INFORMATION PACKAGE

NURS 4032
Level Four Practicum

August 2006–December 2006 Edition

WPC #22334 06/06

NURS 4032
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Information Package
August 2006 – December 2006

Table of Contents

A POLYTECHNIC INSTITUTION

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

Course Outline

NURS 4032
Nursing Practicum 4

Start Date: August 14, 2006 **End Date:** December 8, 2006

Total Hours: 270 **Total Weeks:** 15 **Term/Level:** 4 **Course Credits:** 11

Hours/Week: **Lecture:** **Lab:** **Shop:** **Seminar:** 1 **Other:** 17

Prerequisites

Course No.	Course Name
NURS 1060	Pharmacology
NURS 3000	Applied Nursing Science 3
NURS 3033	Family Nursing Theory
NURS 3034	Nursing of Families Practicum
NURS 3036	Mental Health Theory
NURS 3038	Mental Health Practicum
BHSC 3329	Immunology for Nursing

NURS 4032 is a Prerequisite for:

Course No.	Course Name
NURS 7030	Nursing Practicum in a Specialty Unit
NURS 7100	Community Nursing

Corequisites

Course No.	Course Name
NURS 2040	Professional Practice 2
NURS 3020	Clinical Techniques 3 — Laboratory
NURS 4000	Applied Nursing Science 4

■ Course Description

From this course students will gain nursing experience in medical and/or surgical acute care units. Students will be expected to provide knowledgeable and safe nursing care. The scope of nursing practice includes recognition and consideration of patient health needs during hospitalization as well as health needs that will require follow-up on discharge. Context of practice: Adult Medicine and Surgery.

■ Detailed Course Description

NURS 4032 is a practicum course focusing on nursing care of patients experiencing complex health issues that require hospitalization. Emphasis is placed on developing knowledge, skills, and attitudes relevant to professional nursing practice.

■ Evaluation

- Satisfactory/Unsatisfactory standing based on student and instructor evaluation of course outcomes.
- Successful completion of a self-evaluation journal.
- **During Weeks 12–15, students must show evidence of consistent outcome achievement for three of the four weeks to obtain a satisfactory standing in the course.**

■ Course Learning Outcomes/Competencies

Upon successful completion of this course, the student will meet the course outcomes and related Standards of Practice determined by the CRNBC:

Standard #1: Responsibility and Accountability
Maintains standards of nursing practice and professional conduct determined by the CRNBC and the practice setting

Course Outcomes:

- Provides professional caring based on knowledge and skills.
- Implements technical skills competently with increasing confidence.

Clinical Practice Indicators

1. Consistently arrives on time.
2. Demonstrates responsibility and accountability for attaining and maintaining a safe level of nursing practice.
3. Demonstrates accountability and responsibility for own professional conduct including demonstrating honesty, integrity and respect.
4. Follows BCIT and practicum agency policies, procedures, protocols and care standards.
5. Independently recognizes and intervenes as appropriate when patient safety is jeopardized.
6. Consistently submits all assignments on time, according to criteria.

Standard #2: Specialized Body of Knowledge
Bases practice on best evidence from nursing science and on related content from other sciences and humanities

Course Outcomes:

- Provides professional caring based on knowledge and skills.
- Pursues shared meaning by communicating effectively with people.
- Uses systematic inquiry.

Clinical Practice Indicators

1. Uses current evidence and research to plan and direct nursing practice.
2. Prepares for the clinical experience by:
   - raising questions.
   - discussing health issues and related knowledge from nursing science and other disciplines.
   - identifying necessary patient assessment data required.
   - identifying priority actual and potential problems.
   - identifying related nursing implications.
3. Explores a variety of theoretical perspectives to guide patient care.
4. Actively participates in professional forums such as debriefing sessions and nursing unit rounds.

Standard #3: Competent Application of Knowledge

Determines client status and responses to actual/potential health problems, plans interventions, performs planned interventions, and evaluates client outcomes

Course Outcomes:

- Provides professional caring based on knowledge and skills.
- Pursues shared meaning by communicating effectively with people.
- Uses systematic inquiry.
- Uses creative leadership skills to manage changing patient situations.
- Implements technical skills competently with increasing confidence.

Clinical Practice Indicators

1. Independently performs individualized and comprehensive assessments of all assigned patients (initial and ongoing).
2. Interprets assessments based on established nursing theory.
3. Recognizes significant information and explains how data forms a pattern (i.e., actual and potential problems).
4. Articulates and supports own reasoning process in participating in clinical decision making (i.e., critical thinking and nursing judgements).
5. Adjusts plan of care to address patient problems and issues.
6. Intervenes appropriately with actual and potential problems according to priorities.
7. Organizes care for three to four patients by:
   - setting priorities.
   - completing all required care in a realistic time frame.
8. Performs technical skills competently according to policies, procedures and established patient care standards.
9. Utilizes communication skills to establish, maintain and terminate professional relationships with patients and family members.
10. Modifies technical skills as needed according to context following established principles of patient safety.
11. Performs nursing care with increasing confidence.
12. Documents timely and appropriate reports of assessments, decisions about client status, plans, interventions and client responses.
13. Takes responsibility to follow up on patient needs and concerns
14. Evaluates patient response to interventions and takes appropriate action.

Standard #4: Code of Ethics

Adheres to the ethical standards of the nursing profession

Course Outcomes:

- Provides professional caring based on knowledge and skills.
- Pursues shared meaning by communicating effectively with people.

Clinical Practice Indicators

1. Upholds the values outlined in the CNA Code of Ethics for Registered Nurses (2002):
   - Safe, competent and ethical care
   - Health and well-being
   - Choice
   - Dignity
   - Confidentiality

- Justice
- Accountability
- Quality practice environment

2. Respects cultural diversity (*CNA values: dignity, justice*), respects patients' right to choose (*CNA value: choice*) and values family involvement in care.
3. Recognizes and discusses with instructor ethical dilemmas encountered in the practice setting, with instructor.
4. Fosters a climate of mutual respect, trust, dialogue, and negotiation with patients, instructor, colleagues and members of the health care team to achieve patient goals.

Standard #5: Provision of Service in the Public Interest

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

Course Outcomes:

- Pursues shared meaning by communicating effectively with people.
- Develops collaborative partnerships with members of the health care team.
- Uses creative leadership skills to manage patient situations.

Clinical Practice Indicators

1. Develops professional partnerships with peers, instructor, nurses and other health care team members.
2. Uses effective communication skills when collaborating with members of the health care team
3. Demonstrates an appropriate level of assertiveness with peers, instructor, nurses and other health care team members.
4. Recognizes when communication problems have occurred and begins to resolve them, with assistance.
5. Reports changes in patients' status in a clear, concise, relevant and timely manner, using verifiable information.
6. Advocates appropriately for patients and families in the practice setting.
7. Seeks assistance appropriately and collaborates to ensure care standards are met.
8. Identifies patients' needs related to their discharge and actively participates in planning, implementing, and documenting their discharge.
9. Demonstrates an understanding of nursing leadership within the context of acute care nursing practice.
10. Recognizes and discusses with the instructor, unsafe practice or professional misconduct issues.

Standard #6: Self-Regulation

Assumes primary responsibility for maintaining competence, fitness to practice, and acquiring evidence-based knowledge and skills for professional nursing practice

Course Outcomes:

- Uses systematic inquiry.
- Monitors own practice, determines learning needs, and independently acts upon identified learning needs.

Clinical Practice Indicators

1. Identifies clinical examples that support the achievement of standards.
2. Identifies clinical examples that indicate improvement is required to achieve standards.
3. Seeks and accepts feedback to foster own professional growth.
4. Assumes responsibility for self-directed learning and continuing competence by:
   - identifying and discussing strengths and areas for further development.

- writing goals and specific action strategies in a learning plan, using a variety of resources, as appropriate.
- implementing action strategies in a timely and effective manner.
- evaluating and modifying the learning plan.

5. Reflects on own nursing practice by reviewing and analyzing situations that have occurred in the clinical setting and proposing alternative actions, as appropriate.
6. Maintains own physical, psychological and emotional fitness to practice.
7. Practices within own level of competence.

■ Process Threads Relevant to This Course

Professionalism: Students anticipate and prepare for possible patient care problems on acute medical and surgical nursing units. Incorporating scientific, humanistic, and technical aspects of caring, they provide safe individualized care for three to four acutely ill patients. They independently perform initial, focused, and ongoing assessments and relate nursing actions to assessed data. **They develop a plan of care to resolve patient issues or promote comfort with patients in acute units.** They are able to organize and set priorities and coordinate nursing care for a group of patients. They consult with patients, families, and members of the health care team to plan nursing care. Students respond to significant changes in health status immediately and evaluate and modify the plan to accommodate these changes. Students incorporate a code of ethics consistent with professional practices. Students examine legal implications of nursing care.
Communication: Students are independent in establishing relationships with patients, family, health care team, instructor, and peers based on shared meaning and partnership. **With assistance students utilize communication skills to establish, maintain, and terminate a supportive relationship. Students dialogue with colleagues and teachers in the process of learning. Discussion/feedback is thoughtful.** Students use communication skills to elicit and explore patient's issues. **Students record and report pertinent data, actions, and responses in a legal manner. Students teach using principles of teaching and learning.**

Systematic Inquiry: Students are independent with critical reasoning. **They use questioning and feedback to help them think critically and reflect on their thinking.** They use evidence-based practice and are able to discuss this with various health care professionals. They explore a variety of theoretical perspectives to guide patient care. **Students reflect on their nursing competencies related to knowledge, skills, attitudes, and judgment. Students develop reflective skepticism regarding nursing practice.**

Professional Growth: With increasing confidence students reflect on clinical practice and evaluate their own performance against professional practice standards. *Students develop learning partnerships with peers, instructor, and nurses to explore learning needs and opportunities and act to improve and enhance their own performance.* **Students consult/interact with a variety of health professionals in the hospital. Students assume responsibility for learning and becoming self-starters. Students value continually updating knowledge. Students demonstrate responsibility for attaining and maintaining a safe level of skill performance. Students are responsible and accountable for their actions.**

To obtain satisfactory standing n NURS 4032, students must show evidence of consistent outcome achievement for three of the four evaluative weeks (weeks 12–15).

Creative Leadership: With increasing confidence students engage in collaborative decision making with health team members and participate in resolving patient care issues. Independently students intervene when patients' safety is jeopardized. **They anticipate the continuum of care required for specific patients.** In collaboration with nurses students take an active role in assessment of discharge needs and discharge planning. **Students appreciate the role of nursing in the health care system. They are aware of the various components of the health care system in their context of practice. Students begin to understand nursing leadership within the context of acute care nursing practice.**

Technical Skills: Students anticipate skills to be performed and prepare and organize themselves to perform them. **They review agency policy regarding the skill. They prepare a focused assessment of the patient related to the skill. They demonstrate the communication aspects of nursing skills and maintain patient comfort.** They maintain patient and own safety when performing skills. They are independent with the majority of technical skills learned this term but may require minimal supervision with some. They are able to explain skills to patient and family. With assistance, students show increasing confidence in their ability to modify skills to fit the context of practice.

Specific skills introduced in Level 4 include:

- capillary blood glucose testing
- neurological vital signs assessment
- catheterization
- nasogastric (NG) intubation and NG tube management
- chest drainage systems
- nutritional replacements: enteral and parenteral
- tracheostomy suctioning and care
- intravenous therapy: intermittent infusion devices
- intravenous therapy: central venous catheters
- intravenous therapy: intravenous push medications
- intravenous therapy: blood administration
- complex wound management:
  - normal saline compresses
  - hydrocolloid gel application
- complex wound management:
  - wound irrigations
  - ribbon gauze packing
- modalities for pain management

■ Verification

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

Peggy A. Wyatt — Authoring Instructor

June 12, 2006 — Date

I verify that this course outline has been reviewed.

[signature] — Program Head/Chief Instructor

June 12, 2006 — Date

I verify that this course outline complies with BCIT policy.

[signature] — Dean/Associate Dean

13/06 — Date

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

■ Instructor(s)

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Jacquie Donald		" "	Office Phone: TBA

■ Learning Resources

Equipment:

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

While all students will find it necessary to seek additional reading resources pertaining to their particular clinical setting and patient assignment, the following texts and articles are required:

1. A current medical-surgical text purchased in a previous level such as:
   Black, J.M., & Hawks, J.H. (2005). *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.). Philadelphia: Saunders.

2. A current skills text purchased at a previous level such as:
   Perry, A.G., & Potter, P.A. (2002). *Clinical nursing skills and techniques (5th ed.).* St. Louis, MO: Mosby.

3. A nursing medical dictionary such as:
   Taber, C.W. *Taber's cyclopedic medical dictionary (20th ed.).* Philadelphia, PA: F.A. Davis.

4. A diagnostic tests handbook such as the following:

   - LeFever Kee, J. (2005). *Handbook of laboratory and diagnostic tests: With nursing implications* (5th ed.). Prentice Hall.

5. Articles as posted on course website on my.bcit.ca

6. Spratto, G.R., & Woods, A.L. (2005). *PDR nurse's drug handbook.* New York: Thomson Delmar Learning.

7. Aschenbrenner, D.S., & Venable, S.J. (2006). *Drug therapy in nursing.* Philadelphia: Lippincott Williams & Wilkins.

8. Evans-Smith, P. (2005). *Lippincott's atlas of medication administration.* Philadelphia: Lippincott Williams & Wilkins.

9. Jarvis, C. (2004). *Physical examination and health assessment* (4th ed.) Philadelphia: W.B. Saunders.

10. Canadian Nurses Association. (1997). *Code of ethics for nurses.* Ottawa: Author.

11. College of Registered Nurses in British Columbia. (2005). *Professional standards for registered nurses and nurse practitioners.* Vancouver: Author.

■ Information for Students

(*Information below can be adapted and supplemented as necessary.*)

Assignments: Late assignments, lab reports, or projects will **not** be accepted for marking. Assignments must be done on an individual basis unless otherwise specified by the instructor.

Makeup Tests, Exams, or Quizzes: There will be **no** makeup tests, exams, or quizzes. If you miss a test, exam, or quiz, you will receive zero marks. Exceptions may be made for **documented** medical reasons or extenuating circumstances. In such a case, it is the responsibility of the student to inform the instructor **immediately**.

Ethics: BCIT assumes that all students attending the Institute will follow a high standard of ethics. Incidents of cheating or plagiarism may, therefore, result in a grade of zero for the assignment, quiz, test, exam, or project for all parties involved and/or expulsion from the course.

Attendance: The attendance policy as outlined in the current BCIT Calendar will be enforced. Attendance will be taken at the beginning of each session. Students not present at that time will be recorded as absent.

Illness: A doctor's note is required for any illness causing you to miss assignments, quizzes, tests, projects, or exam. At the discretion of the instructor, you may complete the work missed or have the work prorated.

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

Course Outline Changes: The material or schedule specified in this course outline may be changed by the instructor. If changes are required, they will be announced in class.

1. Students are responsible for identifying their own learning needs and consulting with the instructor to discuss how to meet these needs.

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

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

3. Unforeseeable circumstances may necessitate the alteration of course content, sequencing, timing, or evaluation. As much as possible, students will be given adequate notice of such changes.

4. Students are expected to conduct themselves appropriately at all times. This applies to any institutional-related activity on or off campus. Please refer to Misconduct policy #5251 located on the BCIT website.

■ Journals

1. The journal will consist of two parts: a self-evaluation portion and a reflective portion.
2. Students will keep a journal during this course.
3. The instructor will discuss journal writing requirements for this course during orientation week. The student's reflective journal will be confidential between the student and the teacher. Sharing of any part of the student's writing will only occur when written permission has been given to do so.

■ Participation

1. Students will research patient information at the assigned agency the Wednesday prior to the practicum experience. Student preparation is required before the clinical experience in order for students to have an understanding of the reason for hospitalization, type of illness, and the nursing care the patient(s) might require. The practicum experience will occur on Thursdays and Fridays for 16 hours per week. Depending on the agency this will be either day or evening shift.

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

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

4. A copy of "Student Medical Certificate" must be submitted for illness/absence of over 10% from practicum. This is approximately 3 days.

■ Student Evaluation

Regular dialogue between instructor and student serves to promote learning and achievement of the course outcomes. Student-instructor meetings, writing self-evaluations and reflective journals facilitate regular dialogue throughout the course. *All self-evaluation and reflective journals must be completed to achieve a satisfactory standing in this course. Both journals must show sufficient thoroughness and thought in order to be accepted.* Towards the end of this practicum the student must show evidence that the course outcomes are being met. The student and instructor will contribute to the final summary of outcome achievement. *The instructor ultimately has the responsibility to recommend a Satisfactory or Unsatisfactory standing in this course.*

■ Attendance

Attendance is required in this course as this practical experience is essential to meet program outcomes and to learn how to nurse. BCIT Attendance Policy applies (see Guidelines for Students in the Nursing Program).

It is expected that the student's own state of health is satisfactory when providing nursing care for people. If students are not able to attend a clinical experience the instructor and agency must be informed before the experience begins for the day.

The BCIT attendance policy (#5002) is enforced in NURS 4032. This states that a student may be "...prohibited from completing their course" when the student is absent ... for any cause for more than 10% of the time of the

prescribed course." Students will be formally advised when they are approaching the 10% absenteeism. In NURS 4032, this means that students will receive a letter if they have missed two clinical days. If students miss more than three clinical days, they will have exceeded the 10% absenteeism and may be prohibited from a successful standing in this course.

■ Evaluation of the Course

Students have the right and the responsibility to evaluate the course. A midterm review of the course aims to help the students who are currently in the course so that student needs and course outcomes can be facilitated in a reasonable manner. An end-of-term review is aimed at modifying the course for subsequent students.

Transition Guidelines

We view practicum learning as a continuum. In order to ease the transition from Level 3 to Level 4, some of the following strategies have been put into place to assist you in this transition.

1. A lab which focuses on experiences that the Level 4 four student will encounter over the next 15 weeks is scheduled in Week 1 to allow some time to practice with previously learned skills such as insulin administration, IV/minibag administration of medications, IMs, aseptic technique. Come to the lab prepared to identify patient problems and perform skills for this situation.

2. A buddy or "shadowing" morning will be arranged for the first day of patient care to enable the student to take an observational role in the clinical area. The student will be assigned an RN from the nursing unit who will act to orient the student to the activities of that unit for the RN's patient assignment.

3. Each student will be assigned one patient at the beginning of the practicum so that the instructor and student can work closely in performing assessments and skills together for the first time in the clinical area. Patient assignments will advance each week as experience and confidence grows.

4. Students will be oriented to the clinical area over a two week period.

5. The student will be expected to identify specific learning needs and share these with the clinical instructor at the beginning of the practicum using a specially designed form. This will enable the instructor to assist the student in meeting these learning needs over the course of the practicum.

6. Specific knowledge that needs to be reviewed by the student includes:

    - head-to-toe assessment,
    - pre/post-op assessments,
    - potential post-op complications of surgery,
    - aseptic technique,
    - common medications for hypertension, pain, nausea, congestive heart failure, diabetes, glucocorticoids,
    - fluid and electrolyte balance,
    - stress response.

Transition Guidelines (cont'd.)

7. Specific skills that need to be reviewed and mastered in the first three weeks of practicum are:

   - priming and management of IVs,
   - administration of IV minibag medications,
   - IV rate calculation,
   - sterile dressings,
   - IM, subcutaneous injections.

   Be sure to make use of the open lab practice times to upgrade your skills.

8. Preparation for practice, data collection in regard to research expectations for weekly clinical will be discussed by practicum instructors and will detail methods of data collection that are adequate and appropriate for this level. Prep includes data collection, problem identification, and an organizational plan.

9. Reflective journals and self-evaluation will be done linking the outcomes to actual practice. This is a requirement for Level 4 and will continue after graduation as seen in the CRNBC competencies. Self-evaluation journals must be written and submitted weekly.

Journal Guidelines

The journal for the Level 4 practicum consists of two components:

a. **the self-evaluation portion** and

b. **the reflective portion**.

Please create two separate sections in your journal for these purposes by using two labeled dividers.

A. Self-Evaluation Journal

The purpose of this self-evaluation portion is to promote your assessment of your nursing practice and to serve as a record of progress towards meeting the course outcomes. You are evaluating your nursing practice in relation to the seven course outcomes listed in the NURS 4032 course outline. In order to be successful in this rotation it is necessary that you meet the seven outcomes and to have done so in a consistent manner during the last three weeks of the practicum experience. Self-evaluation consists of the following:

1. **Professional Learning Plan:** This is to be initiated during Weeks 1 to 3. Based on the seven course outcomes and your experiences thus far in the program, identify your learning needs. Using this self-evaluation write down specific strategies that you will implement in order to meet your learning needs. At this same time, identify your strengths and write them down in your journal.

2. **Self-Evaluation:** Using the seven course outcomes as a framework assess and evaluate your progress in achieving these outcomes. It is unnecessary to address ***each outcome on a weekly basis***, but you will need to write and submit a weekly self-evaluation journal. Focus on outcomes that are most relevant to your practice that particular week. By midterm each outcome should be addressed at least three times. Your examples and analysis will serve as a reference when you and your instructor write your midterm and final summaries. **Provide clarity and meaning by including *specific examples*.** The following questions should be used as guidelines to structure what you write:

   a. What is the specific example?

   b. What went well?

   c. What are your challenges?

   d. How do you plan to overcome these challenges?

3. **A Skills Checklist:** The Skills Checklist is your record and is to be completed weekly by students.

4. **Midterm and Final Summaries:** Your journal self-evaluations will be used to form the basis for the midterm and final summaries.

   When completing the "Evaluation Summary" section identify areas in which you believe significant progress or development has occurred. Next, identify challenges requiring further development. Please allow some space for the instructor to make comments in this section.

   When completing the "Student Comments" section of the Final Summary, please address each course outcome (outlined on the front page of the Final Summary).

B. Reflective Journal

The purpose of this part of your journal is to provide an opportunity for reflection, critical thinking, and ongoing dialogue with your instructor. This journal is confidential, shared between you and your instructor only, and not used for evaluation. Submit the journal to your clinical instructor at least six times during the rotation. Using the course outcomes as a framework, identify at least one event that occurred in your clinical day that was significant to you. Feel free to use a writing style that fits for you and allows optimal self-expression. Some of you may find it useful to describe the event, why it was significant, and what you thought, felt, and did in relation to the event (Paterson, 1995). Whatever style you choose, your comments **must** address the following components:

1. Provide a clear explanation of the issue or what happened. Why was it significant?

2. What were your thoughts and feelings?

3. In analyzing the situation, include your thoughts on other perspectives.

4. How would you resolve the situation in future?

The questions below can be used as guidelines to structure what you write.

- What is your appraisal of the situation? What sense can you make of the situation? Consider the impact on self and others. What are the implication (for self and others)? Were you fair minded in considering competing points of view?

- If you acted in this situation, describe your decision-making process. Did you consider all the relevant data? What else could you have done? In what areas did you demonstrate progress/development? What areas require further development?

- Identify previously learned knowledge/experience that helped in this situation. Describe the resources you utilized. Connect this to what you have learned from this situation.

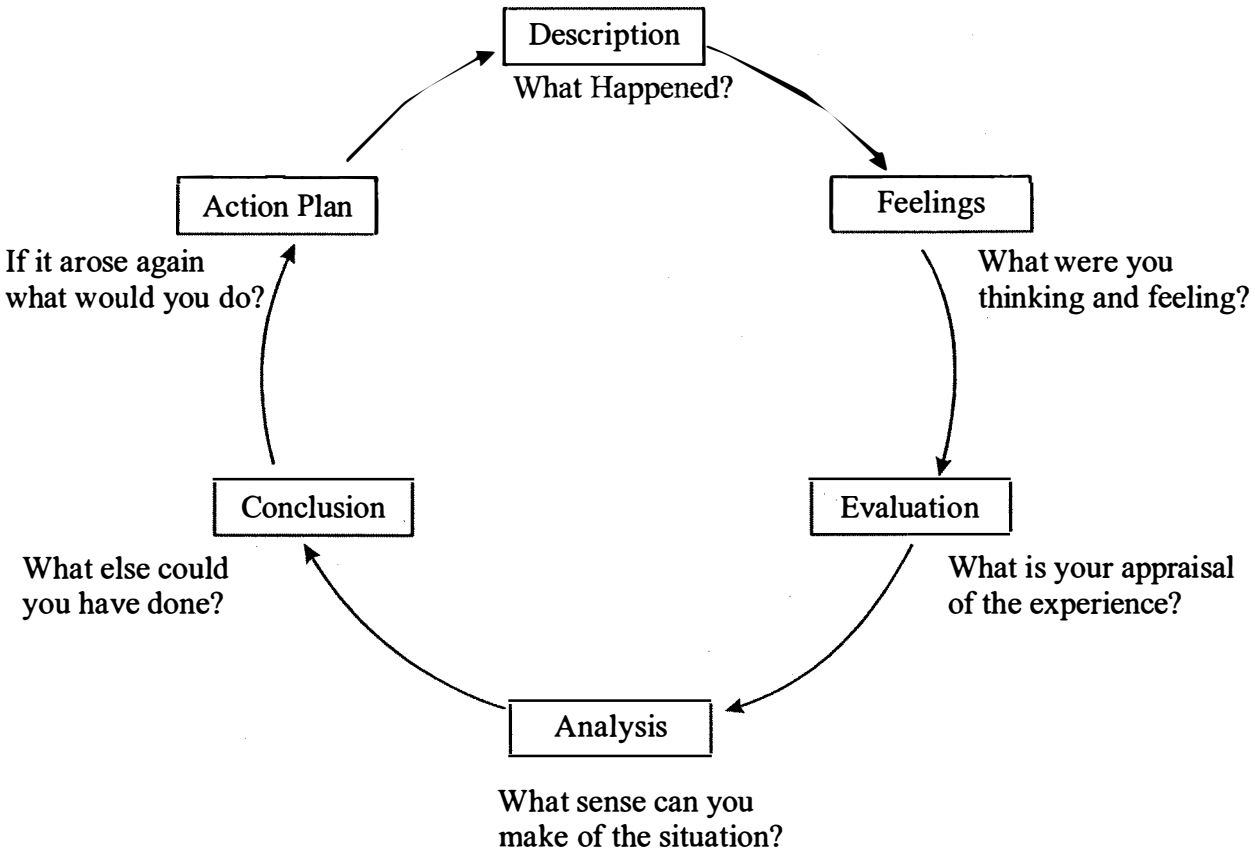
- If a similar incident occurred what would you do?

- What questions or issues arise from this situation? What are the implications for your future practice?

(Palmer & Burns, 1994; Paterson, 1995; Patton, Woods, Agarenzo, Brubaker, Metcalf & Sherrer, 1997)

You may find the structured approach used in the following Reflective Cycle helpful.

REFLECTIVE CYCLE



Palmer, A. & Burns, S. Reflective Practice in Nursing (1994)
London: Blackwell Scientific Pub.

**** The Self-Evaluation and the Reflective Journal are two separate documents.***

References

Palmer, A., & Burns, S. (1994). *Reflective practice in nursing*. London: Blackwell Scientific Pub.

Paterson, B.L. (1995). Developing and maintaining reflection in clinical journals. *Nurse Educator Today*, *15*, 211–220.

Patton, J.G., Woods, S.J., Agarenzo, T., Brubaker, C., Metcalf, T., & Sherrer, L. (1997). Enhancing the clinical practicum experience through journal writing. *Journal of Nursing Education*, 36(5), 238–240.

Guide to Use of the Learning Plan for Students and Instructors

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

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

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

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

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

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

The learning plan contains three sections:

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

Note: The "3 Rs" were created by L. Barratt.

May, 2002.

BCIT
Bachelor of Science in Nursing
Professional Learning Plan

Student Name:
Course:
Date: January 24, 2002

Learning Needs (Sub-outcomes)	Strategies	Progress (Date of Comments)
4.1 Follows BCIT and agency policies and procedures. Late for practicum two times on a Thursday.	1. Leave a note on bathroom mirror to set alarm on Wednesday night. 2. Have one of my classmates phone me at 0530 hours for the next two clinical weeks. 3. Have my uniform, shoes, etc., ready. 4. Make sure that I have enough gas in my car on Wednesday and Thursday nights. 5. Make my lunch the evening before. 6. Go to be by 2200 hours!	February 20, 2002. I have been on time for the last three weeks of clinical. Now I do not have a classmate phoning me and I have regularly set my alarm. The note on the mirror works! I'm also getting a good sleep before clinical.

BCIT
Bachelor of Science in Nursing
Professional Learning Plan

Student Name:
Course:
Date:

Learning Needs (Sub-outcomes)	Strategies	Progress (Date of Comments)

BCIT
Bachelor of Science in Nursing
Professional Learning Plan

Student Name:
Course:
Date:

Learning Needs (Sub-outcomes)	Strategies	Progress (Date of Comments)

Indicate frequency by numbers: Name:

	Week							
1. IM Injections (Type)	1	2	3	4	5	6	7	8
2. Subcutaneous Injections (Type)								
3. Capillary Blood Glucose Monitoring								
4. IV Medications — Bag (Main/Mini)								
5. IV Medications — Push								
6. Saline Lock (Maintenance or Auxiliary Unit)								
7. Central Venous Catheters								
8. TPN								
9. Infusion Pumps								
10. Blood Administration								
11. Dressings: Simple								
12. Dressings: Complex								
13. Wound Irrigation								
14. Drain Shortening or Removal								
15. Suture or Staple Removal								
16. N/G Maintenance								
17. N/G Insertion								
18. Enteral Tube Feeding								
19. Chest-Tubes								
20. Ostomy Care								
21. Neurovital Signs								
22. Doppler								
23. Catheterization (M or F)								
24. Bladder Irrigation/CBI								
25. Suctioning								
26. Trach Care								
27. Pre-op Checklist								
28. Pre-op Care								
29. Post-op Admission								
30. Admission								
31. PCA (P) / Epidural (E)								
32. Neurovascular Checks								
33. Other								

Certification: Blood Glucose Monitoring (Glucometer Elite)

A. Practice: Demonstration and at least two supervised attempts on patients.

B. Theory:

1. According to VGH policies, hypoglycemia is defined by the following blood glucose value _____ mmol/L.

2. Name five symptoms indicating possible hypoglycemia in a conscious patient.

_____

_____

_____

_____

_____

3. What five essential actions will you take (in sequence/priority)?

_____

_____

_____

_____

_____

4. Give two circumstances where it is appropriate to call the physical when your patient is having a hypoglycemic reaction.

_____

_____

5. If a patient is unconscious due to a hypoglycemic reaction, how should this patient be treated by the nurse and physician?

6. Name at least three indications for sliding scale insulin.

_____

_____

_____

7. What type of insulin is always used for SS insulin and why?

8. If your type 1 diabetic patient is fasting, should you withhold the inulin? Explain your answer.

9. When should you have your RN check your blood sugar result?

10. What is the normal range for blood sugar?

11. Will your type 1 diabetic be maintained at a normal range of blood sugar immediately post-op? Explain your answer.

12. What will you do if you detect a pattern of significantly higher or lower blood sugar at particular times of the day and why will you do this?

British Columbia Institute of Technology
NURS 3020 – Clinical Techniques 3

Capillary Blood Glucose Monitoring – Quiz

1. There is usually a gradual onset of symptoms in hyperglycemia and a rapid onset of symptoms in hypoglycemia. True False

2. Patients often refer to hypoglycemia as a "reaction." All patients who become hypoglycemic get symptoms or warning signs when their blood sugar is below the normal value. True False

3. List five common symptoms of **hypoglycemia**.

   A.
   B.
   C.
   D.
   E.

4. Name four potential causes of hypoglycemia in a hospitalized patient.

   A.
   B.
   C.
   D.

5. List five common symptoms of **hyperglycemia**.

   A.
   B.
   C.
   D.
   E.

6. Name four potential causes of hyperglycemia in a hospitalized patient.

   A.
   B.
   C.
   D.

7. Capillary blood glucose monitoring of patients in hospital is performed to assist nurses with the evaluation and management of their care. Name two types of situations where this assessment is indicated.

   A.
   B.

8. When is the best time to perform capillary blood glucose monitoring?

9. Describe two methods for increasing blood flow to a patient's finger prior to lancing the finger.

   A.
   B.

10. How often do you check the accuracy of a meter with a check strip or test strip?

11. Diabetes is considered well controlled when the a.c. blood sugar is between:

    A. 2 and 4 mmol/L.
    B. 4 and 7 mmol/L.
    C. 5 and 9 mmol/L.
    D. 8 and 11 mmol/L.

12. At what blood glucose value should you administer food to your patient? What kind and amount of food is given?

13. When should you have an RN check your blood glucose result?

    A.
    B.

14. At what blood glucose value should the physician be notified and a stat blood glucose level from the lab be ordered?

    A.
    B.

15. At 0930 hours, your diabetic patient complains of feeling faint. Because you are an astute student nurse, you check his blood sugar and get a reading of 2.8 mmol/L. What actions will you take?

16. Should insulin be withheld from fasting patients who are insulin dependent? Explain your rationale.

WEEK 1: CASE STUDY (Bring to class on August 16, 2006)

Welcome to NURS 4032 nursing practicum. In order to help you to review skills from Level 2 and be prepared for more complex skills in Level 4, this introductory lab will give you a chance to brush up on some of the basics. We have used an example of the type of patient situation you may encounter in this level's practicum setting.

To get the most out of this lab activity, the following preparation is required in advance of the lab:

1. Read the case study for Terry Madison.
2. List anticipated potential problems.
3. Outline a focused assessment.
4. Prepare an organizational plan for her care.

The following is a time-line for this activity:

0900–0945	Practicum group discussion of case study. Anticipate problems, do assessment, formulate plan.
0945–1000	Divide into two groups of four. Complete the baseline assessment of Ms. Madison. Identify skills to be done. Revisit your problem list and plan; alter if necessary.
1000–1030	Implement care plan; start skills: one person performs the skill while the other three observe and provide constructive, supportive feedback.
1030–1045	Coffee
1045–1200	Continue with implementation. Each student should do one skill at least.
1200–1220	Debrief and clean up.

Case Study:

Terry Madison, age 63, was admitted to your ward following a small bowel resection surgery for a small bowel obstruction. She is post-op day two, has an abdominal dressing with either: a closed wound, drainage system (hemovac, Davol, Jackson-Pratt). Her history includes Type II diabetes for 10 years, and a myocardial infarction 5 years ago.

Post-Op Orders:

IV 5% dextrose in ½ normal saline with 20 mEq KCl @ 125 cc/hr. May D/C IV when drinking well.
Clear fluids to DAT.
Glucometer QID V/S per routine.
Situation Remove HMV today if drainage less than 25 cc,

Dressing change daily and PRN.

Insulin: Humulin N 15u sc and Humulin R 5u sc QAM @ 0800 before breakfast
Humulin N 10u sc daily @ 1700 before supper

Sliding scale insulin before meals:
10.1–12 give 2 units subcutaneous
12.1.–14 give 4 units
14.1–18 give 6 units
18.1 or higher – give 8 units and call doctor

cefazolin 1 Gm IV Q6H (1000–1600–2400–0600)
Gravol 25–50 mg IM/IV Q6H prn
Maxeran 10 mg IV Q6H PRN
Morphine 5–10 mg IM/sc Q3–4H prn

Morning Report: Day Two

Terry Madison has had a reasonably good post-op night. She was given Morphine and Gravol at 0500 for abdominal pain and nausea. The IV is infusing well with 700 TBA. The abdominal dressing shows a small amount of serosanguineous drainage. The hemovac drainage is 20 cc. The glucometer reading ac breakfast was 14.9. At 0715, she stated that she was very nauseated and her pain was rated at 7/10.

It is now 0740. You have just listened to report.

1. What are Ms. Madison's potential and actual problems? (Try to keep your problem list ***relevant and practical***.)

2. Outline a focused assessment.

3. ***Briefly*** outline an organizational plan. What are the priorities? Recognize the priorities probably will change after you assess Ms. Madison.