MAR 1 3 2003

Course Outline

A POLYTECHNIC INSTITUTION

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

NURS 7030
Nursing Practicum 5

Start Date:	February 28, 2003	**End Date:**	May 9, 2003
Total Hours:	320 **Total Weeks:** 8	**Term/Level:**	5 **Course Credits:** 13
Hours/Week:	40 **Lecture:** **Lab:**	**Seminar:**	40 (Clinical Agency Practicum)

Prerequisites

Course No.	Course Name
NURS 1060	Pharmacology
NURS 2040	Professional Practice 2
NURS 4000	Nursing and Health Issues
NURS 4030	Nursing Practicum 4
NURS 3020	Clinical Techniques 3
•	Current CPR (two person)
	Current RNABC Student Membership

NURS 7030 is a Prerequisite for:

Course No.	Course Name
NURS 7130	Nursing Practicum 6: Community Continuing Care

■ Course Description

This practicum course will occur in a variety of institutions throughout the Lower Mainland and in a variety of units within those institutions. The units may be specialized in focus. Working in collaboration with a RN, preceptorship students are expected to manage the clinical aspects of planning, implementing and evaluating nursing care for a group of patients within the RN's (preceptor's) workload.

■ Detailed Course Description

NURS 7030 is a practicum course focusing on providing nursing care for patients experiencing a variety of health problems that require hospitalization. Students integrate relevant knowledge, skills and attitudes to assume responsibilities of a beginning practitioner in relation to the coordination and management of nursing care for a group of patients.

■ Evaluation

- Satisfactory/unsatisfactory standing based on Student, Preceptor and Instructor evaluation of course outcomes.
- Satisfactory completion of self-evaluation notes.
- Satisfactory completion of a written assignment.

■ Course Learning Outcomes/Competencies

This practicum experience occurs within acute medical and surgical nursing units with individuals who are experiencing complex, acute health problems with the potential for rapidly changing and/or emergency nursing needs. Considering family needs and interacting with patients' families is required.

In this context, the student will:

1. implement professional caring based on integrated knowledge and skill.
2. pursue shared meaning by facilitating communication with people.
3. integrate systematic inquiry into practice by:
   - analyzing client issues for unique aspects and responding with appropriate clinical judgements.
   - thinking critically and reflecting while practicing.
4. monitor and evaluate own clinical nursing practice and act to modify it.
5. assume responsibility for own learning needs and value learning as a way of anticipating future work requirements.
6. work collaboratively with members of the health care team in providing appropriate care for a group of patients.
7. demonstrate assertiveness and organizational skills.
8. implement technical skills with dexterity.

*Please review practicum evaluation form for specific indicators for each learning outcome.

■ Process Learning Threads: NURS 7030

Professionalism

Students are increasingly independent with analysis of assessments, care planning, care implementation and evaluation. They encourage client decision making and integrate this into the plan of care. They collaborate with health professionals to provide holistic care to clients. They defend the client's right to be informed. They begin to consider health promotion as an integral aspect of care. Students take the full RN patient load and delegate back at maximum 25%.

Communication

Students use positive, pro-client caring attitudes and skills to establish partnerships with clients. The shared meaning they achieve is used to solidify their partnership and individualize the plan of care. Students record and report pertinent patient assessments and nursing care in a timely manner. Students formulate a plan of action with rationale concerning the use of specific communication strategies to build partnerships with health care consumers and co-workers. Students dialogue with instructor, preceptor and other health care workers in the process of learning. They use principles of teaching and learning. Students discuss issues thoughtfully, verbally and in writing.

Systematic Inquiry

Students use evidence-based research. They start to critically think and reflect while nursing rather than only after the fact. Students analyze client issues for unique aspects and respond with appropriate clinical judgments. Students raise questions about nursing practices to analyze alternatives. Students reflect on and analyze their values, beliefs and assumptions regarding health and partnership.

■ Process Learning Threads: NURS 7030 (cont'd.)

Professional Growth

Students value learning as a way of promoting professional growth. They assume responsibility for continued knowledge development. They constantly evaluate their care using professional nursing standards and modify their practice to accommodate new learning. Students are responsible for attaining and maintaining a safe level of skill performance. Students continue to develop reflective skepticism. They are responsible and accountable for their actions.

Creative Leadership

Students maintain ongoing communication with colleagues and work to encourage partnerships with them. Students perform effectively in teams. They demonstrate assertiveness. Students are learning to manage a group of clients by becoming more organized, efficient and quicker in giving care. They are beginning to anticipate the work that will be required throughout the day and set priorities to achieve this. 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. They further develop their understanding of nursing leadership within the acute care context of practice.

Technical Skills

Students are developing precision in the implementation of clinical technical skills. They implement a logical sequence of actions, they are coordinated and they give safe care. They need supervision with skills they have not previously mastered. As the course progresses, the time and speed are within reasonable limits so the beginning level of articulation is developing. Students review agency policy regarding skills.

■ Verification

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

Authoring Instructor — Date: June 25, 2002

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — Date: July 8, 2002

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — Date: 8 July 02

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

■ Instructor(s)

Anne Houseman	Office Location: SE12-418 Rm 437 Office Hrs.:	Office Phone: 604-432-8686 E-mail Address: anne_houseman@bcit.ca
Joan Walker	Office Location: SE12-418 Office Hrs.:	Office Phone: 604-453-4083 E-mail Address: jwalker14@my.bcit.ca

■ Learning Resources

Required:

- Previously required textbooks will be useful resources during this practicum experience.
- BCIT Student Guidelines, Policies and Procedures in the Nursing Program.* on-line access available; http://www.health.bcit.ca/nursing/
- Registered Nurses Association of British Columbia (1998). Standards for Nursing Practice in British Columbia, Vancouver, BC.

* You will need to refer to this when you are on the wards.

Recommended:

- a uniform that complies with program policies
- shoes that comply with program policies
- a stethoscope
- a black ink pen
- a pen light
- bandage scissors
- a watch with a second hand
- a lock may be required if you use a hospital locker to store coats, etc. while at the hospital

■ Information for Students

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

Assignments: Late assignments will **not** be accepted for marking unless the late due date has been negotiated with the instructor.

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 is required in this course as this practical experience is essential to meet program outcomes. BCIT Attendance Policy applies. If students take time off for personal reasons other than illness, they are expected to make up that time. A doctor's note is required for any extended illness. What is considered in the end is: "Did the student achieve the course outcomes?"

Illness: A doctor's note is required for any illness causing you to miss more than 10% of the practicum experience.

Refer to the Nursing Profession's re-admission policy.

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.

■ Information for Students (cont'd.)

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

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

    - discussing the course outcomes to achieve shared understanding of them. The discussion should include what experiences are needed to support achievement of the outcomes.
    - identifying the evidence required to demonstrate achievement of the outcomes. The sub-outcomes give direction in this regard.
    - initiating regular dialogue throughout the practicum experience and promoting trust in the student/preceptor relationship, so the preceptor is satisfied and safe nursing care is provided by the student. Regular dialogue between instructor and student serves to promote learning.

3. **In the event of an unusual incident by a preceptorship student, the student must notify the appropriate BCIT instructor within 24 hours. The student may need to fill out a hospital incident report at the time of the incident. A Nursing Program Incident Report is also completed by the student, given to the preceptor for comment and then mailed or faxed to the BCIT instructor.**

4. 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.

■ Student Evaluation

The student must show evidence that the course outcomes are being met. Student are expected to maintain self-evaluation notes throughout the experience. The notes must show sufficient thoroughness and thought in order to be accepted. Students are expected to share their self-evaluation with the preceptor before submitting the document to the instructor. The ongoing self-evaluation notes must be completed to achieve a satisfactory standing in this course.

The student completes the practicum evaluation form as provided. The preceptor may add information to the evaluation form. The instructor may add comments to the evaluation form and ultimately has the responsibility to recommend a Satisfactory or Unsatisfactory standing in this course.

■ Course Evaluation

Students are expected to initiate discussion with the instructor about any aspects of this course.

■ Participation

1. A Level 5 preceptorship student is expected to take responsibility for increasing his/her knowledge base. Students will work with a RN within the RN's assigned workload. Students will assume responsibility to research patient diagnosis, treatment and ordered medications. Students will use information available on the ward in order to function appropriately. This information includes policy and procedure manuals.

■ Participation (cont'd.)

2. Safe nursing care is required. The preceptor will assist the student to gradually accept responsibility for the RN role. As students move along in this experience it is expected that they will work more independently but collaboratively. Students are expected to take responsibility for errors and to document them according to agency and BCIT policies.

3. A student who cannot make progress, is unable to work collaboratively with the preceptor and whose care is viewed as inappropriate and/or unsafe will be removed from this course.

4. A Student Preceptorship Manual provides useful information related to this practicum experience and students are expected to use the manual. Preceptorship students are expected to refer to the **BCIT Student Guidelines, Policies and Procedures** document they received on entry into the program. These guidelines provide information related to medication administration which will assist you in the clinical area. Please review these policies before starting the practicum and take the document to clinical. Current edition of BCIT Student Guidelines, Policies and Procedures is available on-line at http://www.health.bcit.ca/nursing/

■ Written Requirements

A. Self-Evaluation Notes

Students will complete a written self-evaluation for each set of shifts. The self-evaluation is shared with the preceptor. Preceptors read and often add comments to the self-evaluation. The instructor reads the notes and will call the student to clarify, suggest, encourage and support the student in achieving the course outcomes.

Guidelines for Self-Evaluation Notes

1. You will receive a template that will give directions to assist you in completing this requirement. Your instructor will review the template with you during orientation week.

2. Mail, e-mail, fax or deliver your self-evaluation notes to your instructor immediately following the last shift of the set.

3. Share your self-evaluation with your preceptor so that she/he has the opportunity to add comments and to sign the notes. This might be an excellent time to discuss new learning needs and to formulate a plan to meet these needs. Then forward the page with your preceptor's comments to your instructor.

If mailing, the address is:

Name of Instructor
Instructor, Level 5
Nursing Program
British Columbia Institute of Technology
3700 Willingdon Avenue
Burnaby, BC V5G 3H2

If faxing, the number is 604-436–9590. Please include a cover sheet **including the name of sender and receiver**.

■ **Written Requirements (cont'd.)**

B. Written Assignment Related to Discharge Planning

Introduction

The goal of discharge planning is to facilitate continuity of care from one health care facility to another or home. Discharge planning is patient/client focused, interdisciplinary and uses community resources. Hospitals have recognized the need to facilitate discharge planning by supporting a liaison nurse, by conducting multidisciplinary team meetings and by producing written resource materials.

Nurses are required to assess patients for ongoing needs after discharge and to participate in obtaining appropriate follow-up care. Successful discharge planning depends on accurate assessment of needs, involvement of patient/client and family in planning and availability of community resources to meet the discharge needs (Clemen-Stone, McGuire & Eigsti, 1998, p. 267).

Goals of this Assignment

The overall goal of this assignment is to involve the student as an active participant in discharge planning as opposed to a passive observer.

Student will:

- participate effectively in discharge planning within a multidisciplinary team.
- demonstrate initiative and confidence in presenting a nursing perspective in the discharge planning process.
- advocate on behalf of a patient.
- partner effectively with family members in discharge planning.
- appreciate the complexity of discharge planning and make suggestions to make the process more effective.

Identifying a Patient who has Complex Discharge Planning Needs

Indicators that may identify a patient with complex discharge planning needs:

- advanced age
- chronic illness and disability care
- cognitive impairment, confusion
- self-care deficits
- impaired mobility
- poor or no social support or caregiver strain
- history of multiple visits to the hospital
- multiple medications
- addiction problems

■ Written Requirements (cont'd.)

More specifically, upon discharge a patient may need:

- complex wound care or assistance with stomas and specific tubes
- use of specific medical equipment
- assistance with complex medication schedules
- specific treatment for chronic infections
- nursing intervention because of non-compliance in taking medications
- special teaching
- palliative care
- physiotherapy
- occupational therapy
- speech therapy
- lab/x-ray

Selecting a Patient for this Assignment

Choose ***one*** patient who has ***complex discharge needs***. Answer each question.

1. Assessment Data

Give a clear picture of the patient. Be specific so the reader can understand what this patient is like. Describe the patient at the time of your assessment (include date). Provide data (subjective and objective) that indicate the patient has discharge needs. Include information related to the following:

- diagnosis and previous admissions
- length of current admission
- age
- pre-current admission living situation/support system (identify family members)
- functional status (what assistance does the patient need with feeding, mobility/transferring, bathing, dressing, toileting)
- cognition (perception, judgement, memory)
- behavior (confusion, aggressiveness, depression, agitation)
- sensory deficits
- medications (list the meds, allergies, knowledge of medication regimen)
- communication deficit
- technology dependence (tubes, assistive devices, etc.)

At what point in the current admission did this patient's discharge needs become apparent?

■ Written Requirements (cont'd.)

2. *Multidisciplinary Collaboration in Discharge Planning*

Identify your patient's discharge planning needs. Explain how each need became evident.
Which health care members were involved in discharge planning for your patient?
Describe the specific contribution each professional provided for this patient in planning for discharge?
Which health professional coordinated the discharge planning process?
If the patient is to return home, who will do the assessment of the home environment?
Who assessed the support systems the patient had? What were the findings?
What is the purpose of discharge planning rounds (if applicable)?
How did you collaborate with the other members of the health care team who were part of the discharge planning team for this patient?
What is the patient's perspective regarding hospitalization and discharge planning?
Describe your role in discharge planning rounds or team meetings? If your unit doesn't have these types of meetings, describe how information was exchanged between the health care professionals involved.
What contribution did ***you*** make to ensure that the patient's discharge planning needs were met?

* You are expected to attend a multidisciplinary conference if these are conducted in your unit.

3. *Utilization of Community Resources*

What community resources did the multidisciplinary team identify as necessary for the patient? Who coordinated the contact for the resources?
If the patient is scheduled to go to another facility, who decides which facility is appropriate?
If the patient required assistive devices at home, who coordinated the ordering of the devices?
How did hospital staff collaborate with the community liaison nurse? What was the liaison nurse's specific role in the discharge plans of your patient?

4. *Collaboration with the Patient's Family*

How did you involve the family in the discharge process?
If you attended a family meeting, describe the purpose of the meeting.
What role did you have in this meeting?
What needs did the family have in relation to discharge planning for their relative?
Discuss your role with the family in assisting them with the discharge plans.
What teaching did you or other health care professionals do in relation to the following:

- medications
- diet
- activity
- treatments
- follow-up appointments
- when to call the Dr.
- care of incisions, wounds, etc.
- include other teaching you did

How was the family or support person involved in the teaching? Was the teaching successful? How do you know?
Who decided when the patient was ready for discharge? What role did you have in this decision?

■ **Written Requirements (cont'd.)**

5. ***Reflections on the Process of Discharge Planning***

What hospital factors (documentation, meetings, written resources, staff) were effective in facilitating smooth discharge planning for your patient?
What factors/events, etc. hindered the discharge planning process for your patient?
What changes do you recommend that could make discharge planning more effective? What have you done with your suggestions?

Guidelines for Discharge Planning Assignment

- This assignment is due anytime before April 18, 2003.
- Patient confidentiality must be preserved.
- Format:
  - word processed
  - paragraph format under each heading
  - double-spaced, 1" margins
  - referencing literature sources is not required

References Consulted in Developing this Assignment

Anthony, M.K., & Hudson-Barr, D.C. (1998). Successful patient discharge. *JONA, 28*(3): 48–55.

Blaylock, A., & Cason, C.L. (1992). Discharge planning: Predicting patient's needs. *Journal of Gerontological Nursing, 18*(7): 5–9.

Clemen-Stone, S., McGuire, S.L., & Eigsti, D.G. (1998). *Comprehensive community health nursing.* St. Louis: Mosby.

Green, K., & Lydon, S. (1998). The continuum of patient care. *AJN, 98*(10): 16BBB–16DDD.

Phipps, W.J., Sands, J.K., & Marek, J.F. (1999). *Medical surgical nursing concepts and clinical practice* (6th ed.). St. Louis: Mosby.

Stanhope, M., & Lancaster, J. (2000). *Community health nursing* (5th ed.). St. Louis: Mosby.

Thompson, S. (1997). Community health strategies. *Nurse Educator, 22*(4): 11–14.