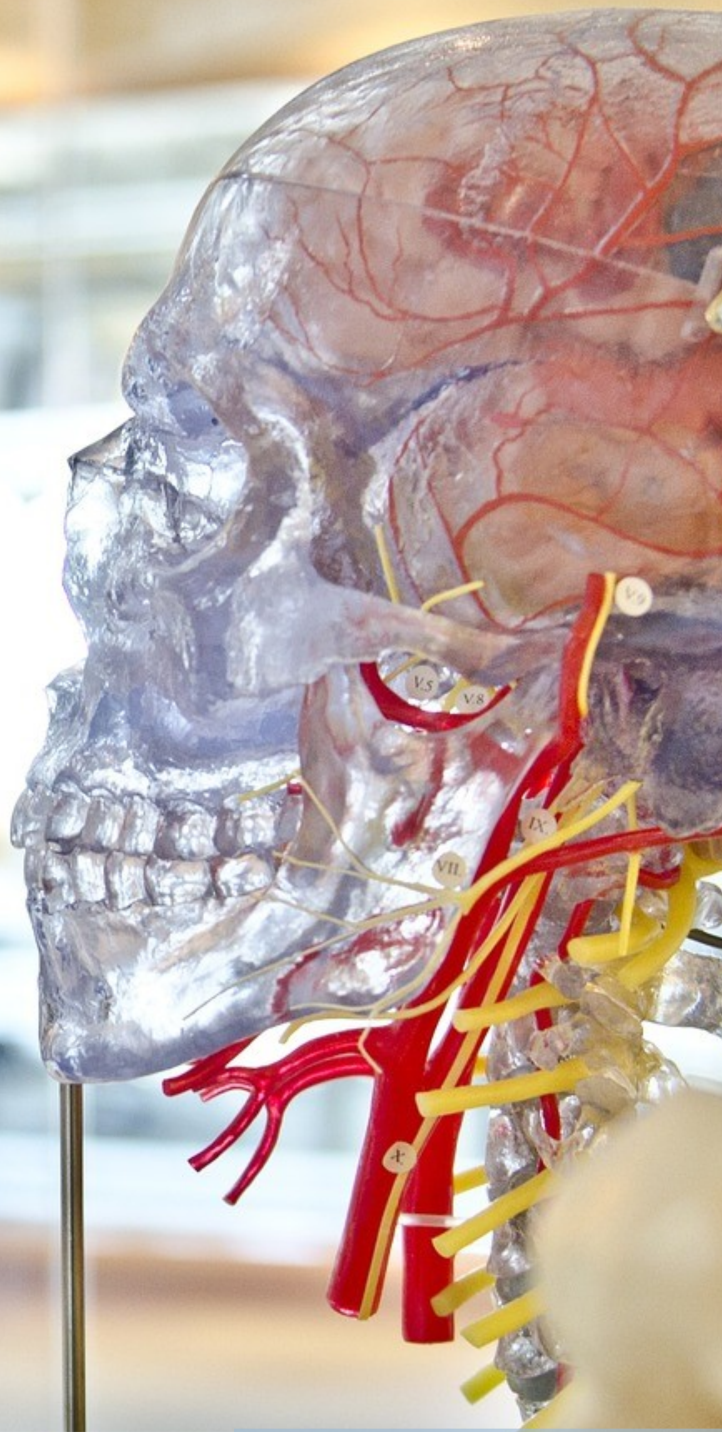
The Scoop of Practice



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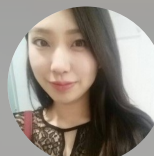

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https://thescoopofpractice.wordpress.com/about/

letter from the editor

Hello friends and readers,

I hope you are all enjoying your summer. I am excited to share with you the first issue of our BCIT Nursing Program's Student-Led Newsletter! I started this newsletter in the hopes of providing an information-sharing platform for students from different levels , as well as instructors, RNs, and other service providers . We are working to provide content on the latest news, research, events (such as conferences and workshops), and technology. In addition, we will be sharing personal experiences and profiling students from different levels of the nursing program as well as instructors and RNs, or other health care providers, from different fields. We will also be featuring guest writers.

This first issue introduces us to a personal experience from Terrelle in caring for a family member with Alzheimer's. The next article provides tips and free resources from someone who had just passed the NCLEX in her first try (congrats Jenny Lee!).

To those of you who are just starting nursing school or who need tips on prioritizing, Neila's article on Eisenhower's Matrix is a good, concise article to look over. If you are interested in adventures or rural nursing and having an all-expenses-paid experience, read up on Anita's article on the Healthcare Traveling Roadshow! Our final article, by Dr. Benjamin Y. Cheung of UBC Psychology, examines how people interpret genetic tests which urges you to consider the intersection between technology and giving appropriate care to patients. On the back of the issue you will find practice NCLEX questions—because that's what our nursing students are always curious about!

Enjoy the rest of your summer and happy reading! We'll see you again in the fall!

Louise Jingco
Editor-in-Chief
The Scoop of Practice

We want to hear from you!

What kinds of content and/or resources would you like to see in future issues of the newsletter?

Please contact us at:

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A Lesson on Love
A personal look into dementia

BY TERRELLE KLOSE

My grandma will always be my grandma; but Alzheimer's is a heck of a disease. I am writing this, not as a nursing student, but as a caregiver – one whose family has been slowly losing their loved one over the last 10 years. As nurses, we must always remember that no matter how frustrating our patients might be, they are still people that can be reached and that deserve dignity.

Over the years, I have seen 3 of my four grandparents pass away. The first of lung cancer, the second of COPD, and the third of a stroke. Of the pain and sadness these losses caused, my grandma with Alzheimer's, by far, scares me the most.

It started about 10 years ago and it started small. The occasional repeated question here, putting things in the microwave for too long there. As a family, we didn't know any better. We thought it was normal forgetfulness. Looking back there were so many clues that we should have seen but when it's so slow, and small, you just don't. You see, my grandma, though forgetful, was very strong. She walked miles per day while my grandpa sat at home, worrying about whether she would find her way home. But he was more afraid about what would happen if the rest of the family became aware about how bad it had gotten.

After my grandpa, her primary caregiver, passed away she moved in with my parents and the true severity of her disease became apparent. As time went on, like a tank with a leak, my grandma started to disappear. She would forget where she was, say she wanted to go home while at home, and think she had been on vacation when she hadn't. (At least if she couldn't remember where she was, she could think she had been for a lovely trip). You could see the spark in her eyes fade and with it so did she. Her time with my parents was taxing. She would wake and pack up thinking that she had to go home. My parents were sleep deprived from waking to coax her back to bed. She would need constant reminding that my grandpa wasn't around anymore and she would have tantrums like a toddler when we couldn't give her the freedom she wanted.

All the stress aside, she would smile, sing along to show tunes, insist on doing the dishes and helping with cleaning so that my mom could rest (even when it would all have to be redone after words). At times the spark would return. It's for this reason that my family will never regret the time that we spent with her.

Now, she's in assisted living. People can only do so much before safety becomes an issue. It was one of the hardest decisions my mom ever had to make. It is still hard. We constantly worry if the nurses are talking to her. Are they reminding her where she is? Are they telling her that we will come and visit? That it has only been 1 day since she's seen us even though it may feel like years to her? Even after half a year at her new home, it is hard not to break down when I picture her scared, thinking that we have forgotten and abandoned her.

We still visit often. We take her swimming, shopping, to church and out for dinner. We keep her chocolate supply plentiful since although she denies it, she loves her sweets and we provided a TV with old musicals for the nurses to play for her when she is restless. We try to bring out the spark as much as we can, knowing that as time goes on it will be there less. Her smile will be empty and her eyes confused. But as family, as caregivers, all we can do is keep trying to bring it back because deep down, she will be there and even if she doesn't remember our visits, while we were there she was happy.

I'm not writing this to make everyone sad. Just as a call to you to never forget, despite the frustration, the repeated questions, the resistance and the confusion, there is a person there. They love and are loved. Do not stop trying to locate the person within. Please be patient.

Getting ready for the NCLEX

The "I and O" of the exam that grants nurse licensure

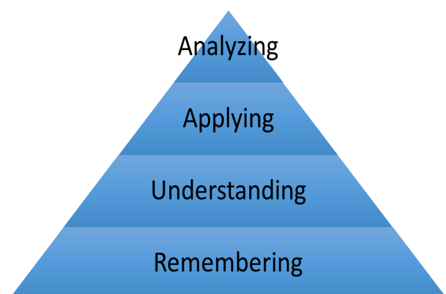
BY JENNY LEE

If you are a beginner nursing student, the NCLEX might be at the back of your mind. For students nearing the end of the program, it is looming in the not too distant future. The NCLEX-RN is the National Council Licensure Examination for the licensing of nurses in the United States and Canada. It is created by the National Council of State Boards of Nursing (NCSBN).

How does the test work?

The NCLEX uses computerized adaptive testing (CAT) to identify each candidate's competence. The computer adapts the exam based on your responses. For example, if you answer a question correctly, the computer gives you a more difficult question from the question bank. If you answer incorrectly, the computer scans the question bank for an easier question. The goal is to consistently answer questions that are more difficult than the passing level standard. But what is the passing standard?

Bloom's taxonomy is a good reference to have as you are studying (it is pictured below). Lower levels of thinking include understanding and remembering, which translates to recall of content and understanding rationale. The NCLEX tests higher levels of thinking at the analyzing and application levels. This requires you to use the knowledge you have, to interpret data, and think about the best answer to keep clients safe. Therefore, candidates must be able to answer questions at the application and analyzing level in order to meet the passing standard.



The minimum number of questions on the NCLEX is 75 and the maximum is 265 for the full 6 hours. The exam will end once the computer has determined your competency and ability.

Test Plan

The current test plan from the NCSBN is effective April 1, 2016 through to March 31, 2019. The NCSBN outlines the content that may be tested during the exam and the content is organized under four main "Client Needs" categories. "Integrated processes" are topics that are woven throughout the categories. They include the nursing process, caring, communication and documentation, teaching/learning, and culture and spirituality.

The distribution of content is as follows:

Client Needs	Percentage of Items from Each Category/
Safe and Effective Care Environment	
Management of care	17-23%
Safety and Infection Control	9-15%
Health Promotion and Maintenance	6-12%
Psychosocial Integrity	6-12%
Physiological Integrity	
Basic Care and Comfort	6-12%
Pharmacological and Parenteral Therapies	12-18%
Reduction of Risk Potential	9-15%
Physiological Adaptation	11-17%

See the following link for specific topics under each category:

https://www.ncsbn.org/RN_Test_Plan_2016_Final.pdf

"We Talkin' 'Bout Practice" – Allen Iverson

What is the best way to get ready for the NCLEX-RN? The most famous answer in all of nursing history – "it depends." It depends on your own needs and how you study best. For example, some resources focus on strategies for answering questions; other resources may have a greater focus on reviewing content you learned in nursing school. The following is a link the NCLEX-RN exam resources that was put together by the Canadian Nurses Association: https://www.cna-aiic.ca/en/becoming-an-rn/rn-exam/nclex-rn-exam-resources

One of the best ways to prepare for the NCLEX is to practice doing questions and reading rationale for answers even if you got the question right. Consider why you got the question wrong and what your strategy was for answering the question. Did you know the content? If not, review it. Did you read the question correctly? If not, identify the topic of the question and read all the response options carefully. Eliminate response options that are incorrect and consider the outcomes of the remaining options.

(see FREE RESOURCES on page 5)

(continued from page 4)

Free Resources

Kaplan offers free sample questions and free online courses on topics such as critical thinking and practice tests: https://www.kaptest.com/nursing/nclex-prep/free-nclex-prep

Hate multi-selection questions and need more tips on passing the NCLEX? Check out YouTube videos by HeyRona:

“How to break down NCLEX Select All That Apply Questions (Part 1): https://www.youtube.com/watch?v=z-BK6jRBAhk

“How to break down NCLEX Select All That Apply Questions (Part 2): https://www.youtube.com/watch?v=QkD0AkYMBxM

“How to break down NCLEX Select All That Apply Questions (Part 3): https://www.youtube.com/watch?v=EQnh8RGf3Lg

Practicequiz.com offers NCLEX question practice as well as an option to receive a free daily question through email:https://www.practicequiz.com/nclex-rn-exam-practice

Whether you are a beginner or a senior nursing student, the NCLEX may produce some anxiety. However, with continued practice and education, throughout nursing school, you will eventually gain confidence that you will be prepared for obtaining your registration.

References

Kaplan. (n.d.). *The NCLEX-RN in Canada*. Retrieved from https://www.kaptest.com/nursing/nclex-prep/nclex-rn/nclex-in-canada

National Council of State Boards of Nursing. (2015). *NCLEX-RN examination: Test plan for the National Council Licensure examination for Registered Nurses.* Retrieved from https://www.ncsbn.org/RN_Test_Plan_2016_Final.pdf

National Council of State Boards of Nursing. (2012). *NCLEX using CAT – Video transcript.* Retrieved from https://www.ncsbn.org/transcript_NCLEX_Using_CAT.pdf

Want to see NCLEX-type questions?

Flip to the back page of this issue to practice!

Too Much to Do, Not Enough Time!

On prioritizing and the Eisenhower matrix

BY NEILA TONG

I was sitting on my couch the other night, trying to think about what I should do first. I have this article that I must submit by Sunday, but I should also be doing my homework for class. I thought about how I always run into this challenge, where I don't know what to work on first. I recalled a solution that my husband taught me called "Eisenhower's Urgent-Important Matrix":

Image Source: https://www.mindtools.com/pages/article/newHTE_91.htm

After reading more about this matrix, I identified that writing this article is important *and* urgent, and my homework is important, but *not* urgent. This matrix is important in nursing because as future nurses, there will be times that we are overloaded with tasks, and we may not know where to start.

First, we need to figure out what is the difference between urgent and important.

Important activities have an end goal in mind. They consist of steps that help us to achieve our ultimate goal. They can be professional or personal goals. For example, our goal is to become a nurse. All the tasks that will ultimately help us to achieve this goal are important activities: homework, clinical, networking, etc.

Urgent activities require our attention **now**. Often times, but not always, they have to do with accomplishing someone else's goal. If we don't deal with these tasks, the consequences are instant. For example, the patient in room 15 needs her colostomy bag changed. If we don't deal with it, her colostomy bag will overflow.

Next, we list out all our tasks, and categorize them:

1. Important *and* urgent

These are the tasks that Eisenhower recommends we do first. They are the tasks that we should complete on the same day. An example of this type of task could be making sure that the patient in room 15 gets her colostomy bag changed.

2. Important, but <u>not</u> urgent

These are the tasks that we should schedule in our calendar to complete. An example of this type of task could be a term paper that is going to be due in 12 weeks. We can schedule 1-hour once a week in our calendar to work on the term paper. By the end of the 12 weeks, we will have freed ourselves from a cram session, where it would have become an important and urgent task.

3. Not important, but urgent

These tasks are usually the ones that can be delegated to someone else. They are still pretty urgent, but are less important to us. An example of this could be that the hospital has a staff shortage, but you aren't able to make it in. We can delegate this task by suggesting another nurse or by delegating the task back to the manager to find someone else.

4. Not important and not urgent

These tasks are the ones that Eisenhower suggests that we don't do at all. Often times, these are the tasks that we discover are our bad habits, like spending hours on social media. It's very possible that tasks can move up a level, for example from two on the priority scale to a level one. At some point, writing this article was important, but it was *not* urgent. However, I am guilty to say that I spent a lot of my time leading up to this point by doing a whole lot of unimportant and not urgent tasks, like watching K-drama.

In the end, we're only human. There's going to be times when we're going to do some "not important *and* not urgent" tasks before an important task gets done. However, it's important that we don't let any small setbacks keep us from reaching our ultimate goal.

Happy prioritizing fellow future nurses!

Websites to visit:

https://www.mindtools.com/pages/article/newHTE_91.htm

http://www.eisenhower.me/eisenhower-matrix/

Healthcare Traveling Roadshow

Where sock aids, drugs, and catching babies are the new sex, drugs, and rock and roll

BY ANITA SHEN

Maybe you're curious about working in rural BC after grad. Maybe you love adventure. Maybe you've always wondered what a midwife, respiratory therapist, or medical lab technologist does.

If so, I think you'd love the Healthcare Traveling Roadshow. I certainly did.

From May 14-20, I volunteered alongside eleven other healthcare students from BC. Organized by the University of Northern British Columbia, the show invites healthcare students to share their chosen profession with high school students in rural communities.

Together with four medical students, another Nursing student, and one student from each discipline of Respiratory Therapy, Occupational Therapy, Medical Laboratory Technologist, Midwifery, Doctor of Pharmacy, and Audiology, we gave brief presentations about why we chose our field, and set up interactive booths to engage teens in grades 10-12.

This year, the show made three trips: through Northern BC, the Cariboo, and the Southern Interior. My team visited the Cariboo region, which included Quesnel, Williams Lake, and 100 Mile House. In each of the communities, we received a tour of the hospital and primary care clinic, and met local health professionals and health care recruiters. It was interesting to hear the stories of people from all over the world who ended up working and living in the Cariboo.

For me, a city kid who the folks in Interior BC would say hasn't gone "beyond Hope," the trip felt exotic. On our time off, we visited a lumber mill, an Indigenous heritage village, a canyon, a waterfall, and went paddle boarding. I saw my first moose as we drove along the highway to Ten Mile Lake.

For those of us wanting to work in the North—especially us "coastal" kids, as the rest of BC calls us—it helps to get a sense of the community before taking the plunge. Everywhere we went, locals made us feel welcome. Quesnel celebrated its diversity and quiet beauty, Williams Lake sang the praises of its mountain biking culture, and 100 Mile House has incredible supports for its large senior population.

The trip was also really, really fun. I learned what it's like to work as a rural nurse and I bonded with some amazing people while hiking, playing cards, and chatting with local politicians. We also bonded during the long drives. During the demos, the youth asked lots of questions, and some were adorably embarrassed, grossed out, or fascinated by the anatomical models. The biggest hit was the Midwifery student's birth demonstration. Students also loved hitting each others' knees using the medical students' plexor, and inserting a tracheal tube into a dummy with the Respiratory Therapy student.

There was an exciting moment of interprofessional collaboration when a student fainted, and the Respiratory Therapy, Nursing, and medical students worked together to take vitals and reassure the teens.

Overall, I learned a lot. It was reaffirming to explain my future profession and remember how unsure I felt about my future when I was in Grade 12. It was amazing to meet such a diverse and inspired group of healthcare students and hear about their experiences and their plans after graduation. I also got a better sense of two health authorities: Quesnel is part of Northern Health, whereas Williams Lake and 100 Mile House are part of Interior Health.

If a large nursing scope and a high patient load sounds like a healthy challenge to you, you will love rural nursing. If stopping your car on a gravel road to shoo away a herd of cows is your thing, you will fit right in a rural community. And if you're curious to see beautiful BC—all expenses paid—and talk to youth, then the Healthcare Traveling Roadshow is for you.

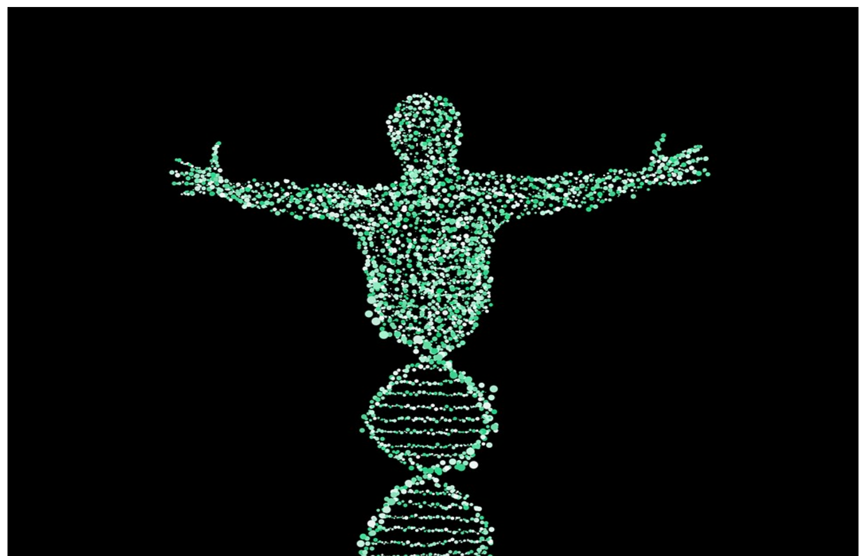
What Genes (Don't) Mean

Genes ≠ fate — despite what your patients might think

BY DR. BENJAMIN Y. CHEUNG

Scanning the world of information around us, we see messages about genes everywhere. The media tells us that there are "warrior genes," "infidelity genes," genes that make some children more susceptible to food advertising, and even genes that predict whether a person gets mugged (e.g. Aamodt & Wang, 2009). And now, thanks to technological advancements in the past couple of decades, anyone can use direct-to-consumer (DTC) personal genetic testing companies like 23andMe and AncestryDNA to learn about their own genes. They just need to spit into a test tube, wait for a few weeks, and receive a printout of their personal genomic code, all for the *relatively* low price of $200. It tells them whether they have a gene linked to increased intelligence, higher likelihood of developing early-onset dementia, and innumerable other health conditions (Heine, 2017). It has never been easier for the general public – many of whom will enter into your care – to have access to more genetic information about themselves than anyone at any time in the history of the world. In fact, with over two million clients using 23andMe alone, you will likely encounter patients communicating their genetic risks to you based on such DTC printouts.

Having patients who can access such an immense amount of information is great, but that assumes that genetic information is actually useful, and people can interpret genetic information properly. Unfortunately, both presumptions are not commonly met.



Issues with the first presumption of useful genetic information is beyond the scope of this article. The simple picture is that genes simply code for proteins, and those proteins are miles away from being actual thoughts, behaviours, or health conditions. In fact, knowing that someone has a gene associated with increased weight or likelihood of developing gout tells us very little about how heavy that person is or how likely they are to have gout. While there are conditions for which genetic profiles almost perfectly predict medical outcomes (e.g. Huntington's disease), such cases are the exception rather than the norm. For example, research suggests that possessing a particular gene raises one's risk for developing lung cancer by 30%. That is a scary number; but the gene simply raises one's lifetime likelihood of developing lung cancer to 12.60% from a baseline of 9.60% for men, versus 5.59% from a baseline of 4.30% for women (based on secondary calculations). These are useful large-sample statistics, but not very helpful for any given individual. And these numbers are that high primarily thanks to people who have that gene *and* smoke – an issue that I will return to at the end.

(continued on page 9)

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The fact that genes are not actually all that diagnostic unfortunately contributes to the second problem – that many people do not interpret genetic information appropriately. In fact, many researchers are now exploring the psychology of genetic information consumption. When people learn that some aspect of humanity has genetic causes, they often respond in a reliable pattern: they think that the genes are deterministic and non-malleable, they assume that genes are the only cause, they believe that people with and without those genes are fundamentally different from each other, and they feel that it is only natural to expect the associated outcome to happen (Dar-Nimrod & Heine, Genetic essentialism: On the deceptive determinism of DNA, 2011). This suite of responses, collectively known as *genetic essentialism*, has important implications for people's behaviours. For example, when people learn that aggressive behaviour has genetic causes, they think that a violent criminal has less control over his actions, has less intention to harm others, and often prescribe a shorter prison sentence (Aspinwall, Brown, & Tabery, 2012; Cheung & Heine, 2015). More germane to healthcare, when people learn that weight and metabolism have genetic (vs. environmental/lifestyle) causes, they feel weight is less controllable, expect to gain more weight over time, and eat more (Dar-Nimrod, Cheung, Ruby, & Heine, 2014). Of course, nothing from geneticists' understanding of genes would warrant these kinds of responses; but people do see genes as some sort of essence – the unchangeable, persistent "stuff" that makes us who we are as people. It is this kind of essentialistic thinking that gave rise to the common fatalistic refrain, "It's in my genes!'

As nurses, patient education should be a responsibility in which you take the most pride (you know, along with being a good patient advocate, conscientious caregiver, careful medical personnel, empathetic listener, and the hundred other things that are expected of you…). It is important that patients tell you what they know; but it is also important that they understand the implications of the knowledge that they yield. Even more important is for patients to understand the non-deterministic nature of genetics. Consider once more the case of lung cancer. Sure, the gene discussed earlier raises risks of developing lung cancer by 30%, but some estimates suggest that smoking raises this risk by almost 1500% (those who smoke or rarely smoke have less than 1% lifetime risk of developing lung cancer). With patients coming to you with more genetic information about themselves than ever before, it is important that you are also familiar with medical genetic information, and strongly emphasize the important role that environments play in one's well-being.

Dr. Benjamin Y. Cheung is a lecturer at the University of British Columbia's Department of Psychology. His research examines the psychological consequences of when people think that genes lie at the heart of various traits and behaviours.

Follow him on Twitter @UBCDrBenCh

References

Aamodt, S., & Wang, S. (2009, March 24). Mugged by our genes? *New York Times*. Retrieved from https://opinionator.blogs.nytimes.com/2009/03/24/guest-column-mugged-by-our-genes/?mcubz=2

Aspinwall, L. G., Brown, T. R., & Tabery, J. (2012). The double-edged sword: Does biomechanism increase or decrease judges' sentencing of psychopaths? *Science, 337*(6096), 846-849. doi:10.1126/science.1219569

Cheung, B. Y., & Heine, S. J. (2015). The double-edged sword of genetic accounts of criminality: Causal attributions from genetic ascriptions affect legal decision-making. *Personality and Social Psychology Bulletin, 41*(12), 1723-1738. doi:10.1177/0146167215610520

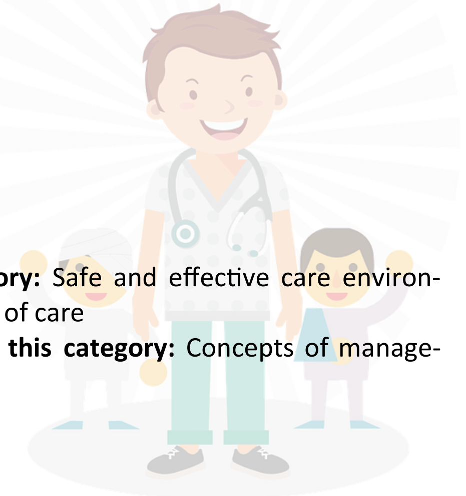
Dar-Nimrod, I., & Heine, S. J. (2011). Genetic essentialism: On the deceptive determinism of DNA. *Psychological Bulletin, 137*(5), 800-818. doi:10.1037/a0021860

Dar-Nimrod, I., Cheung, B. Y., Ruby, M. B., & Heine, S. J. (2014). Can merely learning about obesity genes affect eating behavior? *Appetite, 81*(1), 269-276. doi:10.1016/j.appet.2014.06.109

Heine, S. J. (2017). *DNA is not destiny: The remarkable, completely misunderstood relationship between you and your genes.* New York City: W. W. Norton.

Some NCLEX Fun!

Nursing questions—because why not?



1. A 34-year-old woman who developed Stevens-Johnson syndrome while undergoing treatment with carbamazepine is being transferred in stable condition from the intensive care unit to the medical unit. There are 4 beds available. The nurse knows the BEST choice of roommates for this client is which of the following?

1. A 40-year-old man with methicillin-resistant *Staphylococcus aureus (MRSA)*
2. A 28-year-old woman diagnosed with diarrhea
3. A 72-year-old man with fever of unknown origin
4. A 68-year-old woman with atrial fibrillation

2. The physician orders an MRI of the brain for an adult male client. Which of the following findings in the client's history should the nurse report to the physician?

1. Allergy to contrast dye
2. Implanted cardiac pacemaker
3. Chronic obstructive pulmonary disease (COPD)
4. Hernia repair

3. New parents are concerned about an unexpected characteristic of their newborn baby. Which of the following would cause the nurse to initiate contact with the physician?

1. Swollen genitals and breast
2. High-pitched crying
3. Misshapen head
4. Milia

ANSWERS

1. Answer: 4

Rationale/Strategy: Stevens-Johnson syndrome is characterized by blistering and skin shedding, leading to impaired skin integrity and increasing the risk for infection. When deciding room assignments for clients at risk for infection, select the option describing a patient with a non-infectious disease process. A client with atrial fibrillation is not infectious.

Client needs category: Safe and effective care environment: Management of care
Related content to this category: Concepts of management

2. Answer: 2

Rationale/Strategy: If the nurse needs to report a finding to the physician, it might indicate a contraindication or a safety concern for the client. A contraindication for MRI includes having metallic items, such as metallic implants (cardiac pacemaker). A contraindication for CT scans is allergy to contrast dye (option 1). COPD and hernia repair are not contraindications for MRI (options 3 and 4).

Client needs category: Safe and effective care environment: Safety and infection control
Related content to this category: Accident/injury prevention; Safe use of equipment

3. Answer: 2

Rationale/Strategy: Think about the expected and unexpected findings for newborns. Swollen genitals and breast are normal due to maternal hormones (option 1). A misshapen head is normal due to descent through the birth canal (option 3). Milia is normal due to blocked sebaceous glands (option 4). High-pitched crying is not normal and can be due to a neurological problem (option 2).

Client needs category: Health promotion and maintenance
Related content to this category: Ante/intra/postpartum and newborn care

Reference:

Kaplan. (2015). *NCLEX-RN 2015-2016 strategies, practice & review with practice test. New York, NY: Kaplan Publishing.*