BSN Student Scope of Practice

STANDARDS
LIMITS
CONDITIONS

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STANDARDS, LIMITS, AND CONDITIONS

This document is modeled after the British Columbia College of Nurses and Midwives (BCCNM) Scope of Practice for Registered Nurses (BCCNM, 2020c).

This document provides direction for the University of British Columbia Okanagan (UBCO) and Okanagan College (OC) Bachelor of Science in Nursing (BSN) program on which skills nursing students may and may not perform, and describes the specific standards, limits, and conditions under which certain skills may be performed.

Standards: BCCNM (2012) defines a standard as "a desired and achievable level of performance against which actual performance can be compared. It provides a benchmark below which performance is unacceptable" (p. 6). There are two levels of standards that BSN students must meet in this nursing program:

1. **BCCNM Professional Standards**: BSN students are expected to practice according to the BCCNM Professional Standards (2012).
2. **UBCO and OC BSN Competencies and Quality Indicators**: Students in the UBCO or OC BSN program are expected to meet the competencies and quality indicators described in the domains of the Practice Appraisal Form (PAF) for all nursing practice courses.

SCOPE OF PRACTICE FOR BSN STUDENTS

In addition to the BCCNM Scope of Practice for Registered Nurses (BCCNM, 2020c) the UBCO School of Nursing and OC Nursing Program places additional limits and conditions on the practice of BSN students.

BSN students are expected to recognize their own limitations, act responsibly at all times, and take responsibility for ensuring their own continued competency and learning. BSN students must at all times adhere to the Canadian Nurses Association (CNA) Code of Ethics (2017) and act in conformity with the BCCNM Professional Standards (BCCNM, 2012) and Practice Standards (BCCNM, 2020a).

Limits: Limits describe the activities that BSN students are not permitted to perform. For example, BSN students may not, under any circumstances, take blood for an **arterial blood gas** analysis.

Conditions: Conditions describe the specific circumstances in which BSN students may perform certain activities. For example, BSN students must always be supervised by a Registered Nurse when **removing a chest tube**.

While most student practice placements take place within the Interior Health (IH) region, some placements may occur in other sites. Students must familiarize themselves with the policies and procedures in the health region/agency within which they will be practicing. The MOST restrictive is what the student must follow. **See Appendix A for a figure and examples to illustrate and apply the controls on practice for a UBCO or OC BSN student.**

UBCO and OC BSN Student Limits and Conditions Categorized:

Category A: Skills/activities that must be directly observed by a qualified health care provider until the BSN student is deemed competent	Category B: Skills/activities that must always be directly supervised by a Registered Nurse	Category C: Skills/activities that require additional education and supervision by a Registered Nurse	Category D: Skills/activities that must not be performed by a BSN student

Refer to Appendix B for a detailed list of skills students may encounter in practice, and where they fall within the limits and conditions.

PROCEDURE TO IDENTIFY A STUDENT'S ABILITY TO COMPLETE A SKILL IN THE CLINICAL PRACTICE SETTING

Students must verify the following steps before performing a psychomotor skill (a skill that requires both knowledge and manual dexterity) on any client:

1. Obtain permission from the students' instructor/preceptor to perform the skill.
2. Ascertain that the activity is ethical (taking into consideration factors such as informed consent, minimizing risk to the client, etc.)
3. Verify that the student has received the related theory, knowledge, and lab practice in the UBCO or OC BSN program and that there are no additional restrictions (Appendix B) placed on this activity by the School of Nursing. See #7 for skills not taught in the lab practice setting.
4. Verify that there are no additional restrictions placed on this activity by an outside agency (i.e. health authority, agency, BCCDC, etc.) and ensure compliance with agency policies and procedures relating to that skill – always following the most restrictive policies.
5. Ensure appropriate regulatory supervision is in place (see the School of Nursing Regulatory Supervision Standard (UBCO, 2019), the BCCNM Regulatory Supervision standard (BCCNM, 2020b), and Appendix B for BSN student restrictions).
6. Once it has been ascertained that the student can perform the skill, the student should review the skill procedure as provided by the health authority, collect supplies, and confirm with their preceptor/instructor that they are ready to perform the skill.
7. For skills not taught in the lab:
    1. The skill must not fall under Appendix B Category D. If the student has not obtained certification for the skill through the health authority's defined process, the student cannot perform the skills listed under Appendix B Category C.
    2. The student must first observe the skill being performed by a qualified, competent Health Care Provider
    3. Then, students must be observed by a qualified, competent health care provider when performing the skill until deemed competent

***If student has reviewed this document and Appendix B, and is still uncertain if they can perform a skill, the student should consult with practice teacher for direction.**

Guidance regarding BSN student limits and conditions on skills and activities can be found in the following resources:

- Appendix A: Controls of Nursing Student Practice
- Appendix B: Skills/activities with limits and conditions in the BSN student scope of practice
- Appendix C: High alert and restricted medications
- Appendix D: Independent double check procedure for medication administration
- Appendix E: Psychomotor skills across the curriculum

REFERENCES

CNA (2017). *Code of ethics for Registered Nurses.* https://cna-aiic.ca/html/en/Code-of-Ethics-2017-Edition/files/assets/basic-html/page-1.html#

BCCNM (2012). *Professional standards for Registered Nurses and Nurse Practitioners: Accountability, knowledge, service, ethics.* https://www.bccnp.ca/Standards/RN_NP/StandardResources/RN_NP_ProfessionalStandards.pdf

BCCNM (2020a). *Practice standards for Registered Nurses and Nurse Practitioners.* https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Pages/Default.aspx

BCCNM (2020b). *Regulatory supervision of nursing student activities*. https://www.bccnp.ca/Standards/RN_NP/PracticeStandards/Lists/GeneralResources/RN_NP_PS_RegulatorySupervision.pdf

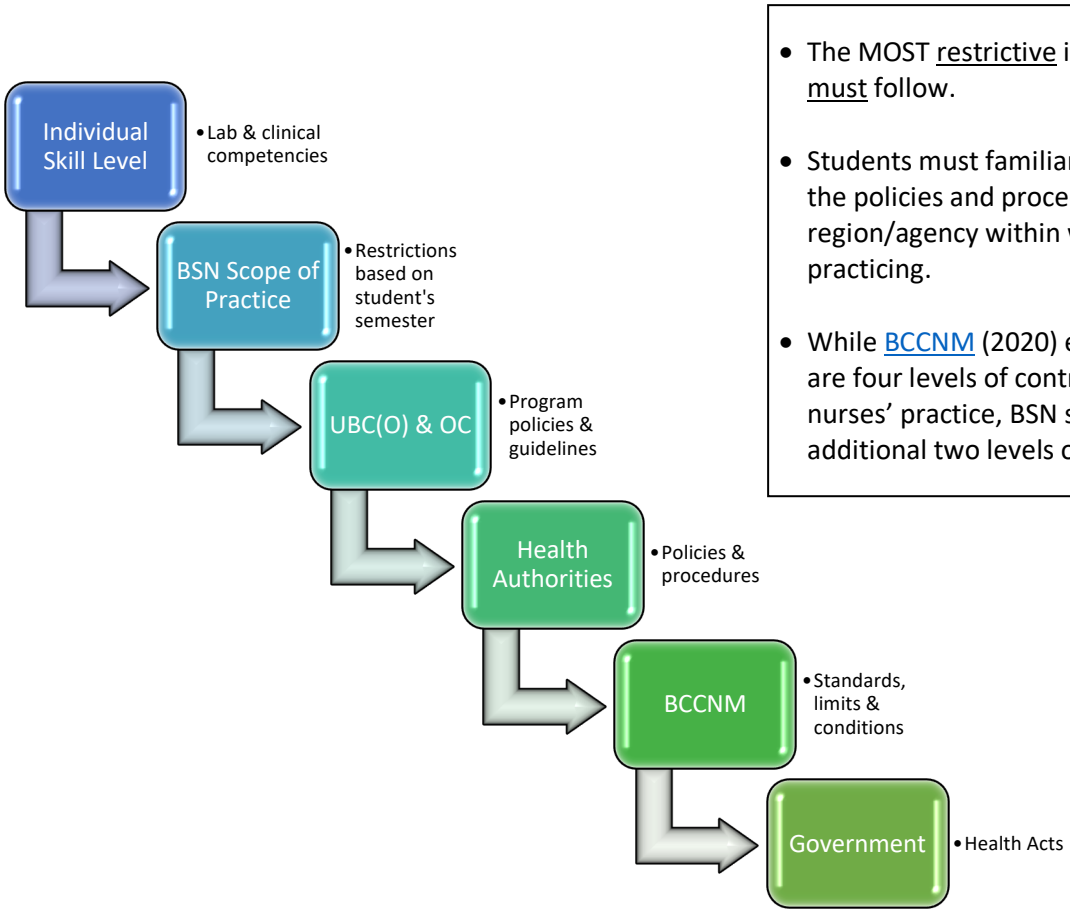
BCCNM (2020c). *Scope of practice for Registered Nurses: Standards, limits, conditions*. https://www.bccnp.ca/Standards/RN_NP/StandardResources/RN_ScopeofPractice.pdf

Institute for Safe Medication Practices (2018). *ISMP's list of high-alert medications*. https://www.ismp.org/sites/default/files/attachments/2018-10/highAlert2018new-Oct2018-v1.pdf

Interior Health (2013). *Independent double check procedure.* http://insidenet.interiorhealth.ca/Clinical/Documents/Independent%20Double%20Check%20-%20Quick%20Reference%20Guide.pdf

UBCO (2020). *Scope of Practice for BSN Students Policy: Regulatory Supervision Standard.* https://nursing.ok.ubc.ca/wp-content/uploads/sites/6/2019/12/Regulatory-Supervision-Standard.pdf

Appendix A:
Controls on Nursing Student Practice



- The MOST restrictive is what the student must follow.
- Students must familiarize themselves with the policies and procedures in the health region/agency within which they will be practicing.
- While BCCNM (2020) explains that there are four levels of control on registered nurses' practice, BSN students have an additional two levels of control.

Example 1: A BSN student is caring for a patient who needs to be transferred with a ceiling lift system. The student has been trained to use a variety of lifts, but is not familiar with the type of ceiling track system used in this facility. Can the student independently transfer this patient?

No. Although this activity is within the scope of an RN's practice, follows employer policies, is within UBCO School of Nursing or OC Nursing Program policies, has been taught in a previous practice course, but the student has judged himself/herself as not competent with this particular system. The student must seek out assistance or supervision to perform this activity safely (Level 6 of Figure 1).

Example 2: A BSN student is caring for a 2 year old child on the pediatric ward of Kelowna General Hospital who needs an immunization. There is a doctor's order for the immunization, and the RN is willing to supervise the student. Can the student perform this activity?

No. Although the UBCO and OC BSN Scope of Practice: Psychomotor Skills permits a student to administer immunizations with supervision, IH policy has a limit that does not allow students to immunize children under the age of 4 years. (Level 3 of Figure 1). Review Health Authorities' policies.

Appendix B: Skills/activities with limits and conditions for the UBCO / OC BSN Student

Refer to the full BSN Student: Standards, Limits, Conditions document for more information on the scope of practice for BSN students (p. 5), the standards, limits and conditions placed on their practice, and the requirement for regulatory supervision (p. 6). **See Appendix E for an overview of psychomotor skills taught across the curriculum.**

Category A: Skills/activities that must be directly observed by a qualified health care provider (designated by the student's practice teacher or preceptor) until the BSN student is deemed competent

Category B: Skills/activities that MUST ALWAYS BE DIRECTLY SUPERVISED by a Registered Nurse

Category C: Skills/activities that require additional education AND supervision by a Registered Nurse (see agency policy for certification or additional training requirements)

Category D: Skills/activities that MUST NOT be performed by a BSN student

Topic	Skills / Activities	Category			
		A	B	C	D
Analgesics, Parenteral	Epidural		B		
	Ketamine infusion		B		
	Patient Controlled Analgesia (PCA)		B		
Blood & Blood Product Transfusion	Transporter	A			
	See health authority policy for direction on student scope • if there is no policy for students, it is Category B		B		
Cardiac	Epicardial AV line, post-removal monitoring		B		
	Telemetry monitor interpretation			C	
	Ankle Brachial Index (ABI) measurement			C	
	Epicardial, dressing change			C	
	Epicardial, removal of AV wires				D
	Hold pressure on femoral site hematoma post coronary angiocatheter				D
	Identification of cardiac dysrhythmias for the purpose of instituting treatment (beyond basic CPR)				D
	Post coronary angiocatheter checks, radial and femoral				D
	Removal or adjustment of a vascular band or radial compression device				D
	Cardioversion or defibrillation				D
Chest Tubes	Assessment, care, and dressing change of small and large bore chest tube	A			
	Pneumostat, dressing change	A			
	Changing over the chest drainage atrium device		B		
	Removal of small and large bore chest tubes, and tying of purse-string sutures if applicable (Note: the student must be supernumerary to the two qualified nurses removing the chest tube)			C	
	Intermittent irrigation with normal saline ONLY			C	
	Obtaining fluid samples			C	
	Pneumostat, changing of device			C	
	intermittent irrigation with medications				D
	Pleurx drain, dressing change and draining of the drain				D
Constant Care	Constant Care Provider (commonly referred to as a 1:1 nurse)				D
Critical Care & Emergency	Triage, assessment and management		B		
	The initial assessment of all patients in emergency and critical care settings (documentation must be co-signed by a qualified RN). Supervision and co-signing of all ongoing assessments as determined by the RN.		B		
	Telemetry Monitor Rhythm Interpretation			C	
	Measurement of arterial and central venous pressure, or wedge pressure (Swan-Ganz catheters)				D

	Mechanical Ventilator, setting up and supervising operation				D
	Remove arterial lines				D
	Identification of cardiac dysrhythmias for the purpose of instituting treatment (beyond basic CPR)				D
	Arterial puncture (i.e. arterial blood gas collection)				D
	Endotracheal intubation or extubation				D
Death	Care of the body	A			
	Documentation of				D
	Notification of death to Next of Kin				D
	Pronouncement of				D
Diabetic Care	Blood glucose monitoring	A			
	Hypoglycemia protocol	A			
Dialysis	Set up/strip down/clean dialysis machine	A			
	Pre-dialysis assessment, in hemo unit	A			
	Medication administration, oral	A			
	Peritoneal dialysis, assessment and care			C	
	Medication administration, parenteral				D
	Permacath or tunneled CVAD line care				D
	Hemodialysis (i.e. insertion of hemodialysis needles)				D
	Hemodialysis, initiation and monitoring				D
Documentation	Completing nightly review of charts and MAR		B		
	Verifying a client's signature on a consent form				D
Emergency Response	Code blue/pink, initiate on a COVID-negative or **not** suspected-COVID	A			
	Care and management of aggressive persons				D
	Code white, management				D
	Physical or chemical restraints				D
	Code blue/pink, initiate on a suspected/positive COVID patient				D
	Code blue/pink, management of any patient				D
	Cardioversion or defibrillation				D
	Documentation of resuscitation events				D
Epidural	Epidural, assessment		B		
	Epidural catheter, removal		B		
Escort	Accompany patients requiring nursing supervision with the designated RN/LPN for observation only		B		
	Designated escort for patients requiring nursing supervision during transport.				D
Immunization	Acute care. See BCCDC policy and health authority policy		B		
	Community, See BCCDC policy and health authority policy			C	
Lifts & Transfers	Utilize patient handling equipment, including mechanical lifts, slings, and devices for lateral transfers or repositioning	A			
Medication	TB skin test		B		
	Wastage of all narcotics/controlled substances		B		
	TPN, preparation and administration		B		
	Dispensing (including preparation and transfer of a medication to a client)		B		
	High alert medications (see Appendix B)		B		
	Pyxis/Omnicell narcotic count		B		

	Preparation and administration of ANY medication while in the Emergency Room		B		
	Preparation and administration of ANY medications designated as High Alert (see Appendix B)		B		
	Preparation and administration of ANY parenteral medication, or HIGH alert medication by ANY route to a newborn or a pediatric client (15 years of age and under)		B		
	Subcutaneous lidocaine infusion for chronic pain management			C	
	Low dose ketamine infusion				D
	Completing a manual narcotic and controlled substance count				D
	Administration of local parenteral anaesthetics				D
	Restricted medications (see Appendix B)				D
Nasogastric Tube	Insertion, nasogastric tube without a nasal bridle	A			
	Assessment, care, documentation	A			
	Flushing, with saline or water	A			
	Insertion, small bore or weighted feeding tube	A			
	Medication administration	A			
	Monitoring of large bore tube with gastric decompression (suction)	A			
	Monitoring, care and maintenance for enteral nutrition	A			
	Removal of NG or small bore feeding tube	A			
	Nasal bridle application on small bore feeding tube			C	
Neonatal	Blood glucose monitoring		B		
Perinatal	Fetal Health Surveillance monitoring interpretation			C	
	Delivery of a newborn				D
	Vaginal and/or Cervical Examinations				D
Physician Orders	Transcribing physician orders		B		
	Taking a verbal or phone order				D
Tracheostomy	Changing dressing	A			
	Suctioning, cleaning, and changing of inner cannula	A			
	Changing/removing a tracheostomy tube				D
	Trach cuff, inflate or deflate cuff				D
	Changing trach ties				D
Trauma	Intraosseous devices, insert or remove				D
	Management of unstable C-spine, e.g. Stabilizing the neck of a patient with skull tongs, with/without a hard collar				D
Urinary	Foley insertion (indwelling or in and out), latex and silicone, non-coude tip	A			
	Urostomy care and maintenance	A			
	Foley care, maintenance, removal	A			
	Manual/intermitted foley irrigation	A			
	Continuous bladder irrigation- care and maintenance, initiation and discontinue.	A			
	Insertion of coude tip catheter		B		
	Insertion/removal of suprapubic catheter			C	
	Urostomy stent removal				D
Venous Access Device	**PVAD- Short AND EXTENDED DWELL CATHETER**				
	PVAD & Extended dwell IV catheter: care, maintenance and removal	A			
	Medication, non-narcotic and non-high alert with existing IV infusion	A			
	PVAD Insertion on clients 16 years of age and over		B		

	PVAD Insertion on clients 5-15 years of age (only once student has had at least 3 successful PVAD insertions on adult clients)		B		
	TPN, preparation and administration		B		
	Extended dwell IV catheter, insertion				D
	PICC (Peripherally Inserted Central Catheter)/CENTRAL LINE				
	PICC/CVAD dressing changes	A			
	PICC & CVAD, Flushing and aspirating for patency		B		
	Drawing blood samples, PICC		B		
	CVAD, removal, care, maintenance		B		
	TPN, preparation and administration		B		
	IVAD- Implanted Venous Access Device				
	Implanted venous access device (i.e. Port-a-Cath), care and maintenance		B		
	Implanted venous access device (i.e. Port-a-Cath), accessing or de-accessing			C	
	Hemodialysis				
	• Change settings on hemodialysis machines, remove needles and discontinue hemodialysis treatment, access and view computerized records		B		
	• Hemodialysis (i.e. insertion of hemodialysis needles)				D
	• Permacath line care				D
	Phlebotomy			C	
Wound Care	Simple wound care	A			
	Hemovac/Jackson Pratt/Penrose drain care and removal	A			
	Suture and staple removal	A			
	Complex wound care - with packing (not a VAC)	A			
	Leech therapy		B		
	Flap checks		B		
	Percutaneous drain removal		B		
	Wound compression therapy (complete relevant agency education module)			C	
	Pico and Prevena dressings			C	
	VAC (Vacuum Assisted Closure) (complete relevant agency education module)			C	
	Epicardial, dressing change			C	

Appendix C: High Alert and Controlled Medications

The following lists describe medications that have a high risk for patient harm when administered in error and/or medications that are commonly administered in error. See your health authority's list of medications requiring an Independent Double Check (IDC).

High-Alert Medications

Students must have the following medications double-checked and co-signed by a qualified designate (as approved by preceptor or clinical instructor)

Anticoagulants/antithrombotics:
- Unfractionated heparin
- Low molecular weight heparins (i.e. enoxaparin, fraxaparin, dalteparin, nadroparin)
- Anticoagulants that require regular blood testing (e.g. warfarin)

Insulin and hypoglycemics (all types)

Chemotherapy (including Methotrexate) any route

Intravenous electrolytes/medications/solutions:
- Solutions containing potassium chloride
- Hypertonic saline (greater than 0.9% concentration)
- All medications (excluding saline/dextrose solutions)

Parenteral nutrition solutions, including:
- IV dextrose at a concentration of 10% or greater

Epidural or intrathecal medications

Controlled substances (i.e. opioids, benzodiazepines)

*For all high-alert medications requiring an infusion device and subcutaneous insulin, the student and the nurse verifier must go to the patient bedside **together** and verify the patient using two identifiers.*

Controlled Medications

Students must have ALL controlled medications double-checked and co-signed by a qualified designate (as approved by preceptor or clinical instructor)

ADDITIONAL SAFETY PRECAUTIONS for controlled IVP/Infusions:
- In addition to double-checking and co-signing, students must ***ALWAYS*** have the medications ***observed at the bedside*** by a qualified designate (as approved by preceptor or clinical instructor)

The care of medication infusions includes monitoring, hanging new bags, changing infusion rates, and administering bolus doses (including IVP, PCA, epidural, intrathecal, nerve plexus infusions, ketamine infusions, etc.).

Restricted Medications: Students **MAY NOT** administer the following classes of medications*
IV adrenergic agonists and/or inotropes
IV adrenergic antagonists
IV antiarrhythmics
IV radiocontrast agents
General anesthetic agents, inhaled or IV
Cardioplegic agents
Chemotherapy agents by ANY route, when the indication is for chemotherapy (i.e. methotrexate for RA is permitted)
Dialysis solutions
Neuromuscular blocking agents
Oxytocin

**Refer to a current drug reference for a full list of medications within each class*

References: Institute for Safe Medication Practices (2018). *ISMP's list of high-alert medications*. Retrieved from https://www.ismp.org/sites/default/files/attachments/2018-10/highAlert2018new-Oct2018-v1.pdf

Appendix D: Independent Double Check Procedure for Medication Administration

To promote safety in medication administration, students must follow this procedure when administering a high alert medication (see Appendix C), based upon the IH independent double check policy (IH, 2013).

** Note that some health authorities may have their own policies or procedures relating to independent double checks or medication administration practices. Students should follow the policy that is the most restrictive.*

WHO CAN COMPLETE THE INDEPENDENT DOUBLE CHECK (IDC) FOR A STUDENT?

- UBC nursing instructor (registered nurse)
- Registered nurse
- Registered psychiatric nurse
- If a registered nurse is not available, a licensed practical nurse (LPN) **might** be able to perform the IDC, in the following circumstances:
    - If the medication administration is within the scope of practice of the LPN
    - AND if the nursing instructor or preceptor responsible for the student follows the BCCNP Regulatory Supervision guidelines
    - AND if the LPN is not prevented from performing the IDC by facility policy

WHEN SHOULD CHECKS BE COMPLETED?

- Students should complete 3 checks prior to administering medications:
    1. When removing medications from the med cart, Pyxis, or Omnicell
    2. When checking medications prior to administration (this is when the independent double check takes place)
    3. At the bedside, including the patient, right before medication administration

WHAT "RIGHTS" MUST BE CHECKED?

ALL MEDICATIONS

1. Right **CLIENT**
2. Right **TIME**
3. Right **DRUG**
4. Right **DOSE**
5. Right **ROUTE**
6. Right **REASON**
7. Right **ASSESSMENT**
8. Right **CLIENT TEACHING**
9. Right **DOCUMENTATION**
10. Right **EVALUATION**

ADDITIONAL RIGHTS FOR PARENTERAL MEDICATIONS

1. Right **DILUTION**
2. Right **COMPATIBILITY**
3. Right **RATE OF ADMINISTRATION**

ADDITIONAL RIGHTS FOR AN INFUSION DEVICE (IV PUMP, PCA, EPIDURAL, SYRINGE PUMP)

1. Right **INFUSION DEVICE**
2. Right **PROTOCOL**
3. Right **PROGRAM SETTINGS**

INDEPENDENT DOUBLE CHECK (IDC) PROCEDURE FOR STUDENTS

Step 1	**BEFORE** taking out medications:
	• Look up relevant drug information • Assess client to see if medication administration is appropriate • Perform dosage calculations • If any medications requiring an IDC will be removed from their original packaging (e.g. pouring a liquid or drawing a medication into a syringe), have the nurse performing the IDC watch the full procedure, beginning at Step 2. All medications should be labeled accordingly.
Step 2	**STUDENT PERFORMS CHECK 1**
	Gather MAR and medications (e.g. from med cart, Pyxis, or Omnicell) ** Note that for narcotics: The nurse performing the IDC MUST see the narcotic being removed from the original packaging to verify the correct drug and dose*
Step 3	**STUDENT PERFORMS CHECK 2**
	Prepare medications for administration and verify the rights • Leave all unit dose medications within their packages • Ensure all other medications removed from their packages are labelled with the drug name, dose, route, and 2 patient identifiers • After completing the second check, place a small dot to the right of the med administration time on the MAR, indicating the med has been prepared (e.g. 0900 •_____)
Step 4	**NURSE PERFORMS INDEPENDENT DOUBLE CHECK (VERIFYING CHECK 2)**
	FOR INJECTABLE MEDICATIONS: • Be sure to prepare injectable medications in front of the nurse completing the IDC, so that the correct drug and dose can be verified as the medication is being withdrawn from the ampoule or vial WHEN A MEDICATION DOSAGE MUST BE CALCULATED: • Ask the nurse performing the IDC to calculate the required dose independently BEFORE the student reveals the results of his/her own calculations WHEN A PROTOCOL OR PRE-PRINTED ORDER IS USED: • The student must provide the required orders (e.g. insulin or heparin orders) and the relevant data (e.g. blood glucose documentation or lab results) to the nurse performing the IDC
Step 5	**STUDENT PERFORMS CHECK 3**
	Take MAR and medications to the bedside and verify the rights • When checking the patient's identity, also check for an allergy band • Inform the patient about each medication while pouring the medications • Observe the patient take all of the medications • Document the medication administration immediately
Step 6	**DOCUMENTATION**
	Documentation of the IDC on the MAR must include the student and the nurse completing the IDC: • Student: Immediately after administration of the medication, sign in the first position: (e.g. **Student Initials** / _____) • Nurse: After completing the IDC, sign in the second position: (e.g. _____ / **Nurse Initials**)

Appendix E: Mapping Psychomotor Skills Across the Curriculum

	Year 1 Term 2 NRSG 101	Year 2 Term 1 NRSG 201	Year 2 Term 2 NRSG 202	Year 3 Term 1 NRSG 301	Year 3 Term 2 NRSG 302
Strength	• Head to Toe Assessments with Stable Chronic Clients (vital signs)	• Head to Toe Assessments with Acute Care Patients • Assess & Manage • Medication Administration		• Building on Clinical Reasoning • Providing holistic care for 2 complex acute care clients	
Assessment	• Long term care context	• Acute care context			• Post-op assessment
Infection Control	• Hand washing • Personal care • PPE	• Routine precautions • Revisit PPE	• Airborne precautions		
Mobility	• Lifts & transfers	• Acute care mobility (including post op)			
GI	• Feeding • Oral Hygiene		• Tube Feed PEG/PEJ/NG • Assess & Manage • Ostomy Care		NG • Insertion large bore • Suction
Urinary	• Incontinent care • Toileting • Foley hygiene	• Foley assess & manage • Empty foley • CBI management		• Foley insertion • Open irrigation • Supra-pubic and urostomy assess & manage	
Oxygen	• Chronic use	• Low flow • Titrate	• High flow • Positive Pressure Flow (Optiflow) Trach • Assess • Oxygen administration Chest Tubes • Assess		Trach • Drsg change • Inner cannula change • Trach suctioning
Medications	NONE	• PO • Topical / creams /patches • Gtts • Puffers	• Per rectal • Subcu • IM • Interdermal • IV /PICC • Per feeding tubes		
IV	NONE	Assess & Manage			• Initiation

		• Fld Types • Pumps • SL • Drsg			
CVAD	NONE	NONE	• PICC assess & manage	• All types of CVADs • Blood draws PICC	• Drsg changes • Removal
DRSGs	NONE	Simple Drgs • Touch • No Touch • Assess VAC		Complex Drsg • Irrigation • Packing	Surgical Drsg • Sutures • Staples • Drain shortening • Drain removal
Drains		All Tubes • Assess • Empty		Chest Tube • Drsg Change • Removal	
Other			• Accu-checks • Blood & blood products • TPN	Code Management • EWS • CCOD	• PCAs • Epidurals
Medication Dosage Calculation Exams	N/A	NRSG 201	NRSG 202	NRSG 301	NRSG 302 & NRSG 421
Clinical Skills Testing (in-person or video)	Focused Assessment (cardio or resp) marked by Lab Teachers (NRSG 101)	Head to Toe Assessment Video marked by Clinical Teachers (NRSG 236)	Simple Dressing Video marked by Clinical Teachers (NRSG 237)	Foley Insertion CLAS Video (Peer Evaluated) in N301	Simple Dressing Live in practice with Clinical Teachers (NRSG 337)
PASSPORT	Manual Blood Pressure	PO Med Admin	SC Med Admin	IV Piggyback Med Admin	IV Push Med Admin
SIM	COPD Exacerbation Post Fall Assessment Dementia & Delirium Assess	QPA/Safety IDRAW/SBAR Oxygen Titration Heart Failure Exacerbation	High Flow Oxygen Alcohol Withdrawal Blood Transfusion Reaction	Code Management	Pre-op knee replacement Small Bowel Obstruction Post Op AAA dissection Post op ORIF Hip Post AAA dissection – complications Pre-op Craniotomy PCA Resp Depression Post op Bowel Resection