NUR250 Medical Surgical Nursing 1
SS 2019

Before you begin NUR250 Assessment 1

It is strongly recommended that students revisit and ensure they understand the University and Unit policies and guidelines related to academic integrity, plagiarism, submission, extension, and late submission.

The Unit Coordinator cannot be held responsible for information about Assessment 1 that students' access outside of the NUR250 Learnline site.

This includes information students may access from other students, whether enrolled in the unit or not, using social media tools such as Facebook and/or friends and/or colleagues they may discuss their assignment with.

The Unit Coordinator is the person to contact if you have any questions or queries about Assessment 1

NUR250 Assessment 1

Topic: **Nursing care of a patient with a medical condition**

Due date: Week 6 Sunday 22nd December 2019 23:59 hrs ACST

Length: 2000 words ± 10%. Markers will stop reading at the maximum allowable word count. This word count includes the text in the template provided to you.

Contribution to overall grade: 40%

Assessment purpose	Learning objectives
Assessment 1 is the only written academic assignment in NUR250 for students to demonstrate they: • Are developing the ability to locate, interpret, integrate, synthesize and apply nursing knowledge from NUR250 to a relevant nursing practice scenario in medical surgical settings • Are developing appropriate critical thinking, clinical reasoning and sound clinical decision making processes and strategies essential for safe, evidence-based and competent nursing practice in medical surgical settings • Are able to focus their attention to the needs of the individual patient as the key concern of nursing practice in medical surgical settings • Are able to explain and justify or defend their nursing care decisions • Have a developing understanding of the role and scope of practice of the registered nurse in the Australian health care context • Are progressing towards the level of professional written communication required for nursing practice in Australia • Are demonstrating ethical and professional practice by adhering to the University's academic integrity standards and plagiarism policy	This assessment addresses the unit learning outcomes; 1, 2, 3, 4 and 5

Preparation

- Timely completion of study materials including weeks 1-6 with participation or review of online collaborate sessions, pre-recorded lectures or internal classes.

Presentation Guidelines

- On the Assessment 1 template located in the Assessment 1 folder on NUR250 Learnline
- As a computer generated document in Word format.
- 1.5 spaced using Arial or Calibri font in size 11 or 12
- In clear, coherent Australian English that demonstrates progression towards the standard for written communication for professional nursing practice in Australia.
- Written in third person narrative.
- Using appropriate professional terminology
- ***Contents page, title page, introduction and conclusion*** are ***NOT required***
- Unless otherwise indicated, no acronyms, abbreviations and/or nursing jargon
- Unless otherwise indicated, grammatically correct sentences and topic paragraphs are required. Dot points only accepted in the nursing care plan.
- No more than 10% over or under the stated word count. Marking will cease at the 10% over mark.
    - **Note:** Headings, any task information copied in and in-text citations ***are included*** in the word count. 100 words have been excluded from the word count to account for the headings within the nursing care plan template
- Use of trade names is not acceptable. Only generic terms or names are to be used when referring to specific medications or other prescribed treatments or resources that may be used in nursing practice

Referencing

Students are reminded of their academic responsibilities and professional nursing practice requirements when using the work of others in assignments.

Reminder marks are allocated for academic integrity. See the marking criteria for Assessment 1 for full details. Breaches of academic integrity will be lodged on the University system and may have serious consequences for students.

- All information is to be interpreted and restated in your own original words demonstrating your ability to interpret, understand and paraphrase material from your sources
- **CDU APA 6th** referencing style is to be used for both in-text citations and end of assessment reference list.
- All resources for NUR250 assignments should be from quality, reliable and reputable journals relevant to nursing practice and the Australian healthcare industry. Please DO NOT use patient information leaflets.
- All resources must be dated between **2010 and 2019**
- **There must be at least 10 peer-reviewed journal articles and/or evidence based practice guidelines cited in your assignment.**
- Do not use any health facility or local health service policies or procedures
- Only 1 current Australian medication textbook and 2 current Australian medical surgical nursing textbooks to be referenced.

Please complete the assessment task on the next page.

Assessment 1: Case scenario one

Shift handover:

Identify:	Mr Peter Jones, HRN: 123456**,** DOB: 26/03/1958
Situation:	Peter is a 61 year old Indigenous man from a remote community. He has been admitted to the CDU medical ward with chest pain. He has a 6/24 history of central crushing chest pain. His ECG shows that he has suffered from and inferior NSTEACS (NSTEMI).
Background:	Peter lives in a single story home with his wife, 4 children and 2 grandchildren. He is independent with his cares. He has an extensive past medical history including: T2DM, smoker (10 per day), HTN, hyperlipidaemia, rheumatic heart disease and mitral valve regurgitation. No known declared allergies (NKDA).
Assessment:	Airway: Own, patent Breathing: RR 22, Sats 94% on RA. Circulation: HR 96 bpm, BP 160/95 mmHg. Disability: GCS 15/15, 4/10 central chest pain, feels tired and a bit worried. Exposure: Temp 37.0 ^{o}C
Recommendations/Read back:	**Medical orders** • Repeat ECG • Pain management • TED stockings and DVT prophylaxis **Medication orders** <u>New medications:</u> • GTN sublingual spray 400mcg PRN • Oral paracetamol 1g QID • Aspirin 300mg STAT • Clopidogrel 300mg STAT <u>Usual medications:</u> • Metformin XR 1gm BD • Ramipril 10mg OD • Simvastatin 20mg OD

Assessment 1: Case scenario two

Shift handover:

Identify:	Mrs Rose Wilson, HRN: 123678, DOB: 19/02/1962
Situation:	Rose is a 57 year old Caucasian lady from Darwin. She has been admitted to the CDU medical ward with exacerbation of COPD. She has a 2/7 history of dyspnoea, productive cough and a fever.
Background:	Rose lives in a two story home with her husband. She is independent with her cares. She has a past medical history of: T2DM, smoker (20 per day), HTN, hyperlipidaemia and obesity. No known declared allergies (NKDA). She is obese (BMI 30) and drinks 1 bottle of wine every night.
Assessment:	Airway: Own, patent Breathing: RR 26, Sats 89% on RA. Circulation: HR 89 bpm, BP 160/95 mmHg. Disability: GCS 15/15, 2/10 sharp chest pain on inspiration Exposure: Temp 38.6 ^{o}C
Recommendations/Read back:	**Medical orders** • Chest X-ray ordered • Administer medications as charted • Pain management • TED stockings and DVT prophylaxis **Medication orders** <u>New medications:</u> • Oral paracetamol 1g QID • Ceftriaxone 1g BD • Amoxycillin 1g TDS <u>Usual medications:</u> • Metformin XR 1gm BD • Simvastatin 20mg OD • Salbutamol MDI 100 mcg PRN • Seretide MDI; 1 puff BD

Assessment 1 Tasks:

Choose from one of the patients handed over to you. Using the template provided in the Assessment 1 folder and, based on the handover you received at the beginning of your shift today, other information included below and current reliable evidence for practice, address the following tasks.

Task 1: Consider the patient

Based on the case scenario and in grammatically correct sentences:

- Define the patient's condition.
- Discuss the pathophysiology of the disease.
- How does the condition link with the patient's past medical history?

(Approximately 500 words)

Task 2: Care plan

Based solely on the handover you have received and using the **template provided**, complete a nursing care plan for your chosen patient. Your plan must address the physical, functional and psychosocial aspects of care.

Three (3) nursing problems have been provided for you. For each nursing problem on your care plan you need to complete the following sections:

- What it is related to?
- Goal of care
- Interventions
- Rationales for interventions
- Evaluation

Notes for Task 2 only

- Dot points and single line spacing may be used in the care plan template.
- Appropriate professional language must be used – legally recognised abbreviations may be used in this task (care plan) but a KEY with full terminology must be provided after the assignment references – key will be excluded from word count tally
- **All rationale must be appropriately referenced**

(Approximately 500 words)

Task 3: Patient education

Discharge planning

An important aspect of nursing practice is to effectively and succinctly communicate relevant information related to ongoing disease management or prevention of reinfection or deterioration on discharge.

Patient education and discharge planning starts on admission and you need to provide your patient with education during your shift in preparation for discharge home.

- Explain two (2) important points/topics you will need to include in the patient's preparation for discharge to aid healing and prevent further illness.

For each education point identified provide:

- One (1) strategy to assist the patient to implement the education into their daily routine.

(Approximately 500 words)

Task 4: Medication

- Choose two (2) medications that your patient has been prescribed (one (1) from their new medications list and one (1) from their old medications list) and discuss the following:
    - How does the medication work?
    - Why has your patient been prescribed this medication?
    - Are there any red flags/drug interactions that could affect the patient?
    - Use the clinical guidelines provided to support your claim.

(Approximately 500 words)

Your assignment must include a reference list after the completion of the tasks and a key if you have used abbreviations in task 2.

Criteria	5-7.5 Excellent	3-5 Satisfactory	0-3 Needs Development
Criterion: **Task 1: Consider the patient**	Explains clearly, succinctly and specifically the pathophysiology of the patient's disease, considering past medical history.	Explains the pathophysiology of the patient's disease, considering past medical history with some clarity.	Explains the pathophysiology of the patient's disease but the discussion is not clear and/or does not link to the case study.
Criterion: **Task 2: Care planning**	Develops individualised, comprehensive nursing care plan relevant to the case study using the clinical reasoning cycle. All rationale are referenced.	Develops individualised, comprehensive nursing care plan relevant to the case study using the clinical reasoning cycle. Most rationale are referenced.	Care plan has been completed using the clinical reasoning cycle but it is not individualised or comprehensive. There is a discourse between the sections of the care plan.
Criterion: **Task 3: Discharge planning**	Provides relevant and specific patient education discussing two topics with an implementation strategy.	Provides relevant patient education discussing two topics with an implementation strategy. Discussion is not specific or relevant for the patient.	Education is provided but it is not specific to the patient. No implementation strategy is identified.
Criterion: **Task 4: Medication**	Provides relevant and specific discussion about one or two medications. Drug interactions/adverse effects are discussed.	Provides relevant discussion about medications. Drug interactions/adverse effects are discussed. Discussion is not specific.	Provides a limited discussion about medications. Drug interactions/adverse effects are not discussed. Discussion is not specific to the case study.

Referencing	**5** All ideas supported with in-text citations and there is a complete and accurate reference list. No errors detected in CDU APA 6th format	**4** Most ideas supported with in-text citations and there is a complete and accurate reference list. A few errors detected in CDU APA 6th format	**3** Some ideas supported with in-text citations and there is a complete reference list. A few errors detected in CDU APA 6th format	**2** Many references are missing and there are many errors in CDU APA 6TH format	**1** No reference list provided or referencing not in CDU APA 6th format
Presentation	**5** No errors with grammar, syntax, sentence and paragraph structure. Assessment 1 Template used	**4** A few errors with grammar, syntax, sentence and paragraph structure. Assessment 1 Template used	**3** A large number of errors with grammar, syntax, sentence and paragraph structure. Assessment 1 Template used	**2** Many errors with grammar, syntax, sentence and paragraph structure. Writing lacks cohesion. Assessment 1 Template not used	**1** Writing is not clear. Assessment 1 Template not used