the future. In Baumgart, A & Larson, J. (Eds.). Specialization issues, chapter 17. (pp 327-340) RNABC (1994). Position statement: Clinical nurse specialist. (www.rnabc.bc.ca)

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) (RNABC library)

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)

APPENDIX B

NURSING PROGRAM

CURRICULUM OVERVIEW

APPENDIX C

LEGAL ASPECTS OF CHARTING

3.2 KOLESAR VS. JEFFRIES

PIKE VS. PEACE ARCH HOSPITAL

From: *Canadian Nurse*, March 1978

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

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.