A POLYTECHNIC INSTITUTION

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

Course Outline

NURS 1030
Nursing Clinical 1

Start Date: September 23, 2008

End Date: December 3, 2008

Total Hours: 140 **Total Weeks:** 10

Hours/Week: 14 **Lecture:** **Lab:**

Term/Level: 1 **Course Credits:** 5.5

Other: Clinical Experience

Prerequisites

Course No.	Course Name
Current CPR (HCP) certification	
CRNBC Student Registration Application	

Co-requisites

NURS 1020	Clinical Techniques 1 Laboratory
NURS 1019	Clinical Techniques 1Assessment
NURS 1000	Applied Nursing Science 1
NURS 1055	Professional Interpersonal Communication in nursing practice
NURS 1063	Pharmacology 1

NURS 1030 is a Prerequisite for:

Course No.	Course Name
NURS 2030	Nursing Clinical 2
NURS 2000	Applied Nursing Science 2
NURS 2020	Clinical Techniques 2 – 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 Medical Nursing Units**

■ Detailed Course Description

NURS 1030 is a clinical course that focuses on providing nursing care for people experiencing health problems who require hospitalization. Emphasis is placed on developing knowledge, skills, attitudes and judgements relevant to professional nursing practice. **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 weekly 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 standing.
- **Students must achieve 100% in med math by end of week 10 to complete NURS 1030.**

■ Course Learning Outcomes/Competencies

Upon successful completion, the student will be able to:

1. provides professional caring based on knowledge and skills.

2. pursues shared meaning by communicating effectively with people.

3. integrates systematic inquiry to:

   a. recognizes the uniqueness of each patient and/or patient situation and responding with appropriate clinical judgement.
   b. raises questions about nursing practices to explore alternatives.
   c. reflects on own nursing practice.

4. with instructor assistance, monitors own practice, determines learning needs, and independently acts upon identified learning needs.

5. develops collaborative partnerships with members of the health care team.

6. with instructor assistance, uses creative leadership skills to manage changing patient situations.

7. implements technical skills competently and with increasing confidence.

* Student clinical evaluation, combines the above outcomes with the *Professional standards for registered nurses and nurse practitioners* (CRNBC, 2005). See course syllabus for specific expectations.

■ Verification

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

Authoring Instructor — Aug 12/08 — Date

I verify that this course outline has been reviewed.

Program Head/Chief Instructor — August 12, 2008 — Date

I verify that this course outline complies with BCIT policy.

Dean/Associate Dean — August 13/08 — 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	604-454-2217
Judi Campbell	604-451-6957
Maureen Hornak	604-432-8917
Mina Amiraslany	604-451-6956
Connie Johnston	604-451-7189
Merry Van der Gracht	604-454-2214
Tammy Lail	604-454-2210
Cristina Durana	TBA

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). *Nursing documentation.* Vancouver, BC: Author. Retrieved May 23, 2007, from http://www.crnbc.ca/downloads/151.pdf

College of Registered Nurses of British Columbia. (2005). *Professional standard for registered nurses and nurse practitioners.* Vancouver, BC: 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

College of Registered Nurses of British Columbia. (2008). *Medications (2008).* Vancouver, BC: Author. Retrieved May26, 2008, from http://www.crnbc.ca/downloads/3.pdf

Jarvis, C. (2008). *Physical examination and health assessment* (5th ed.). (*Textbook and User's Guide Package for Health Assessment Online.*) Philadelphia, PA: W.B. Saunders.

Required: (Cont'd.)

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. (2006). *Clinical nursing skills and techniques* (6th 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. (2008 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, PA: 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

■ Information for Students (Cont'd.)

withdrawal or failure in any Nursing Clinical 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 clinical 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 clinical 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.

■ Process Learning Threads (Cont'd.)

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 clinical 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 clinical.

2. Safe nursing care is required. The instructor has the responsibility to assist students to provide safe and competent 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 clinical setting. (See Guidelines for Students in the nursing Program.)

3. Students can expect to **attend a weekly clinical 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 self-evaluation** which shows evidence that course outcomes/sub-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-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 clinical 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 Clinical 1

Course Syllabus

Date: May, 2008

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Burnaby, British Columbia

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BCIT Policy Information for Students

Introduction

Welcome to your first nursing clinical course. For many of you, this is your first clinical experience. Clinical is not an escape from classes; you must use more than just common sense to achieve course outcomes. Clinical requires thoughtful preparation, reflection, and integration of learning. Knowledge and skills are required. Clinical 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 clinical 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 clinical 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 clinical 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 clinical 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 clinical 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 evaluation.)

For some students, the requirement to contribute to performance summaries may be a very new experience. How do you go about preparing for such an interview? How do you collect evidence about your abilities and areas for improvement?

Start by reviewing your patient assignment sheets, notes used for clinical preparation and journal entries. They will help you identify what you know and what you have done. As you compare this knowledge and behavior with the course outcomes you will begin to see your progress toward achieving the course outcomes. Record your ideas and be prepared to discuss them with your instructor during the meeting. **At midterm, it is expected that students will identify course outcomes they have not yet achieved.** Begin to consider how you might go about learning to achieve these course outcomes. Remember, sometimes maximizing strengths helps us overcome areas for improvement.

4. During the exam week, all students will meet with their clinical instructor to draft the final summary of outcome achievement. Both will come to the meeting with evidence to support conclusions. (See the final evaluation and the NURS 1030 CRNBC Standards of Practise Course Learning Outcomes.) The instructor has the final responsibility for assigning the course grade.

Assignment Details

1. Students will be given patient information the day prior to the clinical days. **Prior to the first clinical day, students are expected to read their medical-surgical text so they have a reasonable understanding of the nursing care required for assigned patient(s).** This includes:

   - knowing the medical diagnosis and how disease alters usual body functions.
   - understanding the appropriate assessments required for the medical diagnoses and patient issues.
   - anticipating independent and dependent nursing care required.
   - speculating on the possible complications.
   - knowing the medications prescribed for the patient(s) including: the likely purpose of the medication for the patient(s), the action of the drug, the safe dosage, the usual side effects, the contraindications for the drug, and the nursing actions required prior, during, and post administration of the drug.
   - beginning to understand the relevant laboratory tests and knows:
     - Blood Chemistry: K (Potassium), Na (Sodium), Cl (Chloride), BUN (Urea Nitrogen), Cr (Creatinine), glucose
     - Hematology: Hgb (Hemoglobin), Hct (Hematocrit), Platelets, WBC (White blood cell count and Leukocyte count)
     - Cholesterol and Triglycerides: Cholesterol, HDL (High density lipoprotein), LDL (Low density lipoprotein)
     - Coagulation: PTT (Partial prothrombin time), PT (Prothrombin time), INR (International normalized ratio).

2. Students are expected to perform the clinical techniques and skills once learned in NURS 1020. Because of the client population at the assigned agency, the clinical instructor may also teach specific skills.

3. Nursing care must be safe and comfortable for patients and self. Please refer to the *Guidelines for Students in the Nursing Program* for specific policies regarding nursing care.

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 two patients by term's end. These care plans must be **comprehensive and patient individualized.**

6. Concepts from the NURS 1000 and 1040 courses apply to clinical 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 clinical setting according to the *Guidelines for Students in the Nursing Program.*

8. Weekly clinical activities include the hour-long clinical debriefing. The debriefing session is a structured group that allows teachers and students to process, contextualize, understand, reflect, and learn from the clinical 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 clinical 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 clinical 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 clinical 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 clinical situation.

The following guidelines will help you start a journal that will help in the reflection process:

1. Keep all the journal entries together in a book.

2. Describe the experiences briefly.

3. Make at least one journal entry each clinical week. Describe the events as you understood them.

4. Carefully examine your beliefs, feelings, and actions once you record the experience. Questions like "why did I feel that way"? "why did I act that way?" and "why did I use these words to describe the situation?" might help you identify your beliefs and feelings.

5. Record your analysis. Questions like "what have I learned from this event?" "how does this experience connect or relate to previous experiences?" "what would be the consequences if I behaved differently?" and "what might I do differently in the future?" might help you analyze the experience.

6. Consider what the experience tells you about the ways you learn.

7. Consider what lessons you have learned?

8. Include at least one positive statement about your strengths and abilities each week. Also, include an "I wonder..." statement to help you think about the possibilities of practice.

The student's contribution to this journal will be confidential between the student and the instructor. Sharing of any part of the student's writing will occur only when written permission has been given to do so. **All students must complete all the journal activities to achieve a satisfactory grade in this course.**

Instructors will make comments and ask questions to help students reflect on their clinical experiences in greater depth. Please reply to instructor questions.

Once students have been writing journals for a while, they might want to do a different, reflective thinking activity. This second activity is to help students identify another person's perspective of a nursing situation. In the journal:

- describe something significant that occurred in the clinical experience that involved another person (patient, family member, staff member, etc.).
- identify why the situation is significant to you.
- how might your perspective of the situation be different from the perspective taken by the other person?
- how might you validate this different perspective?
- how will the two perspectives impact your future nursing care?

References

Greenwood, J. (1998). The role of reflection in single and double loop learning. *Journal of Advanced Nursing, 27*(5), 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 2–4 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 patient's top 2–4 problems, based on your assessment and patient records? What specific care would you do? Include details — how often, etc.? (Must have 4 **interventions/problems)**	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 clinical 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.

Questions to Consider when Developing the Learning Plan

The following questions may assist the student in identifying their learning needs:

1. What knowledge and skills do you already have? Can you identify your own competencies?
2. What knowledge and skills are included in the course outcomes? What deficits can you identify between these?
3. Can you identify specifics such as patient care situations, clinical skills, and/or communications issues in which you feel you may have some deficits?
4. In what areas of clinical practice do you feel most comfortable? least comfortable?
5. Where and how will you obtain the relevant knowledge, skills, and attitudes?
6. What resources are available to assist you to meet your learning needs? (instructor, peers, written information)

Consider these three questions:

1. Where am I now?
2. Where do I need to be? What do I need to learn? (knowledge, skills, attitudes/values)
3. How will I get there? What or who can help me?

Strategies

Strategies will vary according to learning needs. These may include resources such as materials and human resources or strategies such as techniques and tools.

Related activities for meeting learning needs may include such things as verbal discussions with instructor, peers, other nurses, skill practicing in the lab, written reports on a relevant topic, case studies.

Examples

The student may identify the following needs in their learning plan:

"By September 15, I will consistently demonstrate complete, thorough, and accurate patient assessments." In order to meet this learning need, the student may do a post-conference presentation on the assessment of a patient with shortness of breath. This will include all data related to a respiratory assessment, including medications and lab values.

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)

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

Student Name: _____

Course: _____

Date: _____

Learning Needs (Sub-outcomes)	Strategies	Progress (Date of Comments)
Improve knowledge of the pathophysiology of COPD and key assessment data related to it	1. Review patho text, notes; seek Internet material on COPD; review information from previous patient's chart. 2. Request instructor review patient assessment and seek out patient with COPD to perform chest assessment. 3. Discuss questions and findings with instructor. 4. Have clinical discussion with peers, instructors in post conference.	• Sept. 12th — was able to relate pathophysiology to Mr. J. (patient with emphysema). Was able to identify patient problems based on assessments with appropriate rationale. • Sept. 13th — did presentation of patient in post conference; included all the assessment data relating to COPD.

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 — medication not available at designated time —patient not on ward — SN could not have planned in advance), would include:
  - no attempt made to look up information re drug in advance of time due.
  - SN very slow in preparation and administration of medication.
- not completing seven rights and three checks during preparation of medication.
- 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 administration of medication to wrong patient.
- prn medications not charted immediately.
- medications 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 medications in syringe or IV medications.
- failure to follow BCIT's Policy re medications.
- giving a medication 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.

4. Briefly outline steps you (student) will take to prevent reoccurrence.

5. Which Standard(s) for Nursing Practice in British Columbia relate(s) to this incident? Explain the relationship between the incident and the Standard(s).

Preceptor's/Instructor's comments:

Preceptor's/Instructor's Signature: _____ Date: _____

Course Instructor Notified: ☐ Yes ☐ No Date Notified: _____

Course Instructor's comments:

Course Instructor's Signature: _____ Date: _____

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 clinicals, 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

Course Learning Outcomes/Sub-outcomes

CRNBC Standard 1: Responsibility and Accountability

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

Course Outcomes

- *Provides professional caring based on knowledge and skills.*
- *Develops critical thinking skills and systemizing skills.*
- *With instructor assistance monitors own practice, determines learning needs, and independently acts on learning needs.*
- *Implements technical skills competently and with increasing confidence.*

Clinical practice indicators:

1.1. Is accountable and takes responsibility for own nursing actions and professional conduct.
  1.1.1. Takes charge of patient care rather than just following directions.
1.2. Functions within the legally recognized scope of practice of nursing and within all relevant legislation.
1.3. Follows BCIT and agency policies and procedures. (www.bcit.ca).
1.4. Takes action to promote the provision of safe and appropriate care to patients.
  1.4.1. Assertively questions the health care team when unsure of the rationale behind nursing practices.

CRNBC Standard 2: Specialized Body of Knowledge

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

Course Outcomes

- *Provides professional caring based on knowledge and skills.*
- *Pursues shared meaning by communicating effectively with people.*

Clinical practice indicators:

2.1. Knows how and where to find needed information to support the provision of safe, appropriate, and ethical care.
  2.1.1. Prepares for the clinical experience and is able to discuss potential problems and complications, prescribed medications, relevant lab tests, anticipated nursing interventions, and priority of care.
2.2. Shares nursing knowledge with patients, colleagues, students, and others.
  2.2.1. Performs appropriate teaching to the patient and family members before, during, and after a technical skill.
2.3. Interprets and uses current evidence from credible sources to make practice decisions.
  2.3.1. Asks about and researches alternative approaches to patient problems.
2.4. Understands and communicates nursing's contribution to the health of patients and communicates this to patients and families.
  2.4.1. Shares own thinking about issues and decisions related to patient care.

2.5. Uses knowledge of communication theory and appropriate professional boundaries to communicate effectively.
  2.5.1. Demonstrates respect to patients, family members, staff, instructor, and fellow students.
  2.5.2. Establishes relationships with patients, instructor, fellow students, and health care team.
  2.5.3. Demonstrates the use of basic interviewing skills to elicit information and understand the person's perspective.
    - Asks pertinent questions and clarifies answers.
    - Uses active listening, e.g., paraphrasing, reflection, and clarification.
    - Responds to non-verbal communication.
  2.5.4. Gains patient's trust.
  2.5.5. Displays confidence at the bedside.

CRNBC Standard 3: Competent Application of Knowledge

Makes decisions about actual or potential problems, plans and performs interventions, and evaluates outcomes.

Course Outcomes

- *Provides professional caring based on knowledge and skills.*
- *Pursues shared meaning by communicating effectively with people.*
- *Develops critical thinking skills and systemizing skills.*
- *Implements technical skills competently and with increasing confidence.*

Clinical practice indicators:

3.1. Collects information on patient status from a variety of sources using skills of observation, communication, and physical assessment.
  3.1.1. Performs a focused, thorough, and ongoing assessment.
  3.1.2. Demonstrates an understanding of the patient's situation and context through the use of communication skills with patient.
  3.1.3. Attempts to understand situations from a variety of viewpoints.
3.2. Identifies, analyzes, and uses relevant and valid information when determining patient status and reporting patient outcomes.
  3.2.1. Thinks through nursing situations before coming to conclusions, and clarifies conclusions when necessary.
  3.2.2. Articulates the thinking behind nursing actions and judgment.
  3.2.3. Recognizes and reports promptly to RN and/or instructor when the patient's condition changes.
3.3. Communicates patient status, using verifiable information, in terminology used in the practice setting.
  3.3.1. Reports, in a clear and timely manner, about patient care and progress to appropriate team members.
3.4. Develops plans of care that include data about assessments, planned interventions, and evaluation criteria for outcomes.
  3.4.1. Plans, implements, and evaluates safe, individualized nursing care.
  3.4.2. Involves the patient in planning and/or family in planning care.
3.5. Sets priorities when organizing, planning, and giving care based on nursing assessments and patient's wishes.
  3.5.1. Provides safe basic nursing care for two medical patients.

3.6. Carries out interventions in accordance with policies, procedures, and care standards.
  3.6.1. Intervenes when the patient's safety is in jeopardy.
  3.6.2. Maintains patient and own safety and comfort when performing skills.
  3.6.3. Uses resources to perform skills safely.
  3.6.4. Practices medical asepsis.
  3.6.5. Communicates appropriately with patients and family members.
  3.6.6. Maintains a tidy work area at the patient's bedside.
  3.6.7. Manages time such that nursing care is performed in a timely manner.
3.7. Evaluates patient's responses to interventions and revises the plan as necessary.
3.8. Documents timely and accurate reports of assessments, planned interventions and outcomes.
  3.8.1. Records in a professional manner.
    Clear and concise.
    Accurate and relevant with correct spelling.
    Timely.
    Legally, according to agency guidelines.
  3.8.2. Reports and records observations assessed prior to, during, and after nursing intervention/ skill.
  3.8.3. Researches and administers medications safely using 7 rights / 3 checks.
3.9. Initiates, maintains and terminates professional relationships in a manner appropriate to the setting.

CRNBC Standard 4: Code of Ethics

Adheres to the ethical standards of the nursing profession.

Course Outcomes

- *Provides professional caring based on knowledge and skills.*
- *Pursues shared meaning by communicating effectively with people.*

Clinical practice indicators:

4.1. Knows and upholds the values contained in the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses, namely:
  4.1.1. Safe, competent and ethical care.
  4.1.2. Health and well-being.
  4.1.3. Choice.
  4.1.4. Dignity.
  4.1.5. Confidentiality.
    Maintain confidentiality when discussing patient specific nursing practices.
  4.1.6. Justice.
  4.1.7. Accountability.
  4.1.8. Quality practice environments.
4.2. Consistently practices according to the responsibility statements in the CNA *Code of Ethics for Registered Nurses.*

CRNBC 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.

Course Outcomes

- *Pursues shared meaning by communicating effectively with people.*
- *Develops collaborative partnerships with members of the health care team.*
- *With instructor assistance, uses creative leadership skills to manage changing patient situations.*

Clinical practice indicators:

5.1. Communicates, collaborates, and consults with other members of the health care team about the patients' care.
  5.1.1. Introduces self to team members and explains role and abilities.
  5.1.2. Addresses and solves a communication problem that may occur.
  5.1.3. Follows up on patient issues with other health care professionals.
  5.1.4. Establishes an effective rapport with RN and other nursing staff.
5.2. Assigns appropriately to other members of the health care team.
  5.2.1. Spontaneously helps team members.
5.3. Guides other members of the health care team as appropriate.
5.4. Advocates and participates in changes to improve patient care and nursing practice.
  5.4.1. Attempts to take on a leadership role when appropriate.
  5.4.2. Acts as a patient advocate when situation arises.
5.5. Reports (recognizes and discusses) unsafe practice or professional misconduct to appropriate person or body.
5.6. Assists patients to learn about the health care system and access appropriate health care services.
  5.6.1. Begins to consider incorporating health promotion activities and discharge planning into patient care.

CRNBC Standard 6: Self-Regulation

Assumes primary responsibility for maintaining competence and fitness to practice.

Course Outcomes

- *Develops critical thinking skills and systemizing skills.*
- *With instructor assistance, monitors own practice, determines learning needs and independently acts upon learning needs.*

Clinical practice indicators:

6.1. Maintains current CRNBC registration.
6.2. Practices within own level of competence.
  6.2.1. Recognizes limitations and seeks help from appropriate sources.
  6.2.2. Seeks assistance when limitations are exceeded.
6.3. Meets the requirements for continuing competence, including investing own time, effort, or other resources to meet identified learning goals.
  6.3.1. Writes weekly reflective journals about clinical experiences.
  6.3.2. Celebrates personal and professional growth.

6.3.3. Accepts feedback in an open manner.
6.3.4. Takes charge of own learning.
6.3.5. Develops and participates in a learning partnership with instructor.
- Evaluates own progress.
- Is willing to self-disclose about clinical performance with instructor.
- Sets goals and strategies for action; implements and evaluates strategies
- Asks for help in developing strategies as needed
- Participates effectively in pre/post conferences

6.4. Maintains own physical, psychological, and emotional fitness to practice.
6.4.1. 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.