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**UNIVERSITY OF ALBERTA
COLLABORATIVE BACCALAUREATE
NURSING PROGRAM
Grande Prairie Regional College**

Nursing 2910

Course Outline

Nursing Practice III: 7 (0-3s-28)

Fall, 1998

Instructor:	Liz Richard RN, MN Office: H215 Phone: 539-2754 Email: richard@gprc.ab.ca Office Hours: Following seminar	Monique Sedgwick, RN, MN Office: H202 Phone: 2756 Email: Sedgwick@gprc.ab.ca
Seminar Times:	Fridays 0900-1150	
Clinical Days:	Wednesdays/Thursdays 0700-1900	
Unit:	5 North, QE II Hospital 2 South, QE II Hospital	

NS 2910

Nursing Practice III *7 (0-3s-28)(either term)

Nursing practice will focus on restoration, rehabilitation and support of clients with chronic and less acute variances in health across the life span. Practice will occur primarily in primary level acute care centers and continuing care agencies.

COURSE HOURS:

Seminar: 21

Lab/Clinical: 196

Field Placement:

COURSE DESCRIPTION:

This course will provide opportunities for students to continue to participate in health promotion and primary prevention activities while focusing on restoration, rehabilitation and support. Nursing practice will include health assessment and intervention with clients with less acute and chronic variances in health. The student will experience nursing practice over a continuous block of time in institutional settings providing primary care, e.g. med/surg units, day or short stay surgery, subacute units, continuing care or rehabilitation units.

COURSE OBJECTIVES:

Upon completion of Nursing 2910, the nursing student will be able to:

1. Apply nursing knowledge as well as knowledge from other disciplines (research, models and theories) related to bio, psycho, socio, and spiritual factors to nursing practice with clients experiencing chronic and less acute variances in health.
2. Demonstrate application of legal and ethical standards in nursing practice settings by: support of colleagues, decision making, incorporating clients' values, beliefs, and rights within the social mandate and the role of the professional association.
3. Demonstrate professional behaviors in nursing practice (respect, communication, responsibility, self awareness)
4. Demonstrates openness and receptivity to change and an attitude of inquiry in nursing practice.
5. Apply concepts related to health promotion, primary prevention, support, restoration, rehabilitation, palliation, and death in selected practice settings with clients by:
demonstrating safe nursing practice

coordinating client care using clinical judgment, critical thinking, and innovation
beginning use of mobilization of formal and informal power
understanding of diversity and ambiguity.

6. Demonstrate beginning ability to interact with and develop collaborative partnerships with clients, nurses, and members of other disciplines, displaying valuing, caring, compassion and respecting autonomy.
7. Demonstrates competence in selected skills: communication and informatics, assessment (physical, psychological, family, community), psychomotor, and teaching.

LEARNING EXPERIENCES AND EVALUATION:

In order to pass NS 2910, students must demonstrate safe, ethical nursing practice, professional behavior and complete the following experiences and assignments.

Nursing Practice

Nursing practice will be evaluated by means of the following:

1. Learning Plan: Value 20%

Students will develop a learning plan to guide their nursing practice in NS 2910.

Learning plans enable students to combine learning objectives for the course with their own learning objectives and to consider their particular learning style.

A learning plan is the agreement between the student and the tutor specifying what the student intends to learn, 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 a working document that is to be used by the student and the tutor to select learning opportunities that will assist the student to meet the objectives, and to contribute to both formative and summative evaluation. Use of the learning plan involves ongoing sharing of expectations between the student and the tutor.

The learning plan is intended to:

- provide the student with an opportunity to individualize learning within the framework of the objectives for the course;
- allow students to determine learning objectives in view of their own perception of their strengths and areas for improvement;
- identify strategies for meeting the objectives;
- identify evaluation strategies.

The student will provide evidence to support how the goals outlined in the learning plan

have been met. The Reflective Journal and Field Notes may be used as part of the evidence supporting the learning plan.

a. Field Notes

Field Notes provide a description of the students' clinical activities. Details such as the amount of time the students spent in the activity, where the activity was completed, and what specifically was done are to be included.

b. Reflective Journal

Components of this will include:

1. Reflection on the impact of clinical experience on personal and professional growth.
2. Analysis of the extent to which learning experiences have contributed to achievement of course objectives.
3. Personal reflections to assist in the development, revision and support of the learning plan.
4. Identification of an issue that has arisen in the clinical setting or group, and examination of that issue in terms of objective observations, feelings and values clarification.

2. Direct Clinical Observation

Value 50%

This will be accomplished through observation of the student during nursing practice in the clinical setting. Observations will be made by the instructor and will be supplemented with input from peers, the staff of the clinical setting, and the client.

An oral midterm evaluation and written final evaluation will be completed by the student and instructor.

A. Essential:

Over the 7 weeks students will have a continuous experience in an institutional setting which will include:

1. Care of adults or children with chronic or less acute variances in health.
Within this experience variations of the following activities might occur:
 - a) Assessing mental and physical health status of client and family.
 - b) Providing nursing care.
 - c) Developing appropriate psychomotor skills:
Students will have completed labs for selected skills prior to performing skills on client. (See Labs)
Students will demonstrate competence with skills specific to their clinical environment as needed.

- d) Participating in a client follow through during pre and post medical or surgical procedure.
- e) Participation in client education.
- f) Participating in discharge planning/referral from institutional setting:
 - liaise with home care nurse
 - follow up visit with client at home (assessment, client education)

2. Collaborate with clients, family, nurses and members of other disciplines.

B. Suggested:

- 1. Involvement with specific projects within institutional-based practice.

3. Assignment:

Value 30%

A written assignment arising from the student's clinical experience will be completed.

Suggested topics:

a) Application of Nursing theory/model in Nursing Care Plan

Develop a nursing care plan applying a nursing theory/model for a client with chronic or less acute variances in health. This could include plans for care while the client is in the institution as well as the follow up visit to the client's home where assessment and client education occurs.

b) Application of selected concepts in planning care

Develop a nursing care plan in which selected concepts such as grief, death and dying are applied to restorative or palliative care of a client and family.

Summary of Evaluation:

	<u>Value</u>
1. Learning Plan	20%
2. Direct Clinical Observation	50%
3. Assignment	30%

LABS

Lab #1: Pre & Post Medical or Surgical Procedure Care

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

1. Prepare a client for a diagnostic or surgical procedure:
 - a) assessment
 - b) teaching (re procedure, DB & C, turning, leg exercises, ambulation, pain control)
 - c) physical preparation (skin prep, fasting, specific to procedure)
 - d) documentation

2. Care for client after a diagnostic or surgical procedure:
 - a) assessment of client
 - b) physical care
 - c) documentation
 - d) teaching

Lab #2: Aseptic Technique: Dressing, Drains, Staples, and Sutures

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

1. Demonstrate the principles of aseptic technique:
 - a) creating the sterile field
 - b) maintaining the sterile field

2. Apply principles of aseptic technique in doing:
 - a) simple dressing
 - b) dressing with drains, sutures, staples
 - c) wound drain management
 - Penrose
 - Hemovac
 - Jackson-Pratt
 - d) removal of sutures and staples
 - e) document assessments and actions accurately

Lab #3: Intravenous Therapy: Maintenance, Pumps, and Locks

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

1. Be familiar with principles of I.V. therapy

2. Be aware of equipment and solutions used with I.V. therapy

3. Change I.V. tubing and bags
4. Calculate and regulate intravenous flow rates
 - i. manual
 - ii. use of pumps
5. Calculate intake via I.V. route
6. Care of heparin/saline lock
 - i. flush lock
 - ii. establish or discontinue I.V. infusion via existing lock
 - iii. administer I.V. meds via lock
7. Document accurately assessments, fluid intake, medication administration and action.

Lab #4: Pulmonary Procedures

At the completion of Lab #4, the student will be able to:

1. Assess respiratory function.
2. Assess oxygenation via
 - i. pulse oximetry
3. Administer oxygen via
 - i. nasal canula
 - ii. face mask
4. Perform oropharyngeal and naso pharyngeal suctioning.
5. Teach client re: incentive spirometry.
6. Document accurately assessments and actions.