A POLYTECHNIC INSTITUTION

Course Outline

School of Health Sciences
Program: Bachelor of Science in Nursing
Option:

NURS 1030
Nursing Practicum 1

Start Date:	September 25, 2007			**End Date:**	November 28, 2007		
Total Hours:	140	**Total Weeks:**	10	**Term/Level:**	1	**Course Credits:**	5.5
Hours/Week:	14	**Lecture:**	**Lab:**	**Shop:**		**Seminar:**	**Other:**

Prerequisites

Course No.	Course Name
CRNBC Membership and current CPR will be required prior to commencement of hospital visits. Cards will be checked by instructors week 2 and week 11.	

Co-requisite

NURS 1030 is a Prerequisite for:

Course No.	Course Name
NURS 2030	Nursing Program 2
NURS 2000	Applied Nursing Science 2
NURS 2020	Clinical Techniques 2 – Laboratory
NURS 1020	Clinical Techniques 1 – Laboratory

■ Course Description

In this course, students will be expected to provide knowledgeable and safe nursing care to people in hospitals. The scope of nursing practice includes recognition and consideration of the health needs of people entering the hospital as well as health needs that will require follow-up discharge. **Context of Practice: Adult Acute Medical Nursing Units**

■ Detailed Course Description

NURS 1030 is a practicum course that focuses on providing nursing care for people experiencing health problems who require hospitalization. Emphasis is placed on developing knowledge, skills, and attitudes relevant to a professional nursing identity. **NURS 1030 follows NURS 1019 (assessment course) and is linked and interrelated to the concepts learned in NURS 1019.**

■ Evaluation

- Satisfactory/Unsatisfactory standing based on instructor evaluation and successful completion of a journal.

Comments:

- **Course outcomes must be met consistently for the last two (2) weeks to pass this course.**
- All assignments must be completed to achieve a passing satisfactory standings.
- **Students must achieve 100% in med math by end of week 10 in order to complete NURS 1030.**

■ Course Learning Outcomes / Competencies

(Based on CRNBC Professional Standards-2007)

Upon successful completion, the student will be able to:

1. provide professional caring which is based on knowledge and skills.
2. pursue shared meaning by communicating effectively with people.
3. use systematic inquiry to:
   a. recognize the uniqueness of each patient and/or patient situation and responding with appropriate clinical judgement.
   b. raise questions about nursing practices to explore alternatives.
   c. reflect on own nursing practice.
4. with instructor assistance, monitors own practice, determines learning needs, and independently acts upon identified learning needs.
5. develop collaborative partnerships with members of the health care team.
6. with instructor assistance use creative leadership skills to manage changing patient situations.
7. implement technical skills completely and with increasing confidence.

■ Verification

I verify that the content of this course outline is current.

Authoring Instructor — May 31/07 Date

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — MAY 28, 2007 Date

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — May 31/07 Date

Note: Should changes be required to the content of this course outline, students will be given reasonable notice.

■ Instructor(s)

	Office Phone:
Corrine Schneider	TBA
Judi Campbell	604-456-8073
Terri Karapita	604-431-4975
Jeff Dyck	604-432-8411
Mina Amiraslany	TBA
Connie Johnston	604-451-7189
Merry Van der Gracht	604-454-2214
Kathy Martin	TBA
Connie Evans	604-432-8687

Office Location: SE12-418
Office Hrs: Please see individual instructors.

■ Learning Resources

Equipment:

- A uniform that complies with program policies (see Guidelines for Students in the Nursing Program).
- Shoes that comply with program policies (see Guidelines).
- A stethoscope.
- A pen and notebook.
- A penlight.
- A watch with a second hand.
- A lock may be required if you use a hospital locker to store clothing, etc. while at the hospital.

Required:

Black, J.M., & Hawks, H. (2005). *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.). Philadelphia: W.B. Saunders.

Boyer, M.J. (2006). *Math for nurses: A pocket guide to dosage calculation and drug preparation* (6th ed.). Philadelphia: Lippincott.

Canadian Nurses Association. (2002). *Code of ethics for registered nurses.* Ottawa, ON: Author. Retrieved May 23, 2007, from http://cna-aiic.ca/cna/documents/pdf/publications/CodeofEthics2002_e.pdf

College of Registered Nurses of British Columbia. (2003). *Administration of medications.* Vancouver: Author.

College of Registered Nurses of British Columbia. (2003). *Nursing documentation.* Vancouver: Author. Retrieved May 23, 2007, from http://www.crnbc.ca/downloads/151.pdf

College of Registered Nurses of British Columbia. (2005). *Standard of nursing practice in British Columbia.* Vancouver: Author. Retrieved May 23, 2007, from http://www.crnbc.ca/downloads/128_prof%20standards%202005.pdf

College of Registered Nurses of British Columbia. (2006). *Scope of practice for registered Nurses: Standards, limits, conditions.* Vancouver, BC: Author. Retrieved May 23, 2007, from http://www.crnbc.ca/downloads/433-scope.pdf

Jarvis, C. (2004). *Physical examination and health assessment* (4th ed.). (*Textbook and User's Guide Package for Health Assessment Online.*) Philadelphia: W.B. Saunders.

Nursing Program. *Guidelines for students in the nursing program.* Burnaby, BC, Canada: BCIT http://www.bcit.ca/files/health/nursing/pdf/student_policies_august_2006.pdf

Perry, A.G., & Potter, P.A. (2002). *Clinical nursing skills and techniques* (5th ed.). St. Louis: Mosby, Inc.

Philosophy Task Group. (2006). *Bachelor of Science Nursing curriculum philosophy.* Burnaby, BC: British Columbia Institute of Technology. [This document will be distributed in NURS 1000]

Spratto, G.R. & Woods, A.L. (2007 edition). *PDR Nurse's drug hand book.* [This text is also required in Level 3 for NURS 1060]

Taber, C.W. (2001). *Taber's cyclopedic medical dictionary* (20th ed.). Philadelphia: F.A. Davis.

Recommended:

Care Planning Text

Gulanick, M., et al. (2003). *Nursing care plans: Nursing diagnosis and intervention* (6th ed.). Mosby.

■ Information for Students

(Information below can be adapted and supplemented as necessary.)

The following statements are in accordance with the BCIT Student Regulations Policy 5002. To review the full policy, please refer to: http://www.bcit.ca/~presoff/5002.pdf.

Attendance/Illness:
In case of illness or other unavoidable cause of absence, the student must communicate as soon as possible with his/her instructor or Program Head or Chief Instructor, indicating the reason for the absence. Prolonged illness of three or more consecutive days must have a BCIT medical certificate sent to the department. Excessive absence may result in failure or immediate withdrawal from the course or program.

Cheating, Fabrication, Plagiarism, and/or Dishonesty:
First Offense: Any student in the School of Health Sciences involved in an initial act of academic misconduct- **Cheating, fabrication, plagiarism,** and/or **dishonesty** will receive a Zero (0) or Unsatisfactory (U) on the particular assignment and may receive a Zero (0) or Unsatisfactory (U) in the course, at the discretion of the Associate Dean.

Second Offense: Any student in the School of Health Sciences involved in a second offence of academic misconduct- **Cheating, fabrication, plagiarism,** and/or **dishonesty** will receive a Zero (0) or Unsatisfactory (U) on the particular assignment and may receive a Zero (0) or Unsatisfactory (U) in the course, and the Associate Dean will recommend to the BCIT Vice-President, Education and/or President, that the student be expelled from the program.

Attempts:
BCIT Nursing Program Student Guidelines, Policies, and Procedures which are located online at http://www.bcit.ca/health/nusing/ state: Applicants who have any combination of two instances of withdrawal or failure in a Nursing Theory course will be readmitted to the program "with written permission from the Associate Dean, who will detail any special considerations". Applicants who have a combination of two instances of withdrawal or failure in any Nursing Practicum course(s) for academic or performance reasons, will not be readmitted to the program
Accommodation:

Any student who may require accommodation from BCIT because of a physical or mental disability should refer to BCIT's Policy on Accommodation for Students with Disabilities (Policy # 4501) and contact BCIT's Disability Resource Centre (SW1–2300, 604-451-6963) at the earliest possible time. Requests for accommodation must be made to the Disability Resource Centre and should not be made to a course instructor or Program area.

Any student who needs special assistance in the event of a medical emergency or building evacuation (either because of a disability or for any other reason) should also promptly inform their course instructor(s) and the Disability Resource Centre of their personal circumstances.

■ Process Learning Threads

Professionalism: Students begin to develop an understanding of the professional nurse's role. They develop an understanding of nursing care that is required for safe practice. They are accountable and responsible to follow through with work they have been assigned. They recognize the various contexts in which people live. They begin to use assessment knowledge to guide care with patients in acute medical nursing units. They analyze data and develop care plans to resolve patient issues or promote comfort. With assistance, students incorporate health promotion, illness/injury prevention, and rehabilitation into nursing care and begin to consider planning for discharge. They begin to make clinical judgments and act on those judgments. They begin to evaluate their care according to standards and incorporate a code of ethics consistent with professional practice.

Communication: Students thoughtfully discuss practicum experiences verbally and in writing. They dialogue with colleagues and teachers in the process of learning. Students begin to establish relationships with clients based on shared meaning and partnership. They learn to share information about care with patients. They validate health issues with patients and discuss care with the health care team. They are becoming independent with documentation and reporting of patient assessment and nursing care.

Systematic Inquiry: Students begin to reason critically about assessment data, patient concerns, and care. They are expected to clarify direction and practices to advocate for the patient and investigate alternate approaches to patient care. They begin to appreciate multiple perspectives that can be taken about patient issues. They think and reflect about technical skills by appreciating the research base, recognizing real and potential risks associated with the skills, and making judgments about the skill considering the context.

Professional Growth: Students take responsibility for their learning and for preparing information for practicum that is accurate and relevant. They take responsibility for attaining and maintaining a safe level of skill performance. Also, they are responsible and accountable for their actions. They access a variety of health professionals in hospital. They begin to reflect on their values, beliefs, and assumptions about growth and development, ethnicity, health promotion, health/illness, and nursing concepts. They begin to reflect on their experiences, recognizing their limitations and seeking assistance. They value discussions of their own performance and begin to self-evaluate and act on learning needs. They begin to share knowledge and experience with the group and take responsibility for debriefing sessions.

Creative Leadership: Students identify agency policies prior to acting. They describe the continuum of care as it relates to specific patients. Students begin to establish relationships with members of the health care team. They are assertive with colleagues as they work with health issues. They explain their role and abilities and discuss patient care issues and concerns with health professionals. They are organized to give care to two acute medical patients including setting appropriate priorities for care. They are confident at the bedside and are able to set limits on inappropriate requests. They are beginning to intervene when patient safety is jeopardized. They are beginning to understand where their current context of practice fits in the health care system. Therefore, they are beginning to understand nursing leadership within this context of practice.

Technical Skills: Students demonstrate correct assessment techniques during physical and psychosocial assessments and recognize normal findings and significant patterns of illness. They describe the purpose of skills and prepare a focused assessment of the patient related to the skills. Students anticipate skills to be performed and prepare and organize themselves to perform them. They maintain patient and own safety when performing skills. They are independent with the majority of technical skills learned this term, but may require minimal supervision with some. They are able to explain skills to patients and family. Specific skills include:

- the health assessment process, basic interview skills.
- the health history, functional, nutritional, growth and development, cultural, psychosocial assessment.
- basic physical assessment — the general survey — measurement of temperature, pulse, respiration, blood pressure, pain, height and weight.
- body review — skin, hair and nails, head and neck, including ears, eyes, nose and throat.
- mental status and neurologic assessment.
- respiratory, cardiovascular, peripheral vascular and lymphatic assessment.
- heart, chest and abdominal sounds.
- assessment of abdomen, urinary, and musculoskeletal systems.
- assessment of breast, external male and female genitalia.
- medical asepsis, clean dressing change and transparent dressing application.
- standard precautions, isolation precautions.
- feeding, mouth care, special mouth care, oral suctioning, dental care.
- bedmaking, body mechanics, transfers, assistive devices, restraints.
- hygiene — bed bath, perineal care, catheter care, condom care, incontinent briefs, bedpans, urinals.
- positioning, hazards of immobility, range of motion.
- medications — oral, topical, inhaled, anorectal interventions, oxygen therapy.
- collection of samples, urine testing, intake and output, assessment of tubes.
- therapeutic touch, back massage, relaxation therapies.

■ Assignment Details

1. Students will be given patient information the day prior to the practicum experience. Research is required before the clinical experience so that students have a reasonable understanding of the reason for hospitalization and the nursing care the patient(s) might require. Students will complete written nursing care plan(s) prior to arriving at practicum.

2. Safe nursing care is required. The instructor has the responsibility to assist students to provide safe and comfortable care for the patients. Students are expected to take responsibility for errors and to document them according to agency and BCIT policy. Students whose care is unsafe may be removed from the practicum setting. (See Guidelines for Students in the nursing Program.)

3. Students can expect to attend a weekly practicum conference. Students and the instructor have a joint responsibility to see that these conferences are meaningful. They will decide when the conferences will be scheduled each week and how the conference will be structured. A one hour a week conference is suggested.

4. Students will complete a written midterm and final evaluation on which shows evidence that course outcomes are being met.

■ Reflective Thinking Activity

1. Students will keep a journal during this course. The reflective journal must demonstrate sufficient

thoroughness and thought in order to be accepted.

2. The student's journal will be confidential between the student and the instructor. Sharing of any part of the student's writing will only occur when both the student and the instructor have given written permission.

■ Course Notes

1. Students have the right and the responsibility to evaluate the course. An end-of-end review is aimed at modifying the course for subsequent students.

2. Students are responsible to identify their own learning needs and to consult with the instructor about how they might meet these needs. Students will meet with their instructors at the beginning of the practicum course to discuss their learning needs and prepare a learning plan. The students will update their learning plans as the term progresses.

3. A learning partnership is essential for successful completion of this course. Both student and instructor will communicate openly, will demonstrate respect in the relationship, and will work to maintain a reasonable balance of power in the relationship. This can be achieved by:

- discussing the course outcomes to achieve shared understanding of them.
- identifying the evidence required to demonstrate achievement of the outcomes.
- dialoguing regularly throughout the course.

BCIT NURSING PROGRAM

NURS 1030
Nursing Practicum 1

Course Syllabus

Date: July, 2007

Table of Contents

BCIT Policy Information for Students

Introduction

Welcome to your first nursing practicum course. For many of you, this is your first practicum experience. Practicum is not an escape from classes; you must use more than just common sense to achieve course outcomes. Practicum requires thoughtful preparation, reflection, and integration of learning. Knowledge and skills are required. Practicum is also not another laboratory experience where your learning needs take priority. It is a health/illness experience for the patient in which you are encouraged to participate and from which you learn. The patient's needs will always take priority because the fundamental role of nurses is to provide a public service.

As you begin your journey to become a professional nurse you will have a number of experiences that will help you develop professional nursing knowledge, skills, and attitudes. As nurses care 24 hours a day, many of you will have both day and evening practicum experiences. As the term progresses, you will have increasing responsibility for client care so you may be unable to leave the agency on time. Be prepared to extend your day past the usual stop time.

Outcome Review

At the beginning of the term, the expectations for practicum performance may seem overwhelming. However, the majority of students are successful in this course. Be prepared to collaborate with family members, classmates, instructors, nurses, and other agency personnel to maximize your learning. To help students understand the meaning of the seven course outcomes as related to the CRNBC Standards of Care please refer to the attached document, NURS 1030 *CRNBC Standards of Practise Course Learning Outcomes*.

1. The relationship with your practicum instructor will likely be different from any instructor-student relationship you have had in the past. You are expected to form a partnership with the instructor that is based on open communication, respect, and a balance of power. This means that you will:

    - meet to discuss course outcomes to achieve shared understanding of them.
    - identify the evidence required to demonstrate achievement of the outcomes.
    - regularly dialogue verbally throughout the course. The reflective thinking activity may enhance the dialogue between students and instructors. The dialogue may also enhance the reflective thinking.

2. During the practicum orientation, the evaluation of this course will be discussed. Most of the course will focus on dialogue to promote learning. **Students are expected to use the dialogue to make weekly progress in learning.** Towards the end of the course, the student must **show evidence of consistent outcome achievement** to obtain a satisfactory standing in the course.

3. Between term week ten and eleven (fifth and sixth week of this course), each student will meet with his/her practicum instructor to discuss progress to date. Both will come to the meeting with evidence to support conclusions about strengths and areas for improvement. At the course start, each student will develop an ongoing **learning plan** to help them achieve course outcomes by the end of the term. (See the midterm / final course evaluation attached to this course outline.)

4. Students are expected to document assessment findings, nursing care, and evaluation of care each day for assigned patients. **The daily documentation must include a full system review for each patient.**

5. Regarding **Care Plans**, it is expected that students will be able to develop four patient problems for 2 patients by terms end. These care plans must be **comprehensive and patient individualized.**

6. Concepts from the NURS 1000 and 1040 courses apply to practicum situations. Students would be wise to ask themselves the following questions to help increase understanding:

   - How does this patient situation relate to the concepts from NURS 1000?
   - What do I know about the NURS 1000 concepts that might help me understand this patient situation?
   - What assumptions am I making about this situation? What other perspectives could be taken?
   - What professional issues apply in this situation?
   - What is expected of me according to the Professional Standards (CRNBC, 2005) and the *Code of Ethics for Registered Nurses* (CNA, 2002), *Scope of Practice for Registered Nurses* (CRNBC, 2006)?

7. Students will be expected to document errors according to agency policy and according to the policies of the Nursing Program. Students whose care is unsafe will be removed from the practicum setting according to the *Guidelines for Students in the Nursing Program.*

8. Weekly practicum activities include the hour-long practicum debriefing. The debriefing session is a structured group that allows teachers and students to process, contextualize, understand, reflect, and learn from the practicum experiences. The conference is aimed at reflection, education, critical thinking, stress reduction, group support, and question identification. **Students and instructors have the responsibility to see that these sessions are meaningful. They will decide where and when the sessions will be scheduled each week and how they will be structured.**

9. **For information on BCIT policies, go to BCIT website and read policy section found at www.bcit.ca/health/nursing.**

Reflective Thinking Activity or Journal

The purpose of this activity is to help students develop the ability to reflect on and reason about their practicum activities. It is not a diary in that diaries are usually focused on outside experiences. A journal is a written account of your thinking about the practicum experiences. "The focus will be on your unfolding awareness of yourself and your [nursing] world, as well as the new meanings, values and interrelationships you are discovering" (Reimer, Thomlinson & Bradshaw, 1999, p. 28).

Your journal should include descriptions of events and the impact of these events on you. By recording this, you have the opportunity to critically analyze the events of the practicum experience to identify your assumptions and alternate perspectives. Through this process, you will discover "your biases about yourself as a developing nurse ... [and] your abilities and strengths" (Reimer, Thomlinson & Bradshaw, 1999, p. 41). Also, you will start to think about how you learn best so that you can use this knowledge to enhance your learning in the practicum situation.

Course Notes

1. Students have the right and the responsibility to **evaluate the course**. An end-of-term review is aimed at modifying the course for subsequent students.

2. Students are responsible to identify their own learning needs and to consult with the instructor about how they might meet these needs. Students will meet with their instructors at the beginning of the course to discuss their learning needs and prepare a **learning plan**. The students will update their learning plans as the term progresses.

3. A learning **partnership** is essential for successful completion of this course. Both student and instructor will communicate openly, will demonstrate respect in the relationship, and will work to maintain a reasonable balance of power in the relationship. This can be achieved by:

    - discussing the course outcomes to achieve shared understanding of them.
    - identifying the evidence required to demonstrate achievement of the outcomes.
    - dialoguing regularly throughout the course.

References

Greenwood, J. (1998). The role of reflection in single and double loop learning. *Journal of Advanced Nursing, 27*, 1048–1053.

Reimer, M.A., Thomlinson, B., & Bradshaw, C. (1999). *The Clinical Rotation Handbook: A Practicum Guide for Nurses*. Albany, NY: Delmar Publishers.

Nursing Care Plan

Student: _____ Patient Initials _____ Dx and hx: _____

Monday	Monday Night	Monday Night	Tuesday	Tuesday Night/ Wednesday	Tuesday Night	Wednesday Night Thursday Journal
Data/Info/s/s	**Predicted Problems (4/patient)**	**Validation (4/problem) (Assessment)**	**Validation (Evidence)**	**Identification and Intervention for TOP TWO Problems**	**Rationale**	**Evaluation**
What is the info/data that your patient is experiencing a problem?	Actual or potential problems plus what is or may be causing it.	What would a patient look like that had this problem? What might be the signs and symbols?	Did your assessment provide proof that the problem exists or could exist? (Say yes or no) What is the proof?	What are patients top two problems, based on your assessment and patient records? What specific care would you do? Include details — how often etc.? (Must have 4 **interventions/problem)**	Why does this intervention help? Describe physiology if possible.	Did the interventions work for your patient? Why or why not? ** Only do this part if you implemented your intervention(s)**

Guide to Use of Learning Plans

Purpose

Learning plans allow students to blend course requirements with their own learning needs using their individual learning styles and thereby facilitate learning.

The purpose of the learning plan is to provide an opportunity for each student to individualize their learning needs within the framework of the outcomes of the course.

The plan is an agreement between a student and an instructor which focuses on:

1. what the student needs to learn (outcomes)
2. how this will be accomplished and within what timeframe (strategies)
3. the progress that the student has made.

It is a working document which involves sharing of expectations and goals between learner and instructor.

At the start of every level, students complete a learning plan based on their individual learning needs for that period of time. The expectation is that the students will identify areas that require ongoing work and match these to the practicum course sub-outcomes. Strategies are then identified for each area/outcome.

Learning plans are reviewed by each instructor and student in a meeting situation. Students and instructors review, revise and then roll over each of the areas that have been identified. These plans become part of the student's portfolio which they can take from term to term. Every student is responsible for completing or updating his or her own plan.

The final learning plan is then rolled over and brought into the beginning of the next level.

Learning plans do not become part of the student's permanent fie. Students should keep all their learning plans in a portfolio and work on them throughout the term as required.

Steps in the Development of a Learning Plan

1. Students assess their own strengths and area for continuing development related to the course outcomes. A learning need is a ***gap between where the student is now and where the student wants/needs to be by the end of the course.***

2. Identify the specific learning need and state it as clearly as possible using the course outcomes. Students may consult with instructors or peers about the clarity of these learning needs.

3. Identify strategies that will assist the student in meeting the learning needs.

4. Note progress made in meeting the learning needs. This can be done with the assistance of the instructor and can be done at any time.

Bachelor of Technology in Nursing
NURS 1030
Professional Learning Plan
Learning Plan

Student Name: _____

Course: _____

Date: _____

Learning Needs (Sub Outcomes)	Strategies	Progress (Date of Comments)

Guide for Completion of "Unusual Incident Report"

Guidelines for the completion of BCIT Unusual Incident reports (specific to medication errors):

- late administration without sound rationale (e.g., new order—med. not available at designated time—pt. not on ward—SN could not have planned in advance), would include:
  - no attempt made to look up info. re. drug in advance of time due.
  - SN very slow in preparation and admin. of med.
- not completing seven rights and three checks during preparation of med.
- incorrect calculation of fractional dose (once student has been successful in related math test).
- incorrect dose poured due to: misinterpretation of order, misreading label, unfamiliarity with route, etc.
- patient with allergy given offending drug without due consideration and discussion with instructor/RN.
- outdated drug poured.
- drug past stop order date (see individual agency policy).
- incorrect time.
- incorrect route.
- wrong patient.
- dose omitted.
- improper patient identification:
  - not checking name band prior to administration.
  - name band checked but not carefully enough resulting in attempt/actual admin. of med. to wrong patient.
- prn meds. not charted immediately.
- meds. not signed for in appropriate manner, e.g., wrong route, omitting route, wrong dose, incorrect spelling.
- not taking pulse or BP prior to administration of drug (as required in relation to specific medications).
- failure to check compatibility chart prior to mixing meds. in syringe or IV medications.
- failure to follow BCIT's Policy re: medications.
- giving a med. whose order (MAR/card) is unchecked by RN

BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY
NURSING PROGRAM

Record of Unusual Incident In The Clinical Area

Student: _____ Student #: _____ Level: _____
print

Student's Signature: _____ Date: _____

Date of Incident: _____ Hospital Incident Filed: ☐ Yes ☐ No
day/month/year

Facility where incident occurred: _____

1. Briefly describe the incident. If medication related write out order.

2. Identify actual and/or potential effect on patient.

3. Briefly describe the agency system (procedure, policies, etc.,) related to this incident.

BRITISH COLUMBIA
INSTITUTE OF TECHNOLOGY

3700 Willingdon Avenue
Burnaby, British Columbia
Canada V5G 3H2

Student Medical Certificate

Confidential Information

Student Number: _____

A. To be completed by student:

I, _____, hereby authorize the physician named below to provide the following information to BCIT and, if required, to supply additional information relating to my request for special academic consideration.

_____ _____
Signature Date

B. To be completed by physician:

I hereby certify that I provided medical services to _____, a student at BCIT. On the basis of the care provided, I am submitting the following information for use by BCIT in assessing what special consideration, if any, should be given to this student with respect to missed or affected classes, labs, assignments, tests or examinations.

1. Date(s) patient seen: _____
2. Is this an acute or chronic problem? _____
3. Date of onset of problem (or acute episode if problem is chronic): _____
4. Expected duration of the problem and treatment: _____
5. The immediate and/or ongoing impact of this problem and/or the treatment on the student's ability to meet academic commitments (such as attending classes, participating in labs and workplace practicums, safely operating equipment, completing assignments, preparing for and/or writing tests and examinations, completing courses, etc., is as follows:

_____

_____

_____

_____

_____

6. Diagnosis or nature of health problem: **(Not required)**
(Please do not complete this section unless the student has specifically requested you to do so.)

_____

_____

_____

Office address stamp:

Signature: _____

Name: _____
please print

Date: _____

Please retain copy for the patient's chart
Note: Any cost for this certificate must be paid by the patient

CRNBC Standards of Practice Nursing Practicum 1

Course Learning Outcomes/Suboutcomes

STANDARD 1: Responsibility and Accountability

Maintains standards of nursing practice and professional conduct determined by CRNBC and the practice setting.

- Takes action to promote the provision of safe and appropriate care to patients.
  - Tactfully questions the health care team when unsure of the rationale behind nursing practices.

- Follows BCIT and agency policies and procedures. (www.bcit.ca)

- Is accountable and takes responsibility for own nursing actions and professional conduct.
  - Takes charge of patient care rather than just following directions.

STANDARD 2: Specialized Body of Knowledge

Bases practice on the best evidence from nursing science and other sciences and humanities.

- Knows how and where to find information to support safe, appropriate, and ethical nursing care.
  - Prepares for the clinical experience and is able to discuss diagnosis, potential problems and complications, prescribed medications, relevant lab tests, anticipated nursing interventions, and priority of care.

- Uses knowledge of communication theory and appropriate professional boundaries to communicate effectively.
  - Demonstrates respect to patients, family members, staff, instructor, and fellow students.
  - Able to establish relationships with patients, instructor, fellow students, and health care team.
  - Demonstrates the use of basic interviewing skills to elicit information and understand other person's perspective.
    - Ability to ask pertinent or relevant questions and clarify answers.
    - Uses active listening, e.g., paraphrasing, reflection, clarification.
    - Responds to non-verbal communication.
  - Gains patient's trust.
  - Displays confidence at the bedside.

- Interprets and uses current evidence from credible sources to make practice decisions.
  - Performs appropriate teaching before, during, and after a technical skill to the patient and family members.
  - Asks about and researches alternative approaches to patient problems.

- Anticipates, prepares, and organizes self to perform skills.

STANDARD 4: Code of Ethics

Adheres to the ethical standards of nursing profession.

- Maintains confidentiality when discussing patient specific nursing practices.
- Acts as a patient advocate when the situation arises.
- Knows and upholds the values contained in the Canadian Nurses Association (CAN) Code of Ethics for Registered Nurses, namely:
  - Safe, competent, and ethical care.
  - Health and well-being.
  - Choice.
  - Dignity.
  - Confidentiality.
  - Justice.
  - Accountability.
  - Quality practice environments.

STANDARD 5: Provision of Service in the Public Interest

Provides nursing services and collaborates with other members of the health care team in providing health care services.

- Communicates, collaborates, and consults with other members of the health care team about the patients' care.
  - Introduces self to team members and explains role and abilities.
  - Addresses and solves a communication problem that may occur.
  - Follows up on patient issues with other health care professionals.
- Assigns appropriately to other members of the health care team.
  - Spontaneously helps team members.
- Promotes and participates in changes to improve patient care and nursing practice.
  - Attempts to take on a leadership role when appropriate.
- Begins to consider incorporating health promotion activities and discharge planning into patient care.
- Assists clients to learn about the health care system and access appropriate health care services.
  - Provides safe basic nursing care for two medical patients.
- Provides safe basic nursing care for two medical patients.

Student Name: _____
Student Number: _____
Instructor/Assistant Instructor: _____
Hospital/Nursing Unit: _____
Days absent: _____

(Please print in black ink)

STANDARD 1: Responsibility and Accountability Maintains standards of nursing practice and professional conduct determined by CRNBC and the practice setting.	**Midterm**		**Final**	
	MP	**NI**	**S**	**U**
• Takes action to promote the provision of safe and appropriate care to patients. ▸ Tactfully questions the health care team when unsure of the rationale behind nursing practices.				
• Follows BCIT and agency policies and procedures. (www.bcit.ca)				
• Is accountable and takes responsibility for own nursing actions and professional conduct. ▸ Takes charge of patient care rather than just following directions.				
Instructor Comments: **Midterm:** **Final:**				

MP = MAKING PROGRESS
NI = NEEDS IMPROVEMENT
S = SATISFACTORY
U = UNSATISFACTORY

STANDARD 3: Competent Application of Knowledge Makes decisions about actual or potential problems and strengths, plans and performs interventions, and evaluates outcomes.	**Midterm**		**Final**	
	MP	**NI**	**S**	**U**
• Collects information on patient status from a variety of sources using skills of observation, communication, and physical assessment. ▸ Performs a relevant, focused, and comprehensive assessment, and relates nursing actions to assessed data for assigned patients.				
▸ Demonstrates an understanding of the patient's situation and context through the use of communication skills.				
▸ Attempts to understand situations from a variety of viewpoints.				
• Designs plans of care that include data about assessments, planned interventions, and evaluation criteria for patient outcomes. ▸ Plans, implements, and evaluates safe, individualized nursing care.				
▸ Involves the patient and/or family in planning care.				
• Sets priorities when organizing, planning, and giving care.				
• Identifies, analyzes, and uses relevant and valid information when determining patient status and reporting patient outcomes. ▸ Thinks through nursing situations before coming to conclusions, and clarifies conclusions when necessary.				
▸ Articulates the thinking behind nursing actions and judgment.				
▸ Recognizes and reports promptly to RN and/or instructor when the patient's condition changes.				
• Documents timely and accurate reports of assessments and plans interventions. ▸ Records in a professional manner. – Clear and concise.				
– Accurate and relevant with correct spelling.				
– Timely.				
– Legally, according to agency guidelines.				
▸ Reports and records observations assessed prior to, during, and after performing skill.				
• Communicates patient status, using verifiable information, in terminology used in the practice setting. ▸ Reports, in a clear and timely manner, about patient care and progress to appropriate team members.				
• Carries out interventions in accordance with policies, procedures, and care standards. ▸ Intervenes when the patient's safety is in jeopardy.				
▸ Maintains patient and own safety and comfort when performing skills.				
▸ Uses appropriate resources to perform skills safely.				

STANDARD 4: Code of Ethics Adheres to the ethical standards of nursing profession.	**Midterm**		**Final**	
	MP	**NI**	**S**	**U**
• Maintains confidentiality when discussing patient specific nursing practices.				
• Acts as a patient advocate when the situation arises.				
• Knows and upholds the values contained in the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses, namely: ▸ Safe, competent, and ethical care.				
▸ Health and well-being.				
▸ Choice.				
▸ Dignity.				
▸ Confidentiality.				
▸ Justice.				
▸ Accountability.				
▸ Quality practice environments.				

Instructor Comments:

Midterm:

Final:

STANDARD 6: Self-Regulation Assumes primary responsibility for maintaining competence and fitness to practice.	**Midterm**		**Final**	
	MP	**NI**	**S**	**U**
• Maintains current CRNBC registration.				
• Practices within own level of competence. ▸ Recognizes limitations and seeks help from appropriate sources.				
▸ Seeks assistance when limitations are exceeded.				
• Meets the requirements for continuing competence, including investing own time, effort, or other resources to meet identified learning goals. ▸ Writes weekly reflective journals about practicum experiences.				
▸ Celebrates personal and professional growth.				
▸ Accepts feedback in an open manner.				
▸ Takes charge of own learning.				
▸ Develops and participates in a learning partnership with instructor. – Is willing to self-disclose about clinical performance with instructor.				
– Acts to improve clinical performance.				
– Sets goals and strategies for action.				
– Plans, implements, and evaluates improvement strategies.				
– Participates in pre/post conferences.				
▸ Evaluates own progress.				
• Maintains own physical, psychological, and emotional fitness to practice. ▸ Demonstrates a fitness to practice in the clinical setting by: – Effective coping strategies to deal with anxiety and psychological issues.				
– A support system to help with financial, time management, and emotional issues.				
Instructor Comments: **Midterm:** **Final:**				

STUDENT SUMMARY: (Midterm)

1. Areas of strength:

2. Areas for continuing development:

INSTRUCTOR COMMENTS:

Instructor's Signature: _____ **Date:** _____

Student's Signature: _____ **Date:** _____

STUDENT SUMMARY: (Final)

1. Areas of strength:

2. Areas for continuing development:

INSTRUCTOR COMMENTS:

Instructor's Signature: _____ **Date:** _____

Student's Signature: _____ **Date:** _____