

**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 2004

Course Leader and Home Care Instructor

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Revised by the Learning Experiences Development Committee, May 2004

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Approved: May 2004.

NURSING 3910

Course Outline

NS3910 Nursing Practice V *7 (fi 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: NS 2910, 2940, 2950.

COURSE HOURS: Lecture: 0 Seminar: 21 Lab/Clinical: 196

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 and in Home Care.

COURSE OBJECTIVES:

In addition to maintaining competency with previous course objectives, upon completion of Nursing 391, the nursing student will be able to:

1. Demonstrate professional behaviors in nursing practice:
 - Consistently demonstrates:
 - Commitment to the profession of nursing
 - Competence with communication
 - Interacting with client
 - Interacting with health team members
 - Technology
 - With minimum assistance demonstrates:
 - competency with appropriate documentation
 - Demonstrate professional behaviors in nursing practice
2. With guidance, demonstrate attitudes and skills for learning
 - Competence in information technology
 - Primary responsibility for attaining and maintaining competence in nursing practice

3. Demonstrate an understanding of the role of the nurse in social and political action in the practice setting, at a beginning level
 - Support rights and responsibilities of the client.
 - Identify issues of power that need investigation.
4. Utilize a variety of information technology
5. Demonstrate effective skills in self-directed, context-based, small group learning
6. With guidance, utilize selected knowledge related to biological, psychological, sociological, cultural and spiritual factors in nursing practice with clients experiencing more acute variances in health.
7. Apply a selected model/ theory in nursing practice
8. With minimal assistance apply critical thinking strategies to the care of clients experiencing acute and complex variances in health.
9. With assistance appraise and apply research findings to practice.
10. With assistance, demonstrate competence in the clinical setting in dealing with ambiguity and diversity
 - In assisting in client decision-making
 - In evaluating resource networks
11. Demonstrate beginning competence in leadership and management skills
 - With assistance, demonstrate:
 - Understanding of delegation
 - With minimal assistance, demonstrate:
 - Decision-making
 - Time-management
 - Performance appraisal
12. Analyze concepts and principles of primary health care in more complex practice situations
13. Demonstrate caring behaviour in professional situations:
 - Commitment to the ideal of caring
 - Multiple caring behaviours in interpersonal activities
 - Establishing caring relationships with clients and colleagues
14. With guidance, demonstrate competence in ability to interact with and develop collaborative partnerships with clients, community members, members of other disciplines, and registered nurses

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

- Consistently demonstrates competence with:
 - Selected skills
 - See lab maps
 - Applying nursing process
 - Using appropriate communication skills
 - Using appropriate teaching skills

REQUIRED RESOURCES

1. Working Definitions
2. Lab Maps
3. Graduate Competencies and Level Outcomes

Seminar times and rooms

Home Care group:	Monday 1300-1600 F309
Surgery group:	Friday 1000-1300 G118

Grading System:

Effective July 1, 2003 Grande Prairie Regional College uses the alpha grading system and the following approved letter codes for all programs and courses offered by the College:

Alpha	4-point equivalence	Descriptor
A+	4.0	Excellent
A	4.0	
A-	3.7	First Class Standing
B+	3.3	
B	3.0	Good
B-	2.7	
C+	2.3	Satisfactory
C	2.0	
C-	1.7	

These are considered passing grades in Nursing courses.

D+	1.3	Poor
D	1.0	Minimal Pass
F	0.0	Failure

These are NOT considered passing grades in Nursing courses.

Students *may* receive a grade of D or D+ in an assignment or component of a course, but must have an overall grade of C- to achieve a passing grade in a nursing course.

****Note: Refer to the 2004-05 College calendar for further details regarding the grading policy and p. 148 and 149 regarding Progression Criteria in the Bachelor of Science in Nursing program.**

Attendance:

Students are expected to be punctual during their clinical experience in the agency. Attendance and participation is expected of all students in all seminars, 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.**

Absence from clinical experience of more than 2 days may jeopardize successful completion of the course requirements.

Important Dates to Remember

November 19, 2004 - last day to withdraw from the course without penalty

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** at all times, including in clinical areas you may be observing (OR, RR, PAC).

Preparation for Clinical Experience:

It is expected that you will prepare for each clinical day by researching procedures, medical conditions, medications, surgical procedures, etc. Required psychomotor skills may also need to be reviewed prior to clinical experience. Students should be prepared to discuss their patient plan of care (including the patient priority needs, nursing diagnosis, medication profiles, any patient teaching plan, etc.) with the instructor during clinical time. If a student is not adequately prepared for clinical, the instructor may request the student leave the clinical agency. This would be a decision made after considering patient safety. Students must demonstrate safe, ethical nursing practice.

- **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.** (See 2004-2005 GPRC calendar page 148-149 for Clinical Progression Criteria)

Assignment Policy:

It is expected that ALL assignments must be completed to obtain credit in the course. Assignments are expected to be passed in at the time and place they are due. Extensions may be granted and must be negotiated with the instructor prior to the due date and with a date specified for late submissions.

A penalty of one alpha grade for each working day that an assignment is submitted after the due date will be deducted from the final mark. For example, a paper or assignment marked at B+ would receive an adjusted grade of B if handed in one day late. Late assignments are due by 4:00 p.m. and must be verified (stamped with date and time received) by nursing office personnel.

REQUIRED LEARNING EXPERIENCES:

Course Hours:

Orientation with lab skills	16 hours
Clinical hours	<u>180 hours</u>
	196 hours
Seminar	21 hours

SUMMARY OF EVALUATION FOR SURGERY (4 South)

1. Direct Clinical Observation	50%
2. Perioperative Follow-through	30%
3. Critical Incident Journal	15%
4. Learning Plan	5%

SUMMARY OF EVALUATION FOR HOME CARE:

1. Direct Clinical Observation	50%
2. Reflective Journals	25%
3. Client Profiles	15%
4. Learning Plan	5%
5. Field Notes	5%

SURGERY ASSIGNMENTS

NURSING PRACTICE:

Nursing practice will be evaluated by means of the following:

- 1. Direct Clinical Observation (DCO) Value: 50%**

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

Students MUST pass the DCO in order to pass the course. If a student receives a rating of “F” in any listed behaviour or category on the DCO, the student will not receive a passing grade on the DCO. If a student does not pass the DCO they will obtain an overall grade of no greater than “D” on the alpha scale, in the course.

This will be accomplished through observation assessment and evaluation of the student during clinical practice. Final grades will be assigned 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. Perioperative Follow-through

Value: 30%

Students will be expected to follow one patient's operation during the OR observation day. The student will be expected to draw on general information from the pre-admission clinical and recovery room experiences and apply it to this patient.

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 affects 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 20 pages in length. Follow APA guidelines.**
- **Paper is due one week after perioperative follow-through.**
- **Assignments that are late will be docked one alpha grade per day off the paper grade (example: B+ on paper, handed in 1 day late will be adjusted to a B grade)**
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3. 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 NS3910. 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 were strong or needed improvement.
4. Describe your significant learning. What would you do differently/investigate/ maintain if a similar incident should occur? Describe what you would teach someone else (peer/colleague) about this incident in order to improve your nursing practice. Provide nursing literature/valid resources that support your conclusions.

Due dates for critical incidences:

#1: November 8, 2004

#2: November 15, 2004

#3: November 22, 2004

- Journals **MUST** be handed in by **0830** on the day they are due.
- 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 incidences is attached.

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

4. 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 at least **2 learning goals**, with evidence to support how the goals in the learning plan will be met. Students will develop a learning plan to explore personal learning objectives compatible with the experiences of this course.

Due Date: November 1, 2004

Students will follow up their learning plan at **Mid-term Evaluations the week of November 17-19, 2004** to evaluate their learning goals. A mid-term self-evaluation must be completed.

Students must complete a final review of their learning plan on **November 29, 2004** indicating whether the goals were achieved. Students must provide evidence on how they achieved these goals. A **Final Self-evaluation** must be completed.

HOME CARE ASSIGNMENTS

NURSING PRACTICE:

Nursing practice will be evaluated by means of the following:

1. Direct Clinical Observation (DCO) Value: 50%

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

Students MUST pass the DCO in order to pass the course. If a student receives a rating of “F” in any listed behaviour or category on the DCO, the student will not receive a passing grade on the DCO. If a student does not pass the DCO they will obtain an overall grade of no greater than “D” on the alpha scale, in the course.

This will be accomplished through observation assessment and evaluation of the student during clinical practice. Final grades will be assigned 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. Reflective Journals

Value: 25%

Critical Incidents/Reflection

Identifying critical incidents 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 student to increase their own knowledge of practice.

Students are required to reflect on their practice **weekly** in Nursing3910 and hand in a **minimum of 5 journal** reflections.

Guidelines for Journaling: (5-6 typed pages minimum)

1. Describe a significant event that has occurred. Write a few paragraphs and describe the event/situation, (ie: what you or someone else did as an intervention, communication, etc.) Be specific (give detail) and be as objective as possible. Include your thoughts, feelings and perceptions.
2. Reflect on the event/situation. Why was it important to you and what influenced your decisions, actions or feelings? (eg: such as assessments, previously learned experiences, values, beliefs, stereotypes or biases).
3. Evaluate your strengths and areas needing improvement in this situation.
4. Describe significant learning for you. Would you do anything differently or maintain? What would you investigate if a similar situation should occur? What would you teach a peer/colleague about this incident to improve nursing practice?
5. Provide nursing literature/valid resources that support your conclusions. Use references as per APA guidelines.
6. All entries are **confidential**, so do not name clients or staff. The journals are between student and faculty member only.

Note: Journals are not logbooks or totals of each day's events.

3. Client Profiles

It is expected that you will prepare for each day by researching diagnoses and reviewing psychomotor skills. Review each client chart and research the condition, the identified problems and concerns, medications and treatments and required charting. A **minimum of 5 client profiles** must be completed.

4. Learning Plan

Value: 5%

A learning plan is the agreement between the student, faculty member and preceptor as to what the student intends to learn in this practicum, how this will be accomplished, the time frames for meeting the objectives and the method of evaluation if the objectives have been met. Students will submit **two learning goals** to the faculty member and to the preceptor in the **second** week of the practicum with evidence to support how the goals will be met. These will be reviewed at midterm evaluation and at final evaluation, to determine if learning goals have been met. Goals may be adjusted, revised or changed, depending on clinical experiences and student learning needs.

Learning Plan Process

- Provides the student with an opportunity to make a 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.
- Identifies strategies for meeting these goals.
- Identifies a timeline to meet the goals.
- Identifies an evaluation strategy to meet the goals.

Students are required to submit at least 2 learning goals, with evidence to support how the goals in the learning plan will be met. Students will develop a learning plan to explore personal learning objectives compatible with the experiences of this course.

Due Date: November 8, 2004 (with the first journal). Revisions may be made at midterm and evaluation of plan will occur at final evaluation with preceptor and faculty.

5. Field Notes

Value: 5%

Field notes are to be completed each day, collated and handed in weekly. A form is provided for your use. These notes include the client's initials, diagnosis, location of visit, procedures done and whether you were supervised.