BCIT Nursing Practice Areas of Concern & Strategies for Improvement

STANDARD 1: Professional Responsibility and Accountability

Maintains standards of nursing practice and professional conduct determined by BCCNM.

Concern: Student displays inadequate, incorrect, or inappropriate clinical reasoning/judgment (THIS PROBLEM CAN ALSO BE APPLICABLE TO STANDARD 2)

Strategies:

- **Clinical Reasoning:** Utilize PRE (problem, related to, evidence) - knowing what the problem is and what it is related to will guide you to specific interventions. Knowing the evidence will guide you to what to evaluate.
- Separate your problems and narrow them down/be specific. E.g. impaired perfusion could be: risk for hemorrhage, risk for VTE, fluid overload, hypovolemia, etc. - there needs to be a specific problem to determine specific interventions.
- Remember instructor/MRN do not know your thoughts - share all the connections, not just parts of the connections
- Think about the missing information/conflicting information - do you gather more data/ do you need more than one source? "More than one source, more likely the course".
- Make sure you are not making assumptions - ensure you have supporting evidence.
- **Ask yourself 'why'** regarding each aspect of your patient's care, run through scenarios and think about what you would do - ask a peer what they would do - if something does not make sense, stop and think about the situation, different options, weigh options according to the patient's best interest and try to identify a solution (ask for assistance when required/outside of scope).
- When you "notice" something abnormal make sure you write it down on your cheat sheet. Then once you leave the room, take the time to use your Clinical Judgment Model to help determine how you would "interpret" and "respond".
- At the end of every assessment pause and consider, "what does this information tell me"? Consider how the data validates/invalidates a patient problem. Make the adjustment, then make sense of it. Consider the links to pathophysiology, lab, diagnostics, medications, etc. Consider what is "actually" going on for the patient. If something does not make sense, seek clarity.

- Review clinical reasoning case studies, continue discussing your patients with your instructor and RN to gain understanding of clinical reasoning/judgment, debrief/reflect on your clinical day with a peer and share in post conference. Discuss what you are "noticing" with the RN, instructor, and peers, sometimes talking out loud helps you make links and connections to enhance your clinical reasoning.
- **Continue using Concept Maps & Clinical Judgment Models**: Think about how the patient's medications, fluids, focused assessments, complications/S&S, therapies /treatments relate to medical diagnoses, related tests/Labs (Hi, Lo, WNL), applicable nursing diagnoses, patient teaching/nursing interventions. In other words, how does what we do relate to what is going on with the patient - if something does not make sense then it needs to be questioned.
- Ensure you have a plan of care that is specific for all your patients - Actual and Potential Problems with appropriate assessments and interventions. Look at the plan of care already created for your patients on the unit as a guide. In addition, it will help you "investigate" what is going on with the patient. Don't just fixate on current patient problems, also anticipate what could happen and how you would intervene. Your problems should not be broad concepts e.g. gas exchange, perfusion - they need to be specific to the current state of patient e.g. respiratory depression for post-op. Problems that are specific to your patient with detailed assessment and interventions will provide you a plan of care for your patients.

Concern: Student displays lack of insight in assessing their own nursing practice

Strategies:

- 1:1 meeting with student, preceptor and instructor to discuss the situation
- Ensure the student shares their point of view regarding their nursing practice and what they feel might be areas for improvement
- Suggest counseling and sessions with the Program Head or Student Success Lead
- Encourage self-reflection
- Use a coaching approach to partner with the student and encourage them to self-identify what they need to work on and what they think the best strategies would be.

Concern: Student displays a lack of initiative and/or confidence in nursing practice

Strategies:

- Find ways to boost your internal motivation (e.g. reflect on why you chose to pursue nursing, imagine yourself as a nurse). Continue to seek support from friends and family. Reflect on your success in clinical and the things you do well. When in clinical, move, walk, and talk with "energy" even when you do not feel (this is a behavioral trick that can help boost confidence and morale). Remember you are in the learning process, if you make a mistake, give yourself permission to learn from this and grow in your practice.
- Create a specific learning plan for you - think about what you want to work on. Make your goals specific use SMART Goals Journal/Self-reflect after each shift to consider your progress.
- When feeling yourself losing confidence "Stop" "Breath" and "Organize". When able, advocate for some time to gather your thoughts (be specific: e.g. "can I have 5 minutes to think, then I will come find you and report").
- Continue to build your knowledge and safety as this will increase your confidence. Don't pause or hesitate when a patient asks you something you do not know - provide reassurance and state you will find out - it is okay if you don't have an answer for all the questions a patient asks - listen, validate their concern/questions, and then find shared goals for you to complete your tasks.
- Ensure you are coming to clinical prepared and on time/early to minimize anxiety and increase your confidence.

Concern: Student is inadequately prepared for clinical practice and/or is arriving late

Strategies:

- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation - ask what is hindering preparation or causing lateness?
- Ensure the student shares their point of view and rationale
- Suggest counseling and/or meeting with Program Head
- Have the student refer to BCIT BSN Program Student Guidelines and Procedures

- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Suggest student review the BCCNM Professional Responsibility & Accountability Module

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Concern: Student did not recognize and/or report abnormal patient data

Immediately halt unsupervised patient care until student has demonstrated safe practice consistently while supervised. Review BCCNM Regulatory Supervision of Students.

- Refer to BCIT BSN Program Student Guidelines and Procedures
- Have student fill out hospital authority incident report if required and BSN Safety Event form

Strategies:

- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Suggest student review the BCCNM Professional Responsibility & Accountability Module
- 1:1 meeting with student, preceptor and instructor to discuss the situation - ensure the student shares their point of view and rationale
- Develop a plan with the student e.g. the student must be supervised with care until deemed safe, must report all assessment findings to preceptor

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Concern: Student displayed inappropriate behaviour towards patients, staff, peers or instructor

Refer to BCIT BSN Program Student Guidelines and Procedures

Strategies:

- Suggest student review BCIT Harassment, Discrimination, & Bullying Resources
- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards

- Suggest student review the BCCNM Professional Responsibility & Accountability Module
- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation - Program Head may be present

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Concern: Student displayed avoidance/omission of care or implemented unsafe care

Immediately halt unsupervised patient care until student has demonstrated safe practice consistently while supervised. Review BCCNM Regulatory Supervision of Students.

- Refer to BCIT BSN Program Student Guidelines and Procedures
- Have student fill out hospital authority incident report if required and BSN Safety Event form

Strategies:

- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Suggest student review the BCCNM Professional Responsibility & Accountability Module
- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation - Program Head may be present

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Concern: Student was unable to resolve conflict or negotiate solutions within the team

Strategies:

- Suggest student review BCIT Conflict Resolution Resources
- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Suggest student review the BCCNM Professional Responsibility & Accountability Module
- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation

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Concern: Student performed procedures without prior teaching, adequate supervision, or in violation of program/agency policy

Immediately halt unsupervised patient care until student has demonstrated safe practice consistently while supervised. Review BCCNM Regulatory Supervision of Students.

- Have student fill out hospital authority incident report if required and BSN Safety Event form
- Refer to BCIT BSN Program Student Guidelines and Procedures

Strategies:

- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Suggest student review the BCCNM Professional Responsibility & Accountability Module
- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation - Program Head may be present

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STANDARD 2: Knowledge-Based Practice

Consistently applies knowledge, skills, and judgment in nursing practice.

Concern: Student endangered patient's safety

Immediately halt unsupervised patient care until student has demonstrated safe practice consistently while supervised. Review BCCNM Regulatory Supervision of Students.

- Have student fill out hospital authority incident report if required and BSN Safety Event form
- Refer to BCIT BSN Program Student Guidelines and Procedures

Strategies:

- Suggest student review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Suggest student review the BCCNM Knowledge-Based Practice Module

- 1:1 meeting with student, preceptor and instructor discuss the situation - Program Head may be present
- Avoid rushing to action or speaking with scattered information or missing data. Allow yourself to have the moment to consider the necessary focus. Take a moment to step back to Stop what you are doing, take a deep Breath, and then Organize your thoughts/plan. Confirm that your plan is safe and makes sense to the problem as you focus on "priority problems".
- Use a Clinical Judgment Model - follow through on each step of the CJM-e.g. Noticing, Interpreting, Responding, Reflecting
- In your cheat sheet, identify the interventions that you would need to have "signed off" or that you would need additional monitoring and assessment for. Report your planned intervention to your nurse and instructor. There is a policy or protocol for almost everything in acute care settings. Get in the habit of linking a "safety plan" to your planned intervention.
- Use additional supports to practice your organization and nursing process (e.g. attend Open Lab, work with peers, seek peer tutoring)
- Prior to going into a patient's room - pause - collect your thoughts - and imagine being in the room. What are you going to do first? When you are sensing some uncertainty about your next action - Pause and think - then consider "do I need to clarify something or do I need to act". Ask if you are uncertain.
- Make your ABCS systematic but stay aware of what is happening with your patient so that you notice anything changing etc.

Concern: Student is unaware of own limits and not seeking help appropriately

Immediately halt unsupervised patient care until student has demonstrated safe practice consistently while supervised. Review BCCNM Regulatory Supervision of Students.

- Have student fill out hospital authority incident report if required and BSN Safety Event form
- Refer to BCIT BSN Program Student Guidelines and Procedures

Strategies:

- Review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards

- Review the BCCNM Knowledge-Based Practice Module
- 1:1 meeting with student, preceptor and instructor to discuss the situation - Program Head may be present

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Concern: Student failed to focus on patient's needs

Strategies:

- Utilize concept maps & CJMs to focus on specific patient needs.
- Become familiar with the most common physical or mental illnesses or surgeries/procedures on your unit and familiarize yourself with policies and PPO and then focus on your actual patient. Avoid using care plan books and fixating on A/P definitions of co-morbidities - determine what is going on with the patient and why they have that co-morbidity how you would assess and treat your patient.
- Prior to caring for your patient, think of what patient education you may need to know and have the goals for your patient on the cheat sheet and understand reasoning/education behind these goals. Write out your Actual and Potential Problems for patients on your cheat sheet with assessments and interventions this will help guide your care.
- Look at everything (anatomy/pathophysiology) in a system and relate the co-morbidity to the system, instead of trying to see the links just between the co-morbidities.
- Avoid overthinking, getting stuck at the cellular level, or creating links that are a far "stretch" - understand what you need to know to care for the patient - assessment, interventions, etc. Be concise and clear.
- When you are going into a patient's room have your priority problems in mind so they can guide your assessments - Look at your cheat sheet and verbally review problems. Ensure you have a well-used cheat sheet. Ensure there is an area for Actual and Potential Problems, notes, and questions. Write down what questions you have about your patients during your shift - this will prompt you to find the answers. E.g. why does the patient still have a foley when he is post op day 2?
- Avoid having too many pieces of paper and try to keep your concept map to one page with identified priority problems - expand these on the back with assessments/interventions etc., research.

- Look at the physician's orders and the Kardex/nursing care plan for clues as to what the priority problems are and what might be potential problems E.g. if an antiemetic is ordered, nausea would be an actual or potential problem, if a narcotic is ordered, pain would be an actual or potential problem and if an opioid was given, a potential problem would be side effects from the opioid (resp depression, nausea, constipation, etc.).

Concern: Student has difficulty linking knowledge to practice

Strategies:

- Connect noticing with interpretation: After every assessment pause and consider "what does this information tell me"? "are the problems validated"? Make the adjustment, then make sense of it. Be curious like a detective. Identify the validating S&S and then consider patho, lab, medication links etc. Prior to leaving the bedside, pause and look back at the patient and environment and ask yourself "have I really 'seen' this patient".
- Review your notes/resources from Nursing Knowledge classes.
- Utilize tools from the Learning Skills & Strategies and Learning Strategist and Study Skills/LibGuides
- Utilize resources on campus to practice making connections such as peer tutoring or a study buddy who is strong in clinical reasoning and planning
- After assessing a patient - pause and think. Ask yourself "have my priority problems changed? Have my priority problems been validated"? Take note of your assessment data and pause, think, assess (what more do you need to know or do before acting?).
- Try to memorize common lab values (i.e. K+, Hgb, WBC and more).
- Consider what the most likely priority problem is based on current patient data (diagnosis, procedures, labs, meds etc.). Connect your meds, lab values, tubes/lines/drains and diagnostic tests to your problems (in your care plan and your assessment and intervention plan). Take a few minutes to make links before giving report. Re-prioritize your patient problems prior to report. If needed - ask your nurse or instructor for a few minutes to think before talking (give them exactly how much time you need).

Concern: Student has specific knowledge gaps (A&P, pharmacology etc.)

Strategies:

- Review your notes/resources from Nursing Knowledge classes.
- Utilize tools from the Learning Skills & Strategies and Learning Strategist and Study Skills/LibGuides
- Utilize resources on campus to practice making connections such as peer tutoring or a study buddy who is strong in clinical reasoning and planning
- Utilize BCIT and Health Authority resources. Additionally, look at patient information booklets and read through things in layman's terms as well as medical texts etc.
- Become familiar with the most common physical or mental illnesses or surgeries/procedures on your unit and familiarize yourself with policies and PPO. Collect your care plans and refer back to them for similar types of patients (like a repository).
- Go through clinical reasoning case studies similar to the patients on your assigned unit.
- At the end of every assessment pause and consider "what does this information tell me"? Consider how the information validates or invalidates an anticipated patient problem. Make the adjustment, then make sense of it. Be curious like a detective. Consider the pathophysiology, labs, medications, diagnostics, etc. and how they all link together.

Concern: Struggling to prioritize/prioritizing inappropriately

Strategies:

- **Ranking patients:** first level - ABC issues/potential issues, second level - new concerns, changes in status, increased requirements, untreated problems that need immediate attention, safety risks, third level - stable patients that have no new issues or ABC concerns, patients who will be discharged soon. On your cheat sheet put your 3 priority problems for your patient(s). Refer to this often and adjust if status changes. Prior to caring for your patient(s), you should be clear about your priorities and focused assessment linked to the priorities.
- When identifying priorities, first identify the most "obvious" links (patient diagnosis, planned focused assessment) to match with the patient. You should be able to

explain the rationale for your plan. Be concise and clear. Don't create "far stretched" links. Not everything that you research about your patient can be a priority. Make decisions about your most prioritized problem based on ABCCS and the most likely problems related to the surgery/procedure/diagnosis and data supported by orders/meds.

- Look at the physician's orders and the Kardex/nursing plan for clues as to what the priority problems are and what might be potential problems e.g. if an opioid was given, a potential problem would be side effects from the opioid (resp depression, nausea, constipation, etc. Connect your meds, lab values, tubes/lines/drains and diagnostic tests to your problems (in your care plan).
- The plan of care should be organized and focused on the priority problem. For instance, your assessments should validate (or invalidate) a problem and interventions should "fix/address" the problem. Although priority problems may be inter-linked, you should have a focus when researching and preparing for your plan of care. After every assessment pause and consider "what does this information tell me"? "are the problems validated"? Make the adjustment, then make sense of it. Identify the validating S&S and then consider patho, lab, med links etc. If there is a change in status from what you are anticipating, assess and communicate prior to intervening.
- Build on your systematic assessments to identify a focused assessment for your patient. Ideally perform the focused assessment "first" to validate a priority concern. Follow your gut when you notice abnormal data. Pause and think "is there more information that I need right now, have my priorities changed". Use your cheat sheet as a tool. List all the tasks you need to do and give them a priority (i.e., #1, #2, #3). This strategy will help you with needs to be done "now" versus what can be done "later". Add these tasks to a timeline of your day listed in 15-30 min increments. Ensure you have room in your schedule for unplanned events/needs and frontload care.

Concern: Student is unable to manage timeframes

Strategies:

- Keep a 1 page (front & back) working document/cheat sheet on you that includes a detailed timeline with checkboxes for your whole day (all patients on the same timeline & include: medications, assessments, when to check labs, I&O's, dressing changes/procedures/skills - time set up with instructor if supervision is needed,

patient education, discharges, patients going for tests/surgery, documentation, re-evaluation of interventions, etc.) written in 15-30 min increments. Ensure you have room in your schedule for unplanned events/needs. On this timeline, incorporate times to seek your instructor and RN to give report and to look at charts again in more depth to make connections. Be realistic when estimating how long something will take - ask your peers/RNs/instructor for guidance.

- Set a quiet timer before entering the room so you are aware if you get sidetracked/go over time. Recognize when you are being distracted/interrupted/sidetracked and get back on track asap (be appropriately assertive) - if you can't identify this, ask a peer or your instructor to observe you. Look at your timeline before deciding what to do next - a good place to do this is often after hand hygiene outside the patient's room. Write things down before moving on to your next task and write down times of occurrence and a brief note of anything you need to document. Document as soon as possible after completing priorities.
- Prioritize what is most important throughout the day and what you can delegate if you need to. Take breaks early rather than later (don't keep trying to finish everything, delegate if necessary). Frontload and group all tasks - Start to do things 30min prior to them being due. 1000 meds at 0930, etc. Aim to get most of your "tasks" done before lunch/early in the shift so that you are prepared for the unexpected. Keep all your areas and your patient's room organized, tidy up as you are talking to them. Consider what the patient may be capable of doing and encourage independence. Set boundaries with any patients who are dominating your time with requests.
- Build on your systems and strategies that are already working well. When you practice, assess, report, or document, follow the same system so that it becomes muscle memory. Develop a systematic way of your initial approach for every patient, however, be aware of anything that may need immediate attention. Consider using the system of ABCDE to ensure that your focused assessment is a priority (Airway, Breathing, Circulation, Diagnosis: all assessments related to the patient's current diagnosis/surgery, Equipment: check all tubes, lines, drains and other equipment, including safety equipment). If a patient status changes this a cue to start the system again. Practice this system in lab and at home until it becomes second nature.
- Avoid rushing when you feel anxiety rising - take the moment to step back and Stop, Breathe, and Organize - review what you need to do next. If something unexpected happens - address any urgent/immediate concerns, then take a few minutes to

determine what your top priorities are. Ask for guidance when appropriate as well as reporting/following up with your instructor and RN - make sure you are prepared with what you need to say/ask before you approach someone. Limit going back and forth between patients or charts without fully completing tasks or gathering all information

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Concern: Student has challenges with stress management/anxiety

Strategies:

- Recognize and acknowledge your emotions. Consider external and BCIT supports - Student Health, Wellbeing, Stress, & Anxiety Management, Counselling & Student Development, Mindfulness for managing anxiety or "flooding" of emotion that may impact clinical reasoning and judgment. If you are already accessing these resources, utilize the strategies that you already have experience with or implement new strategies.
- Take a moment to step back to Stop what you are doing, take a deep Breath, and then Organize your thoughts/plan. Every time you go to see your patient, first, pause outside their room. Imagine yourself going in. What are you going to do first? What are you anticipating? It is okay to stop, take a deep breath and give yourself a moment to think. When you feel anxiety creeping in, this is your cue to stop and think (ask yourself "do I need more information? What is the safest decision right now"). "Pause, Think, Act" any time you are feeling flustered.
- Practice being distracted while also needing to complete a task (have a conversation while washing the dishes or fixing something). Find a peer who can be your "reporting person". Practice giving report on case studies, or on previous patients using ISBAR. Ask for feedback.
- At the end of every assessment pause and consider "what does this information tell me"? Consider how the information validates or invalidates an anticipated patient problem. Make the adjustment, then make sense of it. Be curious like a detective. Consider the patho links, lab links, med links etc. Commit some common things to memory (common lab ranges E.g. Hgb, K, WBC, vital sign ranges).
- Practice "thinking" under pressure (e.g. time yourself in a case study, have an observer during open lab). Advocate for yourself if you need more time to think. However, be sure to give a timeline to your RN/instructor for how long you need and then initiate the follow up.

- Use systems and tools that support you: Cheat sheet with a developed timeline in 15-30 min increments; highlight planned focused assessments; write lab value ranges & develop a systematic way of approaching every patient (i.e., A, B, C, D (diagnoses - why is the patient here?), E (equipment - check all tubes lines and drains), S (safety). Practice this same system in clinical and lab. Practice assessments and skills in Open Lab to build confidence. Advocate for yourself- request a few minutes to compose your thoughts or organize your information if you are asked a question and feel flustered. Avoid rushing to respond with scattered information or missing data.

Concern: Student has difficulty individualizing care

Strategies:

- Gather all necessary data prior to your shift - prioritize what you need to know vs nice to know. List all tubes, lines, drains, monitoring required and look up the unfamiliar. Ensure you discuss what you are unsure about with instructor/RN first thing in the morning. Make sure you understand why patient has a tube/line and drain - the purpose of it and what/why you are monitoring. Connect your meds, lab values, tubes/lines/drains and diagnostic tests to your problems. Make sure you understand why each medication is given - specifically for your patient. Determine what nursing interventions/considerations need to be made with the medication.
- Talk to your RN/instructor about your clinical decisions - explain your reasoning/rationale and support this with evidence.
- Put your Actual and Potential Problems for your patient on your concept map/CJM/cheat sheet with assessments and interventions this will help guide your care. Prior to caring for your patient, think of what patient education you may need to know. Have your goals for your patient on the concept map/CJM/cheat sheet and understand reasoning/education behind these goals.
- Look at your patient's history and write out a timeline of what happened first, next, etc. leading up to the present moment. What is their current plan of care? Are they progressing to wellness? Are they declining? Are they under palliative care? Are they close to discharge? Are multiple issues occurring? Do they have a firm diagnosis?

Concern: Student is unable to competently perform skills as required for their term or previous terms

Strategies:

- Practice in Open Lab with a peer
- Observe an RN or peer perform the skill
- Watch additional videos from valid sources
- Look for opportunities for skills during the day - put the word out that you are looking for more experiences
- Read the policy/procedure ahead of time - this can be done on your days off and take notes of the important things to remember

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Concern: Looking at the complete picture- (big picture, small picture, individualized picture)

Strategies:

- Look at the physician's orders for clues as to what the priority problems are and what might be potential problems e.g. if an antiemetic is ordered, nausea would be an actual or potential problem, if a narcotic is ordered, pain would be an actual or potential problem and if an opioid was given, a potential problem would be side effects from the opioid (resp depression, nausea, constipation, etc.)
- Create detailed concept maps/CJMs - if you don't have enough time prior to clinical, do this during or after so you see where the connections are. This can assist you when you experience similar patients - can help you see similarities and differences. Make time to reflect and actively make connections.
- Think through connections & anticipate problems: Think about how the patient's medications, fluids, focused assessments, complications/S&S, therapies/treatments relate to medical diagnoses, related tests/Labs (High, Low, WNL), applicable nursing diagnoses, patient teaching/nursing interventions. In other words, how does what we do relate to what is going on with the patient - if something does not make sense then it needs to be questioned. If you don't have time prior to clinical do this during or after so you see where the connections are. This can assist you when you experience similar patients through seeing similarities and differences.
- When something is abnormal e.g.: high output of JP, take a moment to look at the whole picture of the patient - VS, LOC etc. Then determine your clinical decision and

confidently discuss with all your data. Don't just stop at the abnormal and question it - gather info first (be a detective).

- Research the most common diagnoses and/or surgeries on your unit so you are familiar with A&P and common assessments/interventions. Review PPOS
- Use a CJM and review clinical reasoning case studies. Ask yourself 'why' regarding each aspect of your patients care, run through scenarios and think about what you would do - ask a peer what they would do

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STANDARD 3: Patient-Focused Provision of Service

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

Concern: Student is unable to demonstrate appropriate assertiveness when advocating for patients

Strategies:

- Review the BCCNM Patient-Focused Provision of Care Module
- Seek out opportunities to talk to HCPs and physicians, do not wait for the opportunities to come to you. Challenge yourself to get to know at least 1 HCP per set of shifts. Find out their name and talk to them about your patient.
- You are part of the health care team and have vital information that you can share. In addition, information they have may impact how you care for your patients.
- Take lead in reporting to your instructor. Approach your instructor with your patient's problems - inform them of your assessments, interventions, and what you will re-evaluate. Explain your clinical decision-making process for determining this. Do not wait for them to ask you questions. Work toward independent practice. Write notes or follow a format when talking to your instructor.

Concern: Student has difficulty collaborating

Strategies:

- Build a partnership with your instructor, peers, and other members of the team: Identify shared goals in learning and seek clarity on expectations (each term, site, and instructor may have a new way of implementing the principles of content).
- Advocate for yourself and seek clarity about any identified challenges. Ask for 1:1 time with your instructor to review a clinical day and discuss/articulate your plan/research.
- Take the initiative to set time to seek out your instructor and report (use ISBAR or report on your plan/actions and your decision-making process).

Concern: Student displays inconsistent communication

Strategies:

- Advocate for yourself to have some time to collect your thoughts prior to reporting to your instructor. Try to initiate the report rather than waiting for your instructor to find you. Request a few minutes to compose your thoughts or organize your information if you are asked a question and feel flustered.
- Be specific and clear in your terminology. Avoid using "low" and "high". Use specific values and nursing language. If you are unsure of something, try not to guess "out loud". Seek clarification or identify "I think it is XXX, but I need to look it up to confirm. Commit some information to memory for "quick recall" (for instance, normal Hgb, K+, WBC). Write short notes on your cheat sheet for anything you find difficult to explain.
- Advocate for yourself and clarify your instructor's expectations and the expectations of your clinical practice site. Do this pro-actively rather than waiting for instructions.
- Practice giving unscripted report on case studies. Use your cheat sheet as a 'prompt' in clinical but challenge yourself in practice to make connections without a script. Record yourself giving ISBAR report for reflection. Collaborate with peers to practice giving report. Once you have ensured that you have all the information you need, quickly write down what you need to say in an ISBAR format so you can refer to it while giving report - ensure you are telling a logical story - start at the beginning, explain the middle, and finish at the end/conclusion.
- Anticipate that the patient will ask you questions - you may be able to anticipate the kinds of questions patients will ask based on their chart data (E.g. if they smoke, etc.). Practice being interrupted during a skill or assessment (at home or in lab - ask

someone to interrupt you). Review relational practice techniques until they become comfortable.

Concern: Student displays inappropriate or ineffective communication skills (THIS COULD BE STANDARD 1 as well)

Strategies:

- Advocate for yourself to have some time to collect your thoughts prior to reporting to your instructor. Try to initiate the report rather than waiting for your instructor to find you. Request a few minutes to compose your thoughts or organize your information if you are asked a question and feel flustered.
- Be specific and clear in your terminology. Avoid using "low" and "high". Use specific values and nursing language. If you are unsure of something, try not to guess "out loud". Seek clarification or identify "I think it is XXX, but I need to look it up to confirm. Commit some information to memory for "quick recall" (for instance, normal Hgb, K+, WBC). Write short notes on your cheat sheet for anything you find difficult to explain.
- Advocate for yourself and clarify your instructor's expectations and the expectations of your clinical practice site. Do this pro-actively rather than waiting for instructions.
- Practice giving unscripted report on case studies. Use your cheat sheet as a 'prompt' in clinical but challenge yourself in practice to make connections without a script. Record yourself giving ISBAR report for reflection.
- Collaborate with peers to practice giving report. Once you have ensured that you have all the information you need, quickly write down what you need to say in an ISBAR format so you can refer to it while giving report - ensure you are telling a logical story - start at the beginning, explain the middle, and finish at the end/conclusion.
- Anticipate that the patient will ask you questions - you may be able to anticipate the kinds of questions patients will ask based on their chart data (Eg. if they smoke, etc.). Practice being interrupted during a skill or assessment (at home or in lab - ask someone to interrupt you). Review relational practice techniques until they become comfortable.

STANDARD 4: Ethical Practice

Understands, upholds, and promotes the ethical standards of the nursing profession.

Concern: Student displays dishonesty (STANDARD 1 as well)

Strategies:

- Refer to BCIT BSN Program Student Guidelines and Procedures
- Review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Review the BCCNM Standard 4: Ethical Practice Module
- Review the Canadian Nurses Association (CAN) Code of Ethics
- 1:1 meeting with student, preceptor and instructor to discuss the situation - Program Head may be present

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Concern: Student displays a failure to respect patient's rights

Strategies:

- Refer to BCIT BSN Program Student Guidelines and Procedures
- Review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Review the BCCNM Standard 4: Ethical Practice Module
- Review the Canadian Nurses Association (CAN) Code of Ethics
- 1:1 meeting with student, preceptor and instructor to discuss the situation - Program Head may be present

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Concern: Student displays a failure to maintain patient's dignity

Strategies:

- Refer to BCIT BSN Program Student Guidelines and Procedures

- Review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Review the BCCNM Standard 4: Ethical Practice Module
- Review the Canadian Nurses Association (CAN) Code of Ethics
- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation - Program Head may be present

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Concern: Student fails to report errors (STANDARD 1)

Strategies:

- Refer to BCIT BSN Program Student Guidelines and Procedures
- Review the British Columbia College of Nurses & Midwives (BCCNM) Professional Standards
- Review the BCCNM Standard 4: Ethical Practice Module
- Review the Canadian Nurses Association (CAN) Code of Ethics
- 1:1 meeting with student and instructor outside of the clinical area to discuss the situation - Program Head may be present