CAMOSUN COLLEGE

NURSING DEPARTMENT

Nursing 142

Foundational Nursing Skills and Assessment

Fall 2017

These materials, with foundations developed by the participating institutions in the Collaboration for Academic Education in Nursing, represent a component of the four year integrated BSN Program offered by Camosun College in partnership with the University of Victoria.

Acknowledgement of Territory

Camosun College campuses are located on the traditional territories of the Lekwungen and W̱SÁNEĆ peoples. We acknowledge their welcome and graciousness to the students who seek knowledge here.

University of Victoria and Partners Position Statement

The BSN Partnership (University of Victoria, Camosun, Aurora, Selkirk, College of the Rockies) denounces Canada's historical colonial dominance of Indigenous peoples including abuse in residential schools, and 'Indian' hospitals resulting in ongoing intergeneration trauma and loss of Indigenous culture. We are committed to processes of inclusion and reconciliation as outlined in the Calls to Action of Canada's Truth and Reconciliation Commission and the United Nations Declaration on the Rights of Indigenous Peoples. With respect, we are committed to partnering with Indigenous communities to learn about Indigenous knowledges and ways of being and to support the wellbeing of Indigenous, Métis and Inuit peoples. We intentionally enact these understandings throughout the nursing curriculum.

(Developed by UVic and Partners, April 25, 2017)

Course Outline

Overview

In this course learners are introduced to evidence-informed health assessment across the lifespan. Through experiential learning, simulation, and demonstration of skills, participants will gain knowledge, skills, and abilities foundational to nursing practice. Content includes physical, mental, spiritual, nutritional, and social assessment skills, and technologies and nursing interventions for the promotion of health and healing. Learners will develop effective communication and documentation skills necessary for working in interprofessional teams. Key course concepts and principles inform nursing decision making.

Intended Learning Outcomes

Upon successful completion of this course a student will be able to:

a) Demonstrate competency and safety in performing foundational psychomotor skills across the lifespan
b) Demonstrate infection prevention and control in simulated nursing practice settings
c) Conduct a general survey and priority assessment in diverse contexts
d) Demonstrate proficiency with vital signs assessment
e) Demonstrate proficiency in nutritional assessment
f) Demonstrate prioritization skills, when performing assessments and nursing skills
g) Demonstrate safe patient handling, when performing relevant assessments and nursing skills
h) Demonstrate personal care with respect, dignity and professionalism
I) Document assessment findings using appropriate terminology and format, integrating nursing informatics

Required Materials

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

Basis of Student Assessment

Assignments, due dates, criteria for evaluation and weighting of assignments will be discussed during the first two weeks of the semester.

Learners will be evaluated based on the following:

- Participation 5%
- Skills Test 20%
- Midterm Exam 35%
- Final Exam 40%

Class attendance is mandatory. To successfully complete this course, all assignments (participation, midterm exam, and skill demonstrations/testing) must be completed by the last day of instruction of the semester.

Evaluation for Practice Readiness for each week:

- Self-evaluation
- Peer-evaluation
- Feedback from faculty
- Consistent attendance

The process of lab performance evaluation will be discussed by the teacher and students in their lab groups.

Professional Responsibility

Attendance and preparation is **mandatory for successful completion of this course**. Students are expected to come prepared having completed all the prerequisite reading and activities as outlined in the learning activities. The scope of preparation would inform and prepare students to lead a discussion about the new skill and to contribute to the overall learning of their peers. It is imperative that each student also engage in practicing psychomotor skills outside of the supervised time in the lab. **Credit for this course is based on 4 hours of scheduled class time and 5 hours of independent study outside of class time per week.** It is expected that each student will use this time to read, study and practice the psychomotor skills in order to be fully prepared for safe nursing practice and to ensure success in Semester 1.

Additional Resources

- CRNBC Professional Standards for Registered Nurses and Nurse Practitioners (2012) https://crnbc.ca/Standards/Lists/StandardResources/128ProfessionalStandards.pdf
- Competencies in the Context of Entry Level Registered Nurse Practice in British Columbia –CRNBC (2015) https://www.crnbc.ca/Registration/Lists/RegistrationResources/375CompetenciesEntrylevelRN.pdf

Lab Expectations and Rules

The labs are heavily used. The listed expectations and rules will make the labs run more smoothly for everyone.

- The lab must be treated and maintained like a hospital nursing unit.
- Lab coat or clean nursing uniform top must be worn in lab.
- Closed toed shoes must be worn by all faculty and students in the labs at all times. This is a Work Safe BC requirement.
- Manikins, beds, tables and supply carts must be left clean, tidy and free of garbage at the end of each lab.
- Each week, supplies will be stocked and labelled on the metal supply carts in each lab. Please take note of the labelling for each item as it will indicate how many items per student and notes pertaining to lab set-up. As well, please be aware that many items are re-used and shared amongst all sections.
- Please re-use and recycle when possible. **All SHARPS MUST** be disposed of properly in the sharps containers provided.
- The bottom two shelves of the linen carts have been left empty for student back packs. Please ensure this area is kept clean and tidy. Anything left behind on these shelves will be placed in the student lounge.
- All students and faculty are permitted to have water only while in the labs. The water must be in a sealed container and placed in the middle tables or linen cart ONLY. If there is a spill, please clean it up right away.
- Absolutely **NO Food** is permitted in the labs.

Thank you for your cooperation in the above listed rules and expectations.

Learning Support and Services for Students

There are a variety of services available for students to assist them throughout their learning. This information is available in the College Calendar, Student Services or on the Camosun College Website.
http://www.camosun.bc.ca

Student Conduct Policy

There is a Student Conduct Policy. It is the student's responsibility to become familiar with the content of this policy. The policy is available in each School Administration Office, Registration and on the Camosun College Website in the Policy Section.
http://camosun.ca/learn/calendar/current/procedures.html

Academic Dishonesty: Plagiarism and Cheating

Plagiarism or any form of cheating is considered a very serious offence. Please take the time to refer to **the college calendar so that you are clear about what constitutes plagiarism and what the Camosun College policies are regarding consequences and discipline**.

For information on Camosun College policy on plagiarism please see Policy Supporting Document E-2.5.1 on the Camosun College website:

http://camosun.ca/about/policies/education-academic/e-2-student-services-and-support/e-2.5.1.pdf

Grading System

[X] Standard Grading System (GPA)

[ ] Competency Based Grading System

For information on Camosun College grading system please refer to the Camosun College website:

http://camosun.ca/about/policies/education-academic/e-1-programming-and-instruction/e-1.5.pdf

Course Schedule

Week	Content
Week 1	Orientation to Course & Introductions Module 1 - Infection Control Practices & Precautions
Week 2	Module 2 - Introduction to Assessment & General Survey Module 3 - Subjective Assessment
Week 3	Module 4: Caring and Communication Part 1: Verbal & Non-Verbal Communication Module 4: Caring and Communication Part 2: Documentation Module 5 - Vital Signs
Week 4	Module 5 - Vital Signs Module 5 - Vital Signs Module 6 - Priority Assessment Module 7 - Head to Toe Assessment
Week 5	Module 8 - The Integument System Part 1: Assessing the Integument Module 8 - The Integument System Part 2: Skin Integrity Preventive Measures & Introduction to Pressure Injuries
Week 6	Module 9 - The Musculoskeletal System Part 1: Musculoskeletal Assessment Module 9 - The Musculoskeletal System Part 1: Musculoskeletal Assessment **Midterm: Tuesday, October 10, 2017 (1830-2000) Rooms TBA**
Week 7	Module 9 - Musculoskeletal System Part 2: Safe Movement & Patient Handling Module 9- Musculoskeletal System Part 2: Safe Movement & Patient Handling
Week 8	Module 9- Musculoskeletal System Part 2: Safe Movement & Patient Handling Module 9 - Musculoskeletal System Part 3: Assisting with Mobility
Week 9	Module 10 - Personal Care Module 10 - Personal Care
Week 10	Module 11 - Head & Neck Assessment Module 11 - Head & Neck Assessment
Week 11	Module 12 - Gastrointestinal Assessment Part 1: Assessment Module 12 - Gastrointestinal Assessment Part 2: Ostomy Management & Changing of Ostomy Bag
Week 12	Module 13 - Nutritional Assessment Part 1: Assessment
Week 13	Module 13 - Nutritional Assessment. Part 2: Providing Nutritional Assistance Preparing for Skills Testing & Final Exam
Week 14	Skills Testing in Lab Skills Testing in Lab

This schedule is a guide and is subject to change. It may vary for each individual lab group.

Module 1: Infection Control Practices and Precautions

Overview

In order to keep themselves and others safe, it is essential that nurses have a solid understanding of when a population of microorganisms may be inappropriate and potentially pathogenic and how these microorganisms can subsequently be spread from one area to another. Knowing how to prevent the spread of disease causing organisms, through the use of routine practices, is foundational to safe and competent nursing practice.

Different microorganisms are spread in different ways. When a patient has an infection which can spread to the nurse and others, the practice of wearing a mask, face shield, gown and/or gloves will create a mechanical barrier preventing the spread of germs depending on how the specific organisms are spread. Many microorganisms are easily spread by touch from one person to another. The practice of thorough hand hygiene prior to and following contact with patients significantly reduces the number and spread of microorganisms, helping to keep everyone safe.

Learning Outcomes

Learners will:

- Discuss and identify common health care-associated infections (HAIs)
- Define the chain of infection and describe each of the six components
- State ways to break the chain of infection
- Identify the key elements of Routine Practices and their importance in protecting patients and health care workers
- Explain the difference between sterile technique and clean technique
- Explain and demonstrate proper hand hygiene
- Explain and demonstrate donning and removal of non-sterile gloves
- Explain and demonstrate the donning and removal of personal protective equipment (PPE)

After learning proper hand washing technique in the lab, you will be expected to apply it each and every time you have a simulated patient encounter in subsequent lab classes.

In Preparation

Conduct online video searches of the following skills:

- "nursing skills for hand hygiene using soap and water "
- "hand hygiene using soap and water alcohol based hand rub (ABHR)"
- "nursing skills for donning and removing of non-sterile gloves"
- "nursing skills for donning and removing of PPE (gown, mask, goggles, gloves)"

Watch one or two videos demonstrating each of the above skills.

As you are watching the videos, refer to your Kozier et al. (2018) textbook and notes on:

- Skill 34.1 Hand Hygiene pp. 892-894
- Skill 34.2, Donning and Removal of Personal Protective Equipment – Gloves, Gown, Mask, Eyewear pp. 895-897.

How are the infection control practices and nursing skills in the videos similar or different than what is outlined in your textbook?
Bring notes to class for discussion.

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 34: Health Care-Associated Infection – up to types of microorganisms causing infections, including table's 34-1 & 34-2 (pp. 875-878)
- Chapter 34: The Clinical Spectrum of Infection (p. 882)
- Chapter 34: The Chain of Infection (pp. 883-887)
- Chapter 34: Breaking the Chain: Prevention and Control, includes readings on hand hygiene, donning of clean gloves and other PPE (pp. 887-898)
- Chapter 34: Sterile, Aseptic, and clean technique, definitions (pp. 899-900-NOT Table 34-8)
- Chapter 34: Routine Practices (pp. 910, 914, including Box 34.3)

Module 2: Introduction to Assessment &General Survey

Overview

The technique of performing an assessment involves applying a system of data collection. You will be talking (and listening) to your patient to gather subjective data and performing a physical assessment using the tools of inspection, palpation, auscultation and percussion to gather objective data. As you learn how to think critically about what you find, the data becomes meaningful and creates information. This will take time.

Assessment data is collected in order to create a database of patient information from which to make decisions about what health problems actually exist or may develop. This database consists of **subjective** information, which is gathered directly from the patient or other individuals about the patient, as well as **objective** information, which includes data collected from physical examination and diagnostic tests.

Assessments are very personal. You will be asking very private questions and performing potentially invasive examinations. Consider how your patient will think and feel. What you will think and feel?

Learning Outcomes

Learners will:

- Describe the five phases of the nursing process focusing on assessment phase.
- Distinguish between subjective assessment data and objective assessment data.
- Describe the four types of data collected in the clinical environment (complete or total heath, episodic or problem based, follow-up, emergency)
- Summarize the critical techniques and process of effective communication during the interview part of data collection.
- Identify the three phases of a professional interview (introduction, working and closing).
- Identify interview strategies to collect developmental data across the life span.
- Identify the primary methods of data collection (observing, interviewing and examining)
- Describe the four senses used to gather data through observation.
- Identify the skills required to conduct a physical exam (inspection, palpation, percussion and auscultation.
- Describe and demonstrate a general survey.
- Identify components of a professional introduction
- Begin to develop a professional introduction with feedback from others.

After learning how to perform a general survey in the lab, you will be expected to apply it each and every time you have a simulated patient encounter in subsequent lab classes.

In Preparation

Required Readings:

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 1: Introduction & Assessment - up to "diagnostic reasoning" (pp. 1-2)
- Chapter 1: Data Collection (pp. 9-11)
- Chapter 4: The Interview (pp. 45-57)
- Chapter 9: Inspection, Palpation, Percussion and Auscultation (pp. 138-141)
- Chapter 10: The General Survey – up to 'measurement" (pp. 151-153)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 23: The Nursing Process - up to Diagnosing/Analyzing (pp. 412-428)
- Chapter 23: Types of Data -including Table 23-3, up to "interviewing" (pp. 418-420)

Prior to class consider the following:

Think about the first time that you will approach a patient to perform an assessment. It could be any kind of an assessment. How would you like to introduce yourself and what you are going to do? Find a phrase to professionally introduce yourself that feels comfortable for you and try it out on a few friends or family.

Assessment Summary

General Survey

Subjective Data	Objective Data

Module 3: Subjective Assessment

Overview

Taking a health history involves collecting subjective assessment data directly from the patient. It is always important to remember to minimize "interpreting" the subjective data that you have collected. Be sure to validate what you "think" you heard with the patient when the assessment is complete. Collecting clear, comprehensive and meaningful subjective data requires a thoughtful and unbiased approach to the taking of a health history. Uncovering and recognizing significant subjective information is a skill that takes time, effort and experience to develop.

Do you remember playing a game as a child where everyone would sit in a circle and one person would whisper something into the ears of the person next to them, who would whisper what they heard into the ears of the next person and so on around the circle? The last person would then tell the group what they heard, which was never even close to the first whispered message. The more people the message went through, the more distorted the final message was. Remember this game whenever you are accessing subjective data from anywhere other than the patient themselves. The information is at least one person's interpretation of the patient's information and it may have gone around a sizeable circle before it ended up where you found it. Perception colours everything.

Learning Outcomes

Learners will:

- Review the data collection methods and how the nurse uses this data in a subjective assessment
- Demonstrate basic history taking including past medical history
- Utilize common mnemonics for history taking such as OPQRSTUV
- Continue to develop a professional introduction with feedback from others

After learning how to perform a professional introduction in the lab, you will be expected to apply it each and every time you have a simulated patient encounter in subsequent lab classes.

In Preparation

Required Readings:

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 5: Health History - up to 'review of systems' (pp. 66-69)
- Chapter 5: Functional Assessment, including ADLs (p. 72-73)
- Chapter 5: Perception of Health (pp. 73-74)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 23: Types of Data, including Table 23-3, up to "interviewing" (pp. 418-420)
- Chapter 23: Validating & Documenting Data - including Table 23-4 (pp. 427-428)

Access the Following Online Resource (and subpages)

http://www.fraserhealth.ca/media/SymptomAssesment.pdf

http://www.bccancer.bc.ca/health-professionals/professional-resources/nursing/symptom-management

http://www.bccancer.bc.ca/nursing-site/Documents/Symptom%20Management%20Guidelines/SymptomAssessmentAcronym.pdf

http://www.bccancer.bc.ca/nursing-site/Documents/Symptom%20Management%20Guidelines/BlankNVAssessmentWorksheet1.pdf

Assessment Summary

General Survey

Subjective Data	Objective Data
Presenting complaint • **OPQRSTUV** **Past medical history** • **Family history** • **Risk factors** **Medications** • **Immunizations** **Allergies**	

Module 4: Caring and Communication
Part 1: Verbal & Non-Verbal Communication

Overview

The sending and receiving of messages, whether intended or unintended, is a perpetual human challenge, even for the most insightful individuals in the most ideal of circumstances. The addition of psychological and physical crisis to certain participants and the responsibility of managing these crises for other participants escalates the potential of miscommunication to monumental levels. If the encounter occurs within the health care system, it often happens in an environment where time and resource demand far outstrips supply. In spite of, or maybe because of, so many factors working against quality communication, it is also an environment that recognizes effective communication strategies. It is a place where a single person can make a meaningful difference in another person's life.

Communication occurs wherever there is more than one person. The vast majority of messages are sent non-verbally. Having a solid understanding of which non-verbal messages we send, particularly when we are under stress, is a critical part of developing clear and effective communication. Recognizing the importance of validating messages sent and received further enhances clarity and mutual understanding. There will be times when it is absolutely critical that messages are heard and understood between you and your patient and between you and other care providers.

Learning Outcomes

Learners will:

- Recognize factors that influence how messages are sent and received
- Identify the modes of communications (verbal, non-verbal and electronic)
- Describe different communication and identify when they are used
- Outline and demonstrate using the communication tool "SBAR" (**S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation)

In Preparation

Access the Canadian Nurses Association (CNA) and the College of Registered Nurses of British Columbia (CRNBC) websites and retrieve resources regarding professional communication.

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 22: Caring and Communicating (pp. 385-390)
- Chapter 22: Actions of Physical Attending, including Box 22-2 (p. 393)
- Chapter 24: Reporting (pp.476-478)

Module 4: Caring and Communication
Part 2: Documentation

Overview

The patient record contains written documentation, whether the record is paper, electronic or a combination of both (sometimes called a hybrid). The patient record is a permanent, legal document in which all aspects of care are recorded. It contains confidential information regarding health history, current health status, progress, therapies and treatments, considerations for discharge and follow up care. It serves as a means of communication between health professionals, as a tool for education and research, and as a resource for assessing the quality of care provided.

Nursing professional bodies such as the Canadian Nurses Association (CNA) and the College of Registered Nurses of British Columbia (CRNBC) have developed general standards regarding nursing documentation. In addition, each healthcare agency has its own policies regarding acceptable documentation. It is very important to review and understand these standards prior to documenting within a client record.

During the course of your studies to become a nurse, you will be communicating with your instructors both verbally and in written form. **Assessment and Research Tools** are documents that have historically been developed and distributed among students to help them develop a systematic approach to patient assessment and to help them communicate their clinical decision making to their instructors. These tools get changed, adapted and evolve over the course of the program. Yours will too. They are highly individual and what works for one student or clinical setting does not necessarily work for another. Your instructor will provide examples of assessment tools on the course D2L site.

Learning Outcomes

Learners will:

- Be familiar with legal documentation standards as outlined in nursing professional bodies
- Discuss the purpose of client records and documentation
- Compare and contrast different documentation systems
- Discuss the purpose and legal and ethical considerations of documentation in patient's paper and electronic health records
- Describe different written communication/documentation techniques and identify when they are
  used, including SOAP and APIE
- Identify the generally accepted guidelines for documentation within a client record
- Identify and discuss acceptable and commonly used abbreviations used in clinical documentation
- Define nursing informatics and electronic health records (EHRs) and discuss how information and computer technology (ICT) is used within nursing practice
- Begin to evaluate and critique examples of assessment and research tools

In Preparation

Access

Canadian Nurses Association (CNA) and the College of Registered Nurses of British Columbia (CRNBC) websites and retrieve resources regarding documentation standards.

Review

https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 24: Documentation (pp. 460-476)
- Chapter 25: Nursing Informatics and Technology (pp. 482-490)

Module 5: Vital Signs

Overview

Vital Signs are a series of objective assessments that typically include blood pressure (BP), pulse, respirations, temperature and increasingly includes oxygen saturation (SpO2). Each measurement has a normal range which will vary from one person to another and from one point in time to another. When measuring vital signs, it is important to know which factors affect the vital signs and to assess the importance of these factors for the particular individual.

Vital signs are used to contribute to the initial assessment database and are also often used as a form of ongoing monitoring. Vital signs collected during the initial assessment are affected by underlying medical conditions and medications and will be highly influenced by the psychological or emotional state of the patient as the time. Monitoring vital signs over time may uncover patterns of change that could indicate significant pathology such as developing infection or impending shock. Vital signs are called **vital signs** for a reason.

Some practitioners consider pain to be the fifth vital sign in adults (weight for children) and include this component in their vital signs assessment. Pain is a complex and highly subjective experience that can only be fully understood by the person experiencing it.

The measurement of vital signs has been placed early in your learning to allow time for practice in class throughout the semester. To reinforce this learning, we will attempt to start each weekly assessment with a set of vital signs. As this is most likely a new skill, practice is important to help develop your accuracy and confidence.

Learning Outcomes

Learners will:

- Explain and demonstrate conducting a set of vital signs
- State what is being assessed with each “vital sign”
- Identify the normal ranges in temperature, pulse, BP, respirations, SpO2
- Describe how developmental changes affect vital signs
- Identify factors affecting vital sign readings
- Landmark and palpate radial and brachial pulses
- Discuss the different ways of taking a blood pressure
- Conduct a set of vital signs, including a manual two-step method BP, radial pulse, temperature and respirations
- Differentiate between systolic and diastolic blood pressure including discussing the five phases of Korotkoff sounds
- Discuss the different ways of taking a temperature
- Discuss different ways of measuring oxygen saturation
- Familiarize self with electronic vital signs apparatus and use to assess SpO2
- Identify factors affecting the pain experience

- Identify and demonstrate a pain assessment (OPQRSTUV)
- Document a set of vital signs and a pain assessment, with and without a paper form, using appropriate terminology

In preparation

Prior to Class

- Feel and count your own pulse under a variety of conditions: when you first wake up, when you're excited, tense, and so on. After counting your pulse several times, you may begin to see a "norm" for your resting pulse. How does this compare to the norms listed in your text?
- Many drugstores have machines to measure blood pressure. Measure your own blood pressure in the drugstore. As with your pulse, compare it to the "norms" listed in your text. What do you make of the differences, if any?
- While you're in the drugstore, count the number of tools for measuring temperatures. Were there any surprises for you? How many devices did you find?

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 29: Body Temperature (pp 629-637)
- Chapter 29: Pulse (pp 637-645)
- Chapter 29: Respirations (pp 648-651)
- Chapter 29: Blood Pressure – starting with factors that affect BP (pp 651-662)
- Chapter 29: Oxygen Saturation (pp 662-664)
- Chapter 30: Factors Affecting the Pain Experience (pp 676-679)
- Chapter 30: Pain Assessment- up to "Diagnosing" (pp 679-685)

Module 6: Priority Assessment

Overview

On your first orientation day, you are familiarizing yourself with the unit when a family member appears at the door of a room and calls you for help. You go into the room and find a pale and agitated patient and a very panicky family member. You have no idea who this patient is or what is wrong. There is no one else around…anyone! What would you like to do? How do you feel?

We have a basic physiologic "fight or flight" response that is designed to protect us when our body perceives a threat. Well, our body considers lots of things to be threatening, and performance anxiety is one of those things. When this very sympathetic response is stimulated, it is designed to send oxygenated blood away from the organs that it considers to be least important to send it to the ones that it thinks are most important. Unfortunately, the part of your brain that you use to think is not considered to be a priority organ. That explains a lot of things like how you think and act in crisis; how we all think and act in crisis. This sets the stage for critical clues to be missed in the ensuing chaos and errors in judgment to be made. When a clinical crisis occurs, you want to know that you have the skill to identify potentially life-threatening conditions quickly and accurately and intervene appropriately. This is not an easy task. The more pressured the situation and the more anxious the player, the less anyone is able to think clearly and respond effectively.

As a novice student nurse, you are probably acutely aware of your limitations and may have a few anxieties about your ability to perform in the clinical area…maybe more than a few? The priority assessment is the first step in your patient assessment for this very reason. This assessment is designed to help you quickly and accurately determine whether your patient is unstable and you need to get immediate help. It is the ABCDE (airway, breathing, circulation, disability & discomfort and equipment) of patient assessment. You will build on this assessment as you learn more, and you will eventually have the knowledge and skills that will prepare you to intervene. It will provide you with a tool to help you navigate the minefield of thinking and performing when the pressure is on.

The priority assessment is quick, easy and dependable. In order for it to be useful for you, you need to use it **each and every time** you approach a patient in acute care, complex care or their home; and each and every time you feel a bit unsure about what is happening with your patient. This is the assessment that will keep you focussed on what you really need to know. Be patient with yourself. It will take time for you to become proficient and understand what it is all about, but it will become you and your patient's best safety tool.

The priority assessment is the ABCDE of patient assessment and is sometimes referred to as the "primary survey," because it should always come first.

Learning Outcomes

Learners will:

- Discuss the purpose of performing a priority assessment.
- Explain the distinct parts of a priority assessment, ABCDE (airway, breathing, circulation, disability & discomfort and equipment).
- Demonstrate a priority assessment.

After learning how to perform a priority assessment in the lab, you will be expected to apply it each and every time you have a simulated patient encounter in subsequent lab classes.

In Preparation

Review the Priority assessment algorithms outlined on the following page.

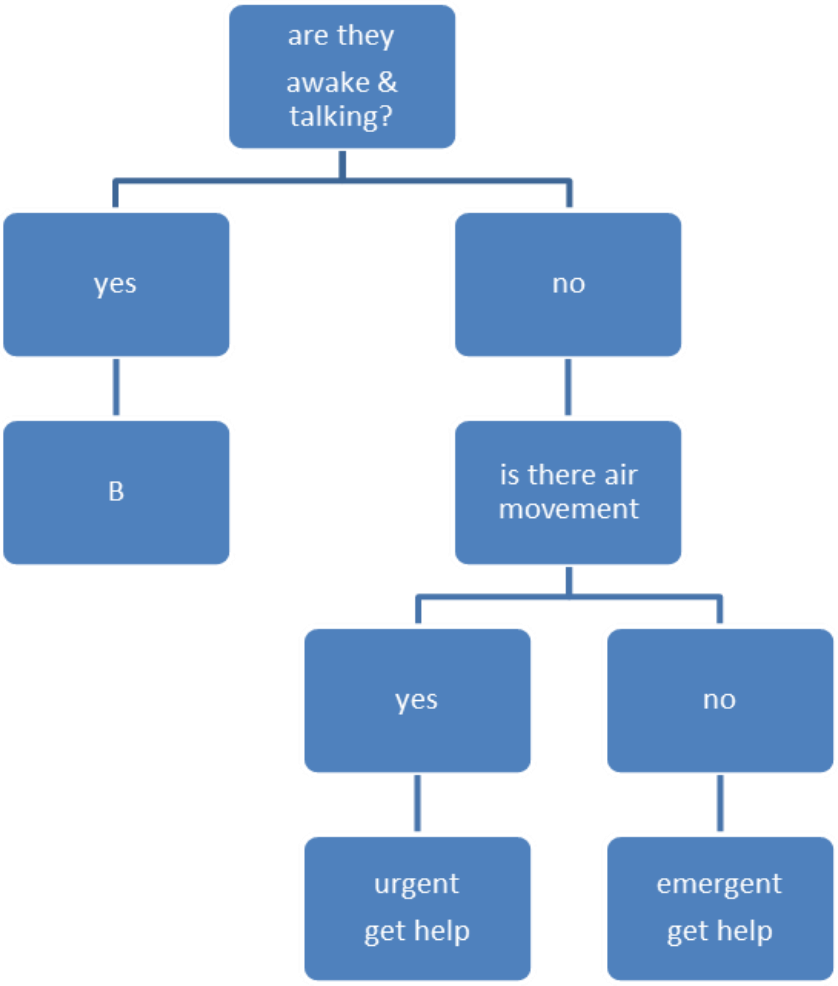
Required Readings:

Considine, J., & Currey, J. (2015). Ensuring a proactive, evidence-based, patient safety approach to patient assessment. *Journal of Clinical Nursing, 24*(1/2), 300-307. doi:10.1111/jocn.12641
(Posted to D2L)

Priority Assessment

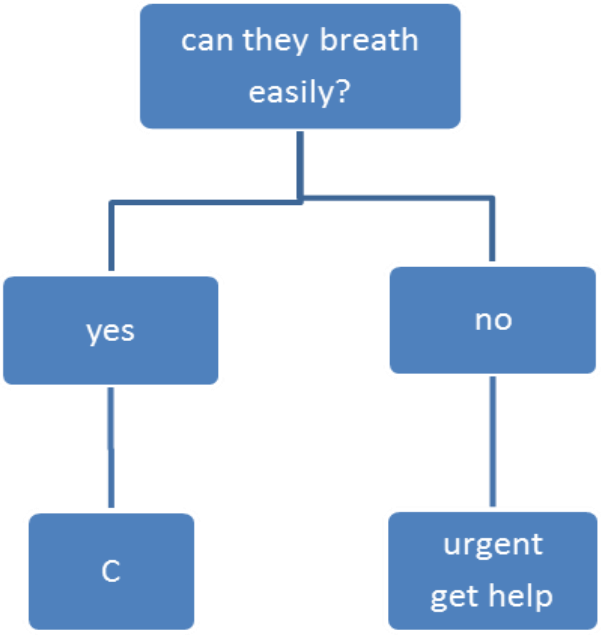
Because the priority assessment helps you recognize when someone is unstable, it also includes appropriate interventions when something critical is identified.

A Airway – do they have a patent airway?



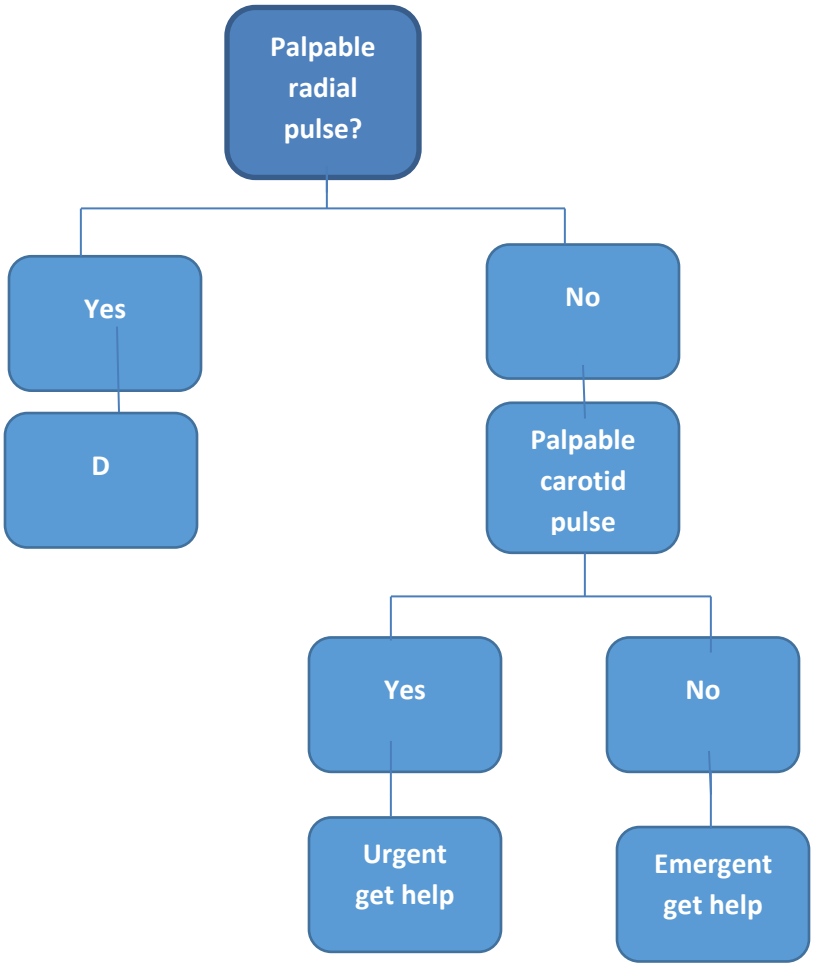
- What would you need if there was a problem?
- Do you know where to get it?
- Would you know what to do?

B Breathing – can they oxygenate?



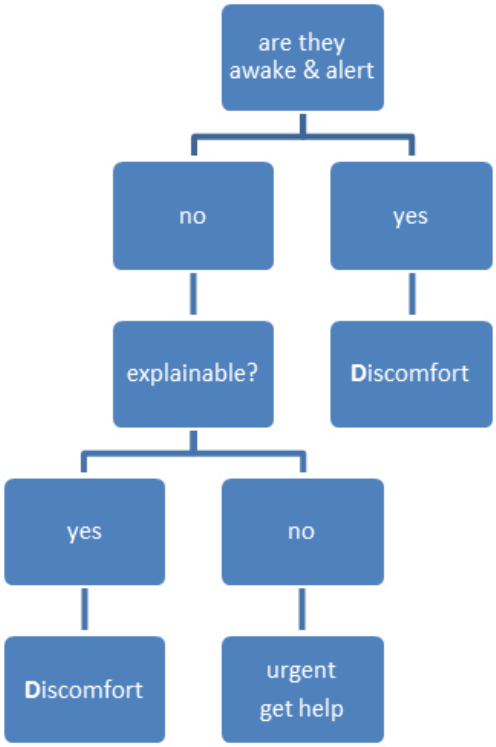
- What would you need if there was a problem?
- Do you know where to get it?
- Would you know what to do?

C Circulation – do they have adequate blood flow?

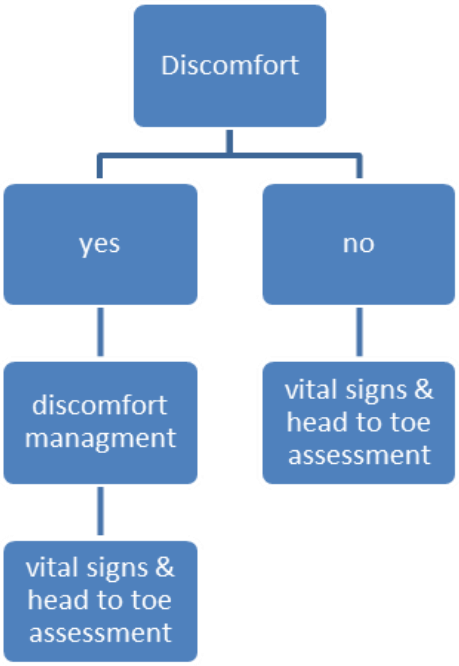


- What would you need if there was a problem?
- Do you know where to get it?
- Would you know what to do?

D Disability – is their mentation altered?



D Discomfort – do they have discomfort



E. Equipment

- What is there? Is it appropriate? How does it look**?**
- Do you know how to use it?

Assessment Summary

General Survey

Subjective Data	Objective Data
Presenting complaint • **OPQRSTUV** **Past medical history** • **Family history** • **Risk factors** **Medications** • **Immunizations** **Allergies**	**Priority Assessment** • **ABCDE**

Remember that the priority assessment contains the most critical patient information. Making this assessment second nature will allow you to use it when the situation becomes chaotic and your mind clouds over. If you are ever in a situation where you are unsure of what is going on with your patient, a quick priority assessment will tell you that your patient is stable or if you need to get help now.

*Just because your patient is awake and talking does **not** mean that they are stable. In order for your priority assessment to be useful, it must be thoughtful. Think through every step as you go and make sure you are prepared. It takes time to develop but it is well worth it.*

Module 6: Priority Assessment
Contributing Resources

College of Registered Nurses of British Columbia. (2012), *Professional standards for registered nurses and nurse practitioners*. Retrieved from CRNBC professional standards.

College of Registered Nurses of British Columbia. (2010). *Practice standards for registered nurses and nurse practitioners*. Retrieved from CRNBC practice standards.

Emergency Nurses Association. (2014). *Trauma nurse core course provider manual* (6th ed.).

Emergency Nurses Association. (2012). *Sheehy's manual of emergency care* (7th ed.). Missouri: Elsevier.

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

Mattox, K. et al. (2013). *Trauma* (7th ed.). Pearson: McGraw-Hill Education e-book.

Naydveh, D. (2009). *Nurse to nurse trauma.* (1st ed.) Pearson: McGraw-Hill Education e-book.

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

Sheppard, M. & Wright, M.(Eds.) (2005). *Principles and practice of high dependency nursing.* (2nd ed.). Toronto, ON: Elsevier.

Module 7: Head to Toe Assessment

Overview

At this point in time you have gathered a significant amount of patient information and you know that both you and your patient are safe and you can continue to collect more health assessment data. The next step is a quick and comprehensive head to toe patient assessment. A head to toe assessment is a data collection survey in which you are looking first, then feeling and listening to gather more data. This assessment is a standardized technique that you will use with every patient regardless of what you think might be the problem. The intent is to work your way from your patient's head to their toes, from the front to the back, making sure that you have covered enough ground so that you can confidently know that there are no other body systems that are of concern. It is sometimes referred to as a "secondary survey." If you find something of concern while you are completing this rapid survey, you will come back and perform a more detailed system assessment when you have finished. You will learn about these more detailed system assessments later in the course and into Nursing 143.

A head to toe assessment takes only a couple of minutes…eventually. Don't be discouraged if you take longer when you are beginning. It is more important that you focus on the quality of your assessment at first. Like any skill, once you get more comfortable with what you are doing, it will become quicker and more comprehensive. This only occurs with practice, practice, and more practice.

A thoughtful and salient head to toe assessment is a critical data collection tool that helps you make sure that you are covering all the assessment bases in an efficient and effective way. It can help you avoid **cognitive bias**. If you are unfamiliar with the term cognitive bias it is strongly suggested that you investigate this concept this week.

Learning Outcomes

Learners will:

- Describe the purpose of a head to toe assessment
- Identify the key components in a head to toe assessment
- At a beginning level, demonstrate a head to toe assessment
- At a beginning level, document a head to toe assessment using appropriate terminology

Assessment Summary

General Survey

Subjective Data	Objective Data
Presenting complaint • **OPQRSTUV** **Past medical history** • **Family history** • **Risk factors** **Medications** • **Immunizations** **Allergies**	**Priority Assessment** • **ABCDE** **Head to Toe Assessment** **(Focused Systems)**

In Preparation

Required Readings

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 29: Assessment of the Hospitalized Adult (pp 804-808)

While you are going through these readings, think about how you might perform these assessments moving smoothly from head to toe. Some of what is included under each system is actually part of a more detailed system assessment. Keep coming back to this as you move through the system assessments and decide what you would like to include in a head to toe assessment and what is a more focused system assessment that you can come back to. To make this decision, you will need to ask yourself how important the assessment finding might be. Is this information that you would want to know sooner than later? These are decisions that you will make as you move through the assessment content and beyond.

A couple of tools are included for you to review before your class. These are examples of an approach to head to toe assessment. You will undoubtedly come across many others. Start developing a tool that works for you.

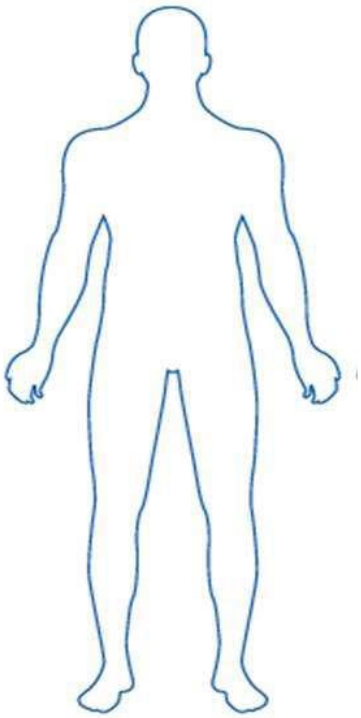
Head to Toe Assessment			
Head	Look	All scalp & face surfaces including eyes and ears	Any abnormalities
		Inside mouth	Any abnormalities Hydration
	Feel	Any areas of concern	For tenderness, swelling or abnormal movement
		Temporal mandibular joint (TMJ) as patient opens mouth	For tenderness or restricted range of motion
	Listen	Speech	Any abnormalities
Neck	Look		Any abnormalities
	Feel	Carotid pulse (one side at a time)	Presence & equality
Arms	Look	Front & back	Any abnormalities Condition of any line insertion sites
	Feel	Front & back	Tenderness, swelling, temperature
		Radial pulses bilaterally	Presence and equality
		Strength (lift hands against resistance) bilaterally	Strength & equality
		Capillary refill (thenar eminence of the thumb) bilaterally	Briskness & equality
Chest	Look	Anterior & lateral surfaces	Any abnormalities
	Feel	Rib cage	Bilateral chest expansion Tenderness on compression
	Listen	Lungs fields - 5 places • RULF, LULF, RLLF, RLLF • Right axillary line	Breath sounds Adventitia
Abdomen	Look	Anterior & lateral surfaces Perineum	Any abnormalities
	Listen	Bowel sounds RLQ	Presence
	Feel	Have patient push belly out and suck it in first (if it is too painful for them to do this, do not palpate)	Tenderness
Legs	Look	Front & back	Any abnormalities
	Feel	Front & back	Tenderness, swelling, temperature
		Pedal pulses bilaterally • Femoral • Posterior tibial, Dorsalis pedis	Strength & quality from side to side
		Strength (dorsi & plantar flex against resistance) bilaterally	Strength & equality
		Capillary refill (toes) bilaterally	Briskness & equality
Back	Look	Anterior & lateral surfaces	Any abnormalities
	Percuss	Costovertebral angle	Tenderness
	Consider starting focused respiratory assessment at the back if indicated		

Head to Toe Assessment

HEAD
- **look**
  - head
  - face
  - nose
  - eyes
  - mouth
- **feel**
  - TM joint
- **listen**
  - orientation

NECK
- **look**
  - jugular veins
- **feel**
  - carotid pulse

ARMS
- **look**
- **feel**
  - skeletal integrity
  - tenderness
  - radial pulses
  - capillary refill
  - arm strength



CHEST
- **look**
- **feel**
  - chest cage
- **listen**
  - breath sounds x 5

ABDOMEN
- **look**
  - shape and contour
  - perineum
- **listen**
  - bowel sounds RLQ
- **feel** (spontaneous wall mov't prior)
  - softness
  - tenderness

LEGS
- **look**
- **feel**
  - skeletal integrity
  - tenderness
  - pedal pulses
  - leg strength

BACK
- **look**
- **feel**
  - CV angle tenderness

Remember that a head to toe assessment is a process of rapid data collection. It is not simply putting a series of focused system assessments into a head to toe format. Make sure you don't get distracted by things you find. If you find something, come back and do a complete assessment of the system that may be involved. You will learn about these more detailed assessments over the course of the next year and beyond. When you proceed with your head to toe assessment, you already know that your patient is stable; your priority assessment told you that. Repeat your priority assessment anytime you need to reassure yourself that your patient is stable.

Module 8: The Integument System
Part 1: Assessing the Integument

Overview

The integument system consists of the skin, hair, and nails. The skin is the largest and most visible organ of the body. It covers 1.86 square metres of surface area in the average adult (Jarvis, Browne, MacDonald-Jenkins & Luctkar-Flude, 2014). The accessibility of this system makes it the easiest of all systems to assess. The skin, hair, and nails provide valuable clues about the health of other body systems. A thorough assessment of the integument may help you determine the health not only in the skin but also in underlying systems (Dillon, 2007).

Learning Outcomes

Learners will:

- Describe how developmental changes affect the client related to the integument system; including structure and function of this organ throughout the lifespan
- Identify the key subjective data related to an integument, hair and nails assessment
- Identify the key objective data related to an integument, hair and nails assessment
- Identify normal and begin to recognize abnormal findings in regards to an integumentary assessment
- Demonstrate the ability to perform an integument, hair and nails assessment
- Explore how this assessment relates and links to various other systems assessments
- Document findings using appropriate terminology and format

Required readings

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 13: Skin, hair and nails (pp. 219-247)
- Abnormal Findings (Look at for reference only) (pp. 248-267)

Optional readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 28: The integument (pp. 547-555)

Reference

Dillon, P. (2007). *Nursing health assessment* (2nd ed.). Philadelphia, PA: FA Davis Company.

Module 8: The Integument System
Part 2: Skin Integrity Preventive Measures & Introduction to Pressure Injuries

Overview

Clients with various health challenges may experience difficulties maintaining skin integrity, which as a result may lead to development of various types of acute and chronic wounds. One example of chronic wounds are pressure injuries (formerly called pressure ulcers, decubitus ulcers or bedsores), which threaten clients with restricted mobility, chronic diseases and older population. Even though pressure injuries are costly health implication for patients, families and to the health system, they are preventable.

A key action for preventing skin breakdown is a thorough and frequent integumentary assessment. Maintaining hydration and good nutritional status are key considerations for promoting a healthy integumentary system in addition to frequent and safe repositioning and turning. It is also important to utilize risk assessment tools such as the Braden Scale.. This assessment is particularly important when caring for clients in a hospital setting, as they are even more vulnerable to infectious agents (Kozier et al., 2018).

Learning Outcomes

Learners will:

- Discuss the intrinsic and extrinsic factors that influence skin integrity
- Be introduced to types of wounds
- Discuss the etiology of pressure injuries and the risk factors
- Discuss the categories/stages of pressure injuries
- Explore ways to prevent pressure injuries
- Conduct an integument assessment with a focus on assessing common pressure sites while utilizing the Braden Scale

In Preparation

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 35: Skin Function and Integrity - including “Continuity of Care” and “Teaching/Clinical - Skin Integrity” Boxes on p. 932 (pp. 931-932)
- Chapter 35: Pressure Injury (pp. 966-975)

Review the following videos

Pressure Ulcers: Prevention, Care and Management
Retrieved from: http://www.youtube.com/watch?v=rAMzhcbtHJY&feature=related

Skin Integrity and Pressure Ulcers - VEA Australia and New Zealand
Retrieved from: https://www.youtube.com/watch?v=OV_SrthUsC0

Extra Resources

The National Pressure Ulcer Advisory Panel (NPUAP) Educational and Clinical Resources
Retrieved from: https://www.npuap.org/resources/educational-and-clinical-resources/

Module 9: The Musculoskeletal System
Part 1: Musculoskeletal Assessment

Overview

Being able to move with ease is important to ensure independence and optimum health. Walking for example, requires smooth co-ordination of strength, balance, and position. It is important for nurses to understand these dynamics; and competently assess patients' mobility, gait, weight-bearing ability, muscle strength and joint flexibility. This assessment supports decision making regarding the client's activities of daily living, their need for medications and their exercise requirements. In collaboration with the health care team, nurses play a pivotal role in maximizing patients' activity. Nurses must assess the environment and the client to ensure safe movement for themselves and others.

Learning Outcomes

Learners will:

- Identify the components of the musculoskeletal system (bones, joints and muscles)
- Describe the functions of the musculoskeletal system
- Describe the role of diet, exercise and nutritional supplementation, age, culture and context in maintaining musculoskeletal health including preventing osteoporosis
- Describe how developmental changes affect the musculoskeletal system
- Identify the key subjective data related to a musculoskeletal assessment
- Identify the key objective data related to a musculoskeletal assessment
- Identify normal and begin to recognize abnormal findings in regards to a musculoskeletal assessment
- Describe the significance of Range of Motion (ROM) exercises and differentiate between passive and active ROM
- Demonstrate the ability to perform a musculoskeletal system assessment including joints, range of motion, muscles, bones, and activities of daily living (functional assessment)
- Document assessment findings using appropriate terminology and format

Required Readings

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 24: Musculoskeletal System, Omit Muscle testing (pp. 599-64)
- Abnormal Findings, Look at for reference only(pp. 642-654)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 39: Physical Exam - Body Alignment, Gait, Appearance and Movement of Joints (pp. 1080-1081)
- Chapter 39: Providing Range-of-Motion (ROM) Exercises (pp. 1106-1108)

Prior to Class

- Think about your own mobility, movement and exercise. How will you maintain musculoskeletal health with the challenges you will find in nursing practice?
- How might the nurse's own values, beliefs and personal meaning around activity influence the assessment of another's activity? How do we deal with this as nurses?
- Find a youtube video of joint movement and all the muscles involved.
- Notice when you are walking or running how many muscles and joints are involved.

Module 9: The Musculoskeletal System
Part 2: Safe Movement and Patient Handling

Overview

In this class learners will explore the use of proper body mechanics and ergonomics. Body mechanics can be described as the proper or most efficient way to perform daily activities that are safe, energy conserving, and help prevent the physical strains that may cause injury. Using proper body mechanics helps prevent back problems, decreases the stress and strains of everyday life, preserves the natural curves in our backs and protects our back's ligaments and muscles. Sooner or later, the lack of proper body mechanics will result in back problems.

Ergonomics refers to the relationship between workers and their working environment. In order to ensure safety and reduce the risk of musculoskeletal injuries (MSI), the work environment needs to be suited to the workers and the work being performed. This includes such things as the physical demands of the work as well as the physical design of the workspace (e.g. computer stations) and the layout of rooms and furniture (e.g. space at a client's bedside and hallway design).

Nurses use knowledge of the principles of body mechanics and mobility to assist in turning, positioning, lifting and transferring patients. Position changes and mobility are crucial to the client's well-being. Proper techniques ensure comfort and safety for the client and the nurse. Co-ordination with the multi-disciplinary team may be required to complete these tasks safely.

Learning Outcomes

Learners will:

- Identify the important components of STABLE
- Practice the principles of safe body mechanics
- Explore how safe body mechanics are utilized in your everyday life as well as in nursing practice
- Examine the ergonomics of learners home, work and health care environments
- Demonstrate proficiency and safety for the following skills
    - Turning and positioning of patients
    - Safe transfers between bed and chair/wheelchair/stretcher
    - Use of assistive equipment such as mechanical lifts- SARA, MAXI and overhead ceiling ANGEL LIFTS

Required Readings

Island Health (IH) (n.d.). *STABLE – Tips to Reduce Injury handout* (pdf). Retrieved from www.viha.ca (provided on following page)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 39: Using Body Mechanics (pp. 1084-1089)
- Chapter 39: Positioning Clients (pp. 1088-1093)
- Chapter 39: Moving and Turning Clients in Bed (pp. 1093-1100)
- Chapter 39: Transferring Clients (pp. 1100-1106)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 11: Safe Patient Handling, Transfer, and Positioning (pp. 271-290)

STABLE

STABLE Tips to Reduce Injuries

S **Maintain the natural curves of your Spine**

Butt out, Chest up, Eyes forward.

T **Avoid Trunk Twisting**

Point your toes in the direction you're reaching.

A **Keep your Arms in close**

Elbow in and Elbows Down.

B **Use a wide Base of support**

Feet shoulder width apart, one foot a half step forward - Staggered Stance.

L **Use your Legs**

Knees and Hips should move the most, arms and trunk stay fixed in position.

E **Evaluate the Load, Environment and Yourself**

Set up first and choose the safest method.

TIPS TO SAFE LIFTING

- When standing in one position, try to keep **one foot up** on a step or shelf
- **Lift one leg up behind** when bending over into bins or when having to reach beyond arm's reach
- When possible do all tasks in the **golden zone** around waist height as close to your body as possible
- Keep elbows close, pretend that there are **$100 bills** in your armpits
- Take **microbreaks** (< 10 seconds) throughout the day to stretch (arch back)
- Remember to **move feet** to avoid twisting your trunk, **toes and nose** should point in the same direction
- **Use your legs** when lifting, by gently flexing your knees and squeezing/contracting the posterior leg muscles as you rise

Retrieved from https://intranet.viha.ca/safety/Documents/stable-poster.pdf

Module 9: The Musculoskeletal System
Part 3: Assisting with Mobility

Overview
Building on the knowledge gained from Part 1 & 2 of Module 9, we continue to consider assessments of patients' mobility, gait, weight-bearing ability, muscle strength and joint flexibility. The information gathered during the assessments will assist the nurse in knowing the safest and most appropriate mobility requirements for the client. This may include some sort of mechanical lift. This may also include assisting clients to safely maintain mobility through the use of ambulation aids for walking. Bandages and binders are used to support and immobilize challenged extremities as well promote healing, aid comfort and prevent further injury (Kozier et al., 2018).

Learning Outcomes
Learners will:

- Demonstrate proficiency in assisting a client with mobility including the use of use mechanical aids to support ambulation (walkers, canes and crutches)
- Demonstrate proficiency in the use of applying elastic antiembolism stockings, compression tensor bandages and slings
- Document assessment of mobilization using correct terminology

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 35: Compression Bandages & Binders/Slings (pp. 957-961)
- Chapter 36: Antiembolism Stockings (pp. 995-997)
- Chapter 39: Ambulating Clients (pp. 1109-1111)
- Chapter 39: Using Mechanical Aids for Walking (pp. 1111-1118)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 12: Applying Elastic Stockings, Procedural Guideline 12.3 (pp. 306-308)

Prior to Class

Think about a time when your mobility was restricted. How did it make you feel?
How is circulation affected by decreased mobility? Observe people around you and identify positions that may cause poor circulation. Begin to think about factors that may be affecting their mobility.

Module 10: Personal Care

Overview

Activities of daily living (ADLs) include personal care activities carried out independently and in private, including bathing, toileting, grooming the hair, mouth, nails and dressing. Assisting with basic hygiene means that nurses collaborate with clients to assess support required, personal preferences and ways to maximize remaining capabilities. Nurses need to consider the client's personal meaning when performing intimate personal care. It is also important for the nurse to be aware of their own feelings and attitudes towards providing personal care.

Learning Outcomes

Learners will:

- Discuss factors that affect personal hygiene and identify appropriate assessments to consider
- Identify how to provide comfort measures, and maintain client dignity and safety while performing personal care
- Review the relationship between body hygiene and skin integrity
- Identify specific factors to consider when performing personal care, such as principles of asepsis
- Discuss and consider client personal hygiene practices as well as review various agents and products used for skin care and hygiene
- Correctly assess and identify your client's need of assistance and implement the appropriate action
- Identify other assessments that could be done while performing personal care
- Practice performing a bed bath (practice on the infant dolls, adult mannequins, and each other)
- Practice performing peri-care on a mannequin
- Practice performing peri-care on a mannequin with an indwelling catheter
- Practice performing oral hygiene and hair hygiene care (practice on the infant dolls, adult mannequins, and each other)
- Practice using urinals, commodes and bedpans
- Practice getting each other dressed (shirt, pants, sweater, socks and shoes)
- Practice brief changes on the dolls in lab (adult and baby), and/or each other
- Change linen on an occupied bed
- Change linen on an unoccupied bed
- Document findings using appropriate terminology and format
- Explore therapeutic benefits of providing gentle massage to clients
- Practice performing a hand massage on each other

Required Readings

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 31: Overview (pp. 710-713)
- Chapter 31: Bathing, including Practice Guidelines 31.1 and Skills 31.1, 31.2, 31.3 (pp. 713-730)
- Chapter 31: Care of teeth and mouth, including dentures and Skills 31.4 and 31.5 (pp. 730-738)
- Chapter 31: Brushing and Combing Hair, including Skill 31.6 (pp. 740-741)
- Chapter 31: Making Beds, including Table 31.6, Practice Guidelines 31.2, and Skills 31.9 and 31.10 (pp. 751-757)
- Chapter 41: Use of commode and bedpan, including positioning and Practice Guidelines 41.1 (pp. 1201-1204)
- Chapter 42: Urinals, see Figure 42.5 and 42.6 (pp. 1229)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). Clinical nursing skills & techniques (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 34: Implementation # 8 & # 9 Catheter Care (p. 889, including STEP 8f (1) p. 890).
- Chapter 16: Cutaneous Stimulation: Massage (p. 413)

Prior to Class

Video:

Massage Therapy: Awesome Hand Massage Techniques
Retrieved from: https://www.youtube.com/watch?v=2KMX4T1NQd8

Think of how you awoke today and carried out basic hygiene. Imagine you had not been able to do this for yourself. What would you want a caregiver to know to be able to assist you?

How will you ensure privacy, choice, respect, and safety is maintained while providing personal care?

Review Module 1 - Infection Control Practices & Precautions, including hand hygiene and the use of PPE.

Module 11: Head and Neck Assessment

Overview

Facial expressions and eyes are one of the first things we notice about others, reflecting emotions, well-being and general state of health. This module consists of assessing the head, neck, eyes, ears, nose and throat. Application and care of eye glasses and hearing aides will also be included.

Learning Outcomes

Learners will:

- Describe how developmental changes affect the head, neck and eyes, ears, nose, throat (EENT) throughout the lifespan
- Identify the key components of a head, neck and EENT assessment
- Identify the key subjective data related to a head and neck and EENT assessment
- Identify the key objective data related to a head and neck and EENT assessment
- Identify normal and begin to recognize abnormal findings in regards to a head, neck and EENT assessment
- Discuss how to care for hearing aids and glasses
- Demonstrate the ability to perform a head, neck and EENT assessment
- Practice putting on and taking off hearing aids and glasses
- Document findings using appropriate terminology and format

Required Reading

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 14: Head and Neck, omit thyroid gland (pp. 269-288)
- Chapter 15: (Eyes pp. 295-310, 312-313, 318-328)
- Chapter 16: (Ears pp. 341-359)
- Chapter 17: Nose, Mouth, Throat (pp. 368-380, 382-393)
- Review Abnormal Findings for reference only (pp. 289-294,328-337, 360-367 394-402)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 31: Hearing Aides (pp. 747-750)
- Chapter 31: Eyeglass Care Only (p. 745)

Module 12: Gastrointestinal Assessment
Part 1: Assessment

Overview:

Ideally food and fluids enter the gastrointestinal tract by the mouth and are broken down in the intestinal tract. Nutrients are absorbed and the remaining contents are expelled through the anus. This process of digestion creates building blocks crucial for all body systems to function. Nurses must understand this system and how to recognize abnormalities. Bowel habits vary among individuals and many contextual and cultural factors may influence the client's perceptions and routines. Privacy and dignity are key components of nursing care. Nurses use their assessment process to gather information needed to make care decisions.

Learning Outcomes

Learners will:

- Identify anatomical landmarks that guide a gastrointestinal assessment.
- Identify the key subjective data related to a gastrointestinal assessment.
- Identify the key objective data related to a gastrointestinal assessment.
- Describe the different assessment techniques of inspection, auscultation and palpation required for a gastrointestinal assessment.
- Demonstrate the ability to perform a gastrointestinal assessment.
- Identify the significant differences between an adult, pediatric/ infant and older adult abdominal assessment.
- Describe the role of diet, exercise, nutritional supplementation, age, culture and context in maintaining gastrointestinal health.
- Identify normal and begin to recognize abnormal findings in a gastrointestinal assessment.
- Identify factors that influence fecal elimination and patterns of defecation.
- Discuss measures that promote regular defecation.
- Demonstrate the ability to collect stool specimens for occult blood, Clostridium difficile (C-diff), ova and parasites.
- Document and communicate data from the gastrointestinal assessment using appropriate terminology and principles of recording.

In Preparation

Required Reading:

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 22: The Abdomen (pp. 546-560)
- Chapter 23: Anus, Rectum and Prostate (pp. 583-590)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process and practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 41: Fecal elimination (pp.1183-1201)
- Chapter 42: Collecting stool specimens (pp.1195-1197)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). Clinical nursing skills & techniques (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 43: Measuring Occult Blood in Stool, Skill 7.2 (pp. 175-177)

Module 12: Gastrointestinal Assessment
Part 2: Ostomy Management & Changing of Ostomy Bag

Learning Outcomes

Learners will:

- Demonstrate empting an ostomy pouch
- Demonstrate changing an established ostomy appliance, including the flange
- Recognize when an ostomy pouch needs to be emptied
- Document changing of an established ostomy pouch using appropriate terminology and principles of recording

In Preparation

Required Reading

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 41: Ostomy Management - include Skill 41.2(pp. 1210-1214)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). Clinical nursing skills & techniques (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 36: Ostomy Care – including Skill 36.1 but NOT Skill 36.2 (pp. 931-938)

Module 13: Nutritional Assessment
Part 1: Assessment

Overview:

Nutritional health is a crucial component of overall health across the lifespan. The determination of an individual's nutritional status is based on the foundation of a thorough nutritional assessment. The assessment portion of the nursing care process incorporates the gathering and interpretation of data often used as part of a nutritional assessment. These data then create the base for later development of appropriate nursing and nutritional interventions aimed at preserving or improving nutritional health.

Learning Outcomes

Learners will:

- Define nutritional status
- Outline factors that influence nutritional health
- Review the essential nutrients found in food that are required for growth and body maintenance
- Explain the essential aspects of energy balance
- Explore a food's glycemic index and the glycemic index approach
- Discuss developmental, social, cultural and religious factors affecting the nutritional status of patients
- Identify the components of a diet history and techniques used for gathering diet history data
- Identify the key subjective data related to a nutritional assessment
- Identify the key objective data related to a nutritional assessment
- Identify physical and laboratory parameters used in a nutritional assessment
- Identify normal and begin to recognize abnormal findings in a nutritional assessment
- Describe nutritional assessment techniques and tools appropriate for the different stages in the lifespan.
- Discuss nutritional variations and needs throughout the lifespan
- Explore the current standards for a healthy diet as outlined by Eating Well by Canada's Food Guide
- Identify appropriate meals for patients to receive and review special diets
- Explore nursing interventions and teaching strategies to promote nutritional continuity of care and nutritional wellness of clients
- Document and communicate data from nutritional assessments using appropriate terminology and principles of recording

In Preparation

Required Reading:

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

- Chapter 12: Nutritional Assessment and Nursing Practice (pp. 197-217)

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 40: Nutrition (pp.1204-1232 & 1236-1240)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 31: Oral Nutrition (pp. 819-826)

Module 12: Gastrointestinal Assessment
Part 2: Providing Nutritional Assistance

Learning Outcomes

Learners will:

- Understand the different special diets.
- Identify symptoms of an individual who has swallowing difficulties.
- Recognize which clients may be at risk for aspiration.
- Demonstrate the ability to assist a client with oral nutrition.
- Identify the levels of liquid foods and levels of semisolid or solid foods for dysphagia diets.
- Demonstrate the ability to assist a client with oral nutrition who is a swallowing alert.
- Demonstrate the use of a yankauer for oral pharyngeal suctioning.
- Recognize when a client needs oral pharyngeal suctioning.
- Document nutritional intake and swallowing using appropriate terminology and principles of recording.

In Preparation

Required Reading:

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

- Chapter 40: Assisting with Special Diets (pp.1159-1161)
- Chapter 40: Assisting Patient with Meals, including Box 40.1 & Box 40.2 (pp.1161-1162)

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

- Chapter 25: Performing Oropharyngeal Suctioning – Skill 25.1 (pp. 674-677)
- Chapter 30: Assisting an Adult Patient with Oral Nutrition (pp.826-837)

Nursing 142 Course Package Contributing Resources

Beckett, A., Gilbertson, S., & Greenwood, S. (2007). Doing the right thing: Nursing students, relational practice, and moral agency. *Journal of Nursing Education, 46*(1), 28-32.

College of Registered Nurses of British Columbia (2010a). *Professional standards for registered nurses and nurse practitioners*. Publication number 128.

College of Registered Nurses of British Columbia (2010b). *Glossary of terms.*

Dillon, P. (2007). *Nursing health assessment* (2nd ed.). Philadelphia, PA: FA Davis Company.

Donatelle, R., Davis, L., Munroe, A., & Munroe, A. (2001). *Health: The basics* (2nd Cdn ed.). Toronto, ON: Pearson Education Canada.

Duffy, J. D. (2009). Mirror neurons and the reenchantment of bioethics. *The American Journal of Bioethics-Neuroscience, 9*(9), 2-4.

Ekebergh, M., Lepp, M., & Dahlberg, K. (2004). Reflective learning with drama in nursing education - A Swedish attempt to overcome the theory praxis gap. Nurse Education Today, 24, 622-628.

Jarvis, C., Browne, A. J., MacDonald-Jenkins, J., & Luctkar-Flude, M. (2014). *Physical examination & health assessment* (2nd Cdn ed.). Toronto, ON: Elsevier Canada.

Kozier, B., Erb, G., Berman, A., Snyder, S. J., Frandsen, G., Buck, M., Ferguson, L., Yiu, L., & Stamler, L. L. (2018). *Fundamentals of Canadian nursing: Concepts, process & practice* (4th Cdn ed.). Toronto, ON: Pearson.

Panosky, D., & Diaz, D. (2009). Teaching caring and empathy through simulation. *International Journal for Human Caring, 13*(3), 44-46.

Perry, A.G., Potter, P.A. & Ostendorf, W. R. (2018). *Clinical nursing skills & techniques* (9th ed.). St. Louis, MO: Elsevier Inc.

Shearer, R. & Davidhizar, R. (2003). Using role play to develop cultural competence. *Journal of Nursing Education, 42* (6), 273-276.