UNIVERSITY OF ALBERTA
COLLABORATIVE BACCALAUREATE
NURSING PROGRAM
Grande Prairie Regional College
Grant MacEwan College
Keyano College
Red Deer College
University of Alberta

NURSING 3910

Nursing Practice V

COURSE OUTLINE

Fall Term 2001

Surgical Instructor

Melanie Hamilton, RN, BN, CPN(C)
Office: H217, Phone: 539-2761
mhamilton@gprc.ab.ca

Home care Instructor

Sharon Peterson M.Ed, BN, RN
Phone: 538-1161
peterson@gprc.ab.ca

Originally developed by Clinical Experience Development Committee of
Caren Cloiston, RDC Barb Gibson, U of A Pat McMullin, Keyano
Monique Sedgwick, GPRC Ruth Stewart, MacEwan Marina Vettergreen, MacEwan

NURSING 3910
Course Outline

NUR 3910 Nursing Practice V *7 (/1 14) (either term, 0-3s-28c in 7 weeks). Practice focuses on restoration, rehabilitation and support (including health promotion and disease prevention) of clients experiencing more acute variances in health across the life span. Practice occurs in primary, secondary and tertiary level acute care or home care settings.

Prerequisites: NURS 2910, 2940, 2950.

COURSE HOURS:

Lecture/Seminar: 21 Lab/Clinical: 196

Drop date deadline: November 23rd/2001-10-17

COURSE DESCRIPTION:

Opportunities will be provided for students to develop advanced skills in health assessment, intervention and communication with clients across the life span. The focus of this clinical course will be the client and their families with more acute variances in health. Students will continue to incorporate health promotion, and all levels of prevention in nursing practice. Nursing practice over a continuous block of time will occur in various acute care settings.

COURSE OBJECTIVES:

Upon completion of Nursing 3910 the nursing student will be able to:

1 Analyse nursing knowledge as well as knowledge from other disciplines (research, models and theories) related to bio-psycho-socio-cultural-spiritual factors in nursing practice with clients experiencing more acute variances in health.

2 Demonstrate application of legal and ethical standards in a variety of nursing practice settings by: support of colleagues, decision making, protecting clients' values, beliefs and rights within the mandate and the role of the professional association.

3 Demonstrate professional behaviors in nursing practice (respect, communication, integrity, responsibility, accountability, self-awareness, self-performance appraisal).

4 With guidance, assumes primary responsibility for attaining and maintaining competence in nursing practice.

5 Analyse concepts related to health promotion, primary, secondary and tertiary prevention, with clients and families with increased complexity and more acute variances in health by:
- demonstrating safe nursing care for a minimum 2-3 clients.
- coordinating client care using sound clinical judgement, critical thinking and innovation with increasing independence.
- demonstrating competence in mobilizing power structures
- demonstrating beginning competence in dealing with diversity and ambiguity, assisting clients with decision making

6. Demonstrate competence in ability to interact with and develop collaborative partnerships with clients, community members, nurses, and members of other disciplines, displaying valuing, respecting autonomy and commitment to caring.

7. Demonstrates competence in selected skills required for nursing care of clients experiencing acute and complex variances in health.

Attendance:

Attendance and participation is expected of all students in all seminars and labs. Absence from clinical experience of more than 2 days may jeopardise successful completion of the course requirements.

Students are expected to be punctual during their clinical experience in the agency.

Absences:

Students are asked to discuss the absence with the instructor to determine the most appropriate way to make up missed seminar, labs and clinical days. If you must be absent from a scheduled activity in the clinical agency, the student must contact the agency directly and also inform the instructor. **If a student misses his/her off unit experience day(s), due to illness it is their responsibility to make arrangements to make up that day.**

Professional Dress:

Students are expected to abide by the dress code of the particular agency. **It is expected all students will wear a Grande Prairie Regional College name tag.**

Late Assignments:

The late assignment policy applies. *A penalty of 5% for each working day an assignment is submitted after the due date will be deducted from the final mark. For example, a paper scored at 75% would receive an adjusted grade of 70% if handed in one day late.* Assignments must be verified, stamped with date and time received by nursing office personnel.

Course Hours:

Orientation and lab skills	21 hours
Clinical hours	175 hours
	196 hours
Seminar	21 hours

REQUIRED LEARNING EXPERIENCES:

- **In order to pass Nursing 3910, students must pass the Direct Clinical Observation (DCO) to pass the course. A "1" in any listed behavior constitutes a failure in the DCO. Each category of the DCO is equally weighted. A minimum pass is 50%.**

- **The instructor, in consultation with the Chair, may immediately deny assignment of a student to, withdraw a student from, or vary terms or conditions or a site of a practicum/clinical placement, if the instructor has reasonable grounds to believe that this is necessary in order to protect public interest.**

- **All assignments must be completed to receive credit in the course.**

Nursing Practice

Nursing practice will be evaluated by means of the following.

1. **Direct Clinical Observation** **Value: 50%**

A formative and written summative evaluation of Nursing Practice will be completed by the student, instructor and preceptor (if applicable).

This will be accomplished through observation assessment and evaluation of the student during clinical practice. Evaluations will be made by the instructor and will be supplemented with input from preceptors or the staff of an agency or nursing unit. Tutors are directed to refer to the current DCO document from the Evaluation Strategies Committee.

A. Essential:

Over the seven weeks, students will have a continuous experience in an acute or home care setting with adults or children which will include:

1. Use of a nursing model to guide nursing practice with clients and families experiencing increased complexity and more acute variances in health.

2. Setting priorities and coordinating safe nursing care for a minimum of 2-3 clients.

3. Collaborating with clients, families, nurses, community members and members of other disciplines.

Students are expected to implement previously learned nursing skills

2. **Assignments:**

HOME CARE

A. Field Notes **Value: 5%**

Field notes are to be completed each day and are to include the client's initials, diagnosis, location of visit and whether you were supervised. A form is provided for you to use.

B. Patient Research **Value: 25%**

It is expected that you will prepare for each clinical day by researching expected conditions and reviewing psychomotor skills. Preparation includes reviewing the client's chart and conducting research on the pathophysiology of the condition, identifying problems, issues or concerns, researching medications and treatments and charting appropriately. A form is provided for you to use.

A total of 10 patient profiles are required over the seven weeks. One to two profiles are to be completed each week.

Assignments are to be submitted each Friday by 4:00 p.m.

C. Critical Incident Journal **Value: 15%**

Identifying critical incidents as a student in nursing education facilitates the integration of theory and practice. It can assist the student to foster reflective practice and personal and professional development. Critical incidences and reflection allows the students to increase their own knowledge of practice. Students will be required to examine three incidences that occurred in NS 3910. The student will examine the incident and identify key elements and issues both within the incident itself and in relation to their own attitudes and actions.

The guidelines for each journal entry are as follows:

1. Describe a significant event/incident that has occurred. Write a few paragraphs describing the incident (i.e. what you or someone else did in an intervention, communication). Be specific (detailed) and objective as possible. Include your thoughts, feelings and perceptions.

2. Reflect on the event/incident. Describe why this event was important to you and what factors influenced your/someone else's decisions/actions/feelings (such as assessments, previously learned experiences, values, beliefs, stereotypes or biases)

3. Evaluate your strengths and areas needing improvement in this situation. Explain why you thought those areas where strong or needed improvement

4. Describe your significant learning. What would you do differently/investigate/maintain a similar incident should occur. Describe what you would teach someone else (peer/colleague) about this incident in order to improve you nursing practice. Provide nursing literature/valid resources that supports your conclusions

Due dates for critical incidences:

#1: November 9th/2001

#2: November 16th/2001

#3: November 30th/2001

- Journals MUST be handed in by 1600 on the Friday the week they are due. Missing or late submissions will be subject to a 5% penalty for each day they are late.
- Critical incidences should be between 5-8 pages typed. Attach the references as per APA format at the end of each journal
- Remember to keep all entries confidential (i.e. not including real names of patients and staff)
- The marking guide for the critical indecencies is attached

****Reminder that this is not a logbook to account for what happened on each shift.****

D. Learning Plan **Value: 5%**

A learning plan is the agreement between the student and the instructor specifying what the student intends to learn during the clinical experience and how this will be accomplished, the time frame for meeting the objectives and the methods by which achievement of the objectives will be measured.

The learning plan is intended to enable the students to work through steps of assessing, planning, implementing and evaluating the learning process. The steps of this process are:

- to provide the student with an opportunity to make an individual learning goal within the framework of the course objectives, BUT does not repeat the course objectives.
- Allows the student to determine learning objectives in view of their own perception of their strengths and areas for improvement
- identify strategies for meeting these goals
- identify a timeline to meet the goals
- identify an evaluation strategy to meet these goals

Students are required to submit 3 learning goals, with evidence to support how the goals in the learning plan will be met.

Due Date: November 6th

Student will follow up their learning plan at the end of the rotation to identify whether their goals where met throughout the rotation

Due Date: December 11th

Students must complete a final review of their learning plan, indicating whether the goals were achieved. Students must provide evidence on how they achieved these goals.

SUMMARY OF EVALUATION:

1.	Direct Clinical Observation	50%
2.	Field notes	5%
3	Patient research	25%
4.	Critical incident journal	15%
5.	Learning Plan	5%

SURGERY (4 NORTH)

A. Perioperative Follow-through **Value: 30%**

Students will be expected to follow one patient through the pre-operative assessment clinic to the operating room, recovery room and back to the ward. The purpose of this assignment is for the students to gain an understanding of the perioperative experience and the issues that may arise throughout a patient's hospital stay.

The perioperative follow through is a chance for students to understand the process of surgery from beginning to end. Perioperative experience is the planned process of systematic, integrated nursing interventions carried out by a variety of nursing disciplines. Each aspect of the surgical experience effects the patient and his/her family. This nursing process is a way of looking at nursing and brings in critical thinking that guide nursing action. This process focuses on the patient and guides the nurse to develop nursing intervention to meet patient needs.

- **Paper cannot exceed 10-12 pages in length**
- **Paper is due one week after perioperative follow-(through (by 1600 on the Friday)**
- **Assignments that are late will be docked 5% per day off the paper grade (example: 80% on paper, handed in 1 day late, final mark 75%)**

B. Critical Incident Journal **Value: 15%**

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2. Reflect on the event/incident. Describe why this event was important to you and what factors influenced your/someone else's decisions/actions/feelings (such as assessments, previously learned experiences, values, beliefs, stereotypes or biases)

3. Evaluate your strengths and areas needing improvement in this situation. Explain why you thought those areas where strong or needed improvement

4. Describe your significant learning. What would you do differently/investigate/maintain a similar incident should occur. Describe what you would teach someone else (peer/colleague) about this incident in order to improve you nursing practice. Provide nursing literature/valid resources that supports your conclusions

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****Reminder that this is not a logbook to account for what happened on each shift.****

C. Learning Plan — Value: 5%

A learning plan is the agreement between the student and the instructor specifying what the student intends to learn during the clinical experience and how this will be accomplished, the time frame for meeting the objectives and the methods by which achievement of the objectives will be measured.

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SUMMARY OF EVALUATION

1.	Direct Clinical Observation	50%
2.	Perioperative Follow-through	30%
3.	Critical incident journal	15%
4.	Leaning plan	5%

LABS

Lab 1: Tracheostomy Care and Suctioning

At the completion of Lab 1 the student will be able to:

1. During discussion, demonstrate knowledge of tracheostomy care, including:

    a. purpose
    b. assessment of client with tracheostomy
        i. respiratory status
        ii. type and consistency of secretions
        iii. condition of tracheostomy site
        iv. oxygenation, hypoxia
        v. aspiration
        vi. teaching
        vii. client and family coping
    c. potential for infection and other risks in clients
    d. treatment of dislodgment
    e. use of ventilator equipment

2. Demonstrate tracheostomy care including:

    a. asepsis
    b. instillation, irrigation
    c. cleanses site
    d. changes dressing
    e. inflates and deflates cuff
    f. suctioning technique: insertion, rotation, withdrawal

3. Perform oropharyngeal and nasopharyngeal suctioning

Lab 2: Care of Client Experiencing Epidural Analgesia

At the completion of Lab 2, the student will be able to:

1. Define epidural analgesia, anesthesia, and spinal analgesia. Discuss the differences between each. State the indications and contraindications for their use.

2. State the purposes of:

   - patient consent for procedures
   - continuous and intermittent therapy
   - maintenance of IV infusion site
   - establishment of ECG and BP automatic monitoring devices
   - agency specific policies and certification

3. Discuss and demonstrate nursing care during the initiation of the therapy and during its duration

   - positioning
   - aseptic field, gloving and masking
   - monitoring vital signs, sensory level, pain assessment
   - catheterization, intake and output measurement
   - oxygen and suction support
   - rationale for having naloxone at the bedside
   - use of antiemetics, antihistamines, opioid analgesics
   - rationale for absence of the use of alcohol in skin preparation solutions
   - contraindicated medications

4. Demonstrate understanding of the side effects, complications and risks associated with this therapy and the related nursing actions required:

   - depressed respirations
   - hypotension
   - oversedation
   - catheter
   - infection
   - headaches
   - pruritus
   - inadequate analgesia
   - nausea and vomiting
   - urinary retention

5. Discuss how the therapy is discontinued and the related nursing assessments and actions:

   - positioning
   - catheter tip assessment
   - sensory assessment
   - skin preparation
   - dressing over site

Lab 3: Case Coordinator

At the completion of Lab 3, the student will be able to:

1. Describe how to complete a Home Care admission including:

    a. receive a telephone referral
    b. organize paper work and equipment
    c. complete an assessment
    d. initiate a care plan
    e. set up the chart
    f. organize services required

2. Describe how to organize a day of home visits by:

    a. review a series of charts
    b. prioritize visits for the day
    c. identify equipment and supplies required
    d. prepare the patient assignment

3. Describe how to review and monitor a caseload by:

    a. survey a caseload
    b. arrange weekly & monthly meetings
    c. schedule visits
    d. review service provision
    e. monitor staffing