2011 Practical Nursing Program

PROVINCIAL CURRICULUM GUIDE SUPPLEMENT:

Program Core Standards, and Teaching and Learning Resources, 2017

This is a companion document to the

2011 Practical Nursing Program

PROVINCIAL CURRICULUM GUIDE

2nd Edition Revised 2017

Ministry of Advanced Education, Skills and Training

The content of this document has been adapted from the [*2011 Practical Nursing Program Provincial Curriculum*](https://pn.bccampus.ca/pluginfile.php/884/mod_resource/content/1/Practical%20Nursing%20Program%20Provincial%20Curriculum.pdf) *Guide*, copyright © 2012 Province of British Columbia. The adaptations to the source content are listed in the Introduction section of this document.



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ACKNOWLEDGEMENTS

This document was created as part of the 2016–2017 Provincial Practical Nursing Program and Access to Practical Nursing Program Curriculum Guide Revision Project*.* The project was sponsored by the Ministry of Advanced Education, Skills and Training, championed by the BC post-secondary institution health deans and directors and led by BCcampus. This collaborative project was guided by the expertise and contributions of the members listed below. We are grateful for their contributions and for their colleagues who worked with them.

|  |
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INTRODUCTION

The 2011 Practical Nursing Program Provincial Curriculum Guide Supplement: Program Core Standards and Teaching and Learning Resources, 2017 (Curriculum Guide Supplement) is a companion document to the Practical Nursing Program Provincial Curriculum Guide, 2nd Edition, Revised 2017 (Curriculum Guide). This companion document has been produced to further refine theCurriculum Guide and to provide a separate, but associated, publication that can be updated more frequently. Institutions must refer to the current versions of all documents listed in the revised Guide and Supplement.

For background on the recommendation that resulted in this Supplement, please view the Introduction of the 2011 Practical Nursing Program Provincial Curriculum Guide, 2nd Edition, Revised 2017.

This Curriculum Guide Supplement incorporates the following sections that were previously included in the 2011 Practical Nursing Program Provincial Curriculum Guide:

1. Program Core Standards

A component of developing a provincial curriculum for practical nursing education in British Columbia requires integrating core standards to maintain consistency, collaboration and coherence. The Program Core Standards have been revised to include changes to the:

* Admission requirements.
* Notes for admission.
* English as an additional language.
* Faculty qualifications.
1. Teaching and Learning Resources

The teaching and learning resources have been revised and updated and include the following sections that were formerly included in the 2011 Practical Nursing Program Provincial Curriculum Guide:

* **Suggested References/Resources** from all course outlines.
* **Indigenous Learning Resources** (formerly in Appendix D).
* **WorkSafeBC Resources** (formerly in Appendix E).
* **Provincial Practical Nurse Program Curriculum Guide Resource List** (formerly in Appendix H).
* **Competency map.**

 Curriculum Guide Supplement Summary Table

The following table provides an overall summary of the revisions applied to this Supplement.

| **Supplement Updates** | **Page Number(s)** |
| --- | --- |
| The *Program Core Standards* section, including *Admission Requirements, Notes for Admission, English as an Additional Language* and *Faculty Qualifications* sections, has been moved from the Guide to this Supplement. | 12 - 14 |
| In *Program Core Standards – Admission Requirements*, “Grade 12 graduation or equivalent (ABE, GED)” has been revised to:“Grade 12 graduation, or equivalent (General Educational Development, Adult Basic Education) or mature student status as defined by the educational institution.” | 12 |
| In *Program Core Standards – Admission Requirements, “*Math 11 Principles with a grade of C (current BC curriculum) OR Math 11 Foundations with a grade of C (commencing 2012)” has been revised to:“Math 11 Foundations with a minimum grade of 60% or equivalent.” | 12 |
| In *Program Core Standards – Admission Requirements*, “English 12 with a grade of C+ OR Technical Communications 12 with a grade of B+” has been revised to:“English 12 with a minimum grade of 65% or English First Peoples 12 with a minimum grade of 65%, or equivalent.” | 12 |
| In *Program Core Standards – Admission Requirements*, “Biology 12 (Human Biology) with a grade of C” has been revised to:“Anatomy and Physiology 12 with a minimum grade of 60% or equivalent.” | 12 |
| In *Program Core Standards – Notes for Admissions,* “Human Anatomy and Physiology for Practical Nurses with a minimum grade of C+ or equivalent must be completed by the start of specified courses” has been revised to:“Human Anatomy and Physiology for Practical Nurses with a minimum grade of 65% must be achieved before taking Variations in Health I, Health Promotion I, Pharmacology I, Integrated Nursing Practice I and Consolidated Nursing Practice I (CPE I).” | 12 |
| In *Program Core Standards – Notes for Admissions,* “The following are to be completed prior to the first practice education experience:” has been revised to: “The following are to be completed prior to beginning CPE I:” | 12 |
| In *Program Core Standards – Notes for Admissions*, “CPR level C” has been revised to:“Cardiopulmonary Resuscitation (CPR) as outlined in the Practice Education Guidelines ([http://hspcanada.net/docs/PEG/1\_6\_Orientation\_Students.pdf)](http://hspcanada.net/docs/PEG/1_6_Orientation_Students.pdf%29).” | 12 |
| In *Program Core Standards – Notes for Admissions*, “Criminal Record Check” has been revised to:“Criminal record check under the terms of the Criminal Record Review Act and the Ministry of Justice process for educational institutions.” | 12 |
| In *Program Core Standards – Notes for Admissions, “*Immunization as required by sites of practice education and recommended by BC Centre for Disease Control (2009): diphtheria and tetanus, polio, hepatitis B, measles, mumps and rubella (MMR), varicella, and influenza” has been revised to:“Immunizations as outlined in the Practice Education Guidelines ([http://www.hspcanada.net/docs/PEG/1\_3\_Immunization.pdf)](http://www.hspcanada.net/docs/PEG/1_3_Immunization.pdf%29).” | 12 |
| In *Program Core Standards – English as an Additional Language, “*Applicants with English as an additional language must meet the language requirements set by CLPNBC (2011), and be successful in one of the following:” has been revised to:“As English is the language of study in BC, students must meet English language proficiency at an appropriate level to be accepted into the provincial Practical Nursing program. These requirements can be satisfied through three years of full-time, face-to-face secondary or post-secondary education at an accredited institution where English is the medium of instruction and is also one of the country’s official languages. English as a Second Language/Additional Language courses are not included in this three-year calculation. Those not meeting this requirement must achieve scores identified in one of the two tests below:” | 12 - 13 |
| In *Program Core Standards – English as an Additional Language,* “International English Language Testing System (IELTS) *–* Academic Version with minimum scores of:* Overall Band Score: 7.5
* Speaking: 7.5
* Listening: 8.0
* Reading: 7.0
* Writing: 7.5”

has been revised to:“1. International English Language Testing System (IELTS) with minimum scores of:* Speaking: 7.0
* Listening: 7.5
* Reading: 6.5
* Writing: 7.0
* Overall Band Score: 7.0”

The following was removed:1. Test d’Evaluation de Français(TEF) with a minimum overall score of 750, and the following scores:
* Speaking: 5.0
* Listening: 4.0
* Reading: 4.0
* Vocabulary and grammar: 4.0
 | 12 - 13 |
| In *Program Core Standards – English as an Additional Language,* “Note: Please view CLPNBC current English requirements at the following site: http://www.clpnbc.org/content\_images/documents/Language%20Proficiency%20Requirement s%20for%20Registration\_July%201.2011.pdf” has been revised to:“In addition to meeting English language requirements for the Practical Nursing program, graduates must be able to demonstrate a level of proficiency required to be performance ready as a condition for registration and practice in British Columbia. See CLPNBC’s website for details.” | 12 - 13 |
| In *Program Core Standards – Faculty Qualifications*, “Current practicing license with one of the nursing regulatory Colleges (CLPNBC, CRNBC, or CRPNBC)” has been revised to:“A current practising license as a LPN, NP, RN or RPN with one of the British Columbia nursing regulatory colleges (CLPNBC, CRNBC, CRPNBC).” | 13 - 14 |
| In *Program Core Standards – Faculty Qualifications*, “A credential in adult education/equivalent or in progress from an accredited postsecondary institution” has been revised to:* “One of the following credentials in adult education from an accredited post-secondary institution:
1. Provincial instructor diploma (PID) (those in progress must have an identified completion date).
2. A formal educational equivalent to PID as described in the BC Transfer Guide http://www.bctransferguide.ca/docs/BCadultedbrochure.pdf (those in progress must have an identified completion date).
3. Proof of completion of a formal Prior Learning Assessment (PLA) conducted by the hiring institution to ensure teaching competencies.
 | 13 - 14 |
| In *Program Core Standards – Faculty Qualifications, “*Other faculty qualifications may be considered for particular courses * + Pharmacology (e.g., undergraduate degree in pharmacy, two years of hospital pharmacy experience, registered with the College of Pharmacists of BC)
	+ Professional communications (e.g., undergraduate degree in a Human Services field or discipline or Counselling Psychology)
	+ Anatomy and Physiology (e.g., undergraduate degree in biology, physiology, physician, or equivalent education and experience)”

has been revised to:“Other relevant undergraduate degrees or professional qualifications degrees may be considered to teach the following courses (e.g., being registered with the College of Pharmacists):1. Pharmacology.
2. Professional communication.
3. Anatomy and physiology.”
 | 14 |
| The teaching and learning resources sections have been moved from the Guide to this Supplement, and updated or replaced as necessary, depending on currency and availability. This includes all *Suggested References/Resources* from course outlines; *Indigenous Learning Resources* (former Appendix D); *WorkSafeBC resources* (former Appendix E); and *Provincial Practical Nurse Program Curriculum Guide Resource List* (former Appendix H). | 15 - 170 |
| *Suggested References/Resources* have been updated and organized alphabetically. Several resources that lacked specific citation details have been removed. | 15 - 66 |
| In *Indigenous Learning Resources*, the term “Aboriginal” has been changed to “Indigenous.” | 67 - 149 |
| The *WorkSafeBC Resources* have been updated with corrected web links.  | 150 |
| The *Provincial Practical Nurse Program Curriculum Guide Resource List* has been updated and resources have been added to the *Suggested References/Resources* section for each course. | 15 - 66 |
| The *Competency Map* has been updated and added to the end of the Supplement.  | 152 - 169 |

Program Core Standards

A component of developing a provincial curriculum for practical nursing education in BC requires integrating core standards to maintain consistency, collaboration and coherence. There are four areas of core standards to teach in the program: 1) general admission requirements, 2) notes for admission, 3) English as an additional language requirements, and 4) faculty qualifications. These minimum standards and expectations of each are outlined below.

Admission Requirements

* Grade 12 graduation, or equivalent (General Educational Development, Adult Basic Education), or mature student status as defined by the educational institution.
* Math 11 Foundations with a minimum grade of 60% or equivalent.
* English 12 with a minimum grade of 65% or English First Peoples 12 with a minimum grade of 65% or equivalent.
* Anatomy and Physiology 12 with a minimum grade of 60% or equivalent.

Notes for Admissions

* Human Anatomy and Physiology for Practical Nurses with a minimum grade of 65% must be achieved before taking Variations in Health I, Health Promotion I, Pharmacology I, Integrated Nursing Practice I and Consolidated Nursing Practice I (CPE I).

The following are to be completed prior to beginning CPE I:

* Cardiopulmonary Resuscitation (CPR) as outlined in the Practice Education Guidelines (http://hspcanada.net/docs/PEG/1\_6\_Orientation\_Students.pdf).
* Criminal record check under the terms of the Criminal Records Review Act and the Ministry of Justice process for educational institutions.
* Immunizations as outlined in the Practice Education Guidelines ([http://www.hspcanada.net/docs/PEG/1\_3\_Immunization.pdf)](http://www.hspcanada.net/docs/PEG/1_3_Immunization.pdf%29).
* Negative TB skin test or chest X-ray.

Students who do not meet the immunization requirements may be prohibited from attending practice education experiences, depending on the particular health authority, practice education site, organization, or agency policy.

English as an Additional Language

As English is the language of study in BC, students must meet English language proficiency at an appropriate level to be accepted into the provincial Practical Nursing program. These requirements can be satisfied through three years of full-time, face-to-face secondary or post-secondary education at an accredited institution where English is the language of instruction and is also one of the country’s official languages. English as a Second Language/Additional Language courses are not included in this three-year calculation. Those not meeting this requirement must achieve scores identified in one of the two tests below:

1. International English Language Testing System (IELTS) with minimum scores of:
* Speaking: 7.0
* Listening: 7.5
* Reading: 6.5
* Writing: 7.0
* Overall Band Score: 7.0
1. Canadian English Language Benchmarks Assessment for Nurses (CELBAN) with minimum scores of:
* Speaking: 8.0
* Listening: 10.0
* Reading: 8.0
* Writing: 7.0

In addition to meeting English language requirements for the Practical Nursing program, graduates must be able to demonstrate a level of proficiency required to be performance ready as a condition for registration and practice in British Columbia. See CLPNBC’s website for details.

Faculty Qualifications

The following outlines the minimum standards of qualifications for faculty to teach in the program:

* A current practising license as an LPN, NP, RN or RPN with one of the British Columbia nursing regulatory colleges (CLPNBC, CRNBC, CRPNBC).
* One of the following credentials in adult education from an accredited post-secondary institution:
1. Provincial Instructor Diploma (PID) (those in progress must have an identified completion date).
2. A formal educational equivalent to PID as described in the BC Transfer Guide http://www.bctransferguide.ca/docs/BCadultedbrochure.pdf (those in progress must have an identified completion date).
3. Proof of completion of a formal Prior Learning Assessment (PLA) conducted by the hiring institution to ensure teaching competencies.
* Three to five years of recent and relevant practice experience (equivalent to full-time hours per year).

Other relevant undergraduate degrees or professional qualifications degrees may be considered to teach the following courses (e.g., being registered with the College of Pharmacists):

* Pharmacology.
* Professional communication.
* Anatomy and physiology.

Teaching and Learning Resources

Overview

This section of teaching and learning resources has been revised and updated and includes the following sections that were formerly part of the 2011 Practical Nursing Program Provincial Curriculum Guide:

1. **Suggested References/Resources** from all course outlines: a sampling of texts, journals, and websites for potential faculty and student use.
2. **Indigenous Learning Resources** (formerly in Appendix D).
3. **WorkSafeBC Resources** (formerly in Appendix E).
4. **Provincial Practical Nurse Program Curriculum Guide Resource List** (formerly in Appendix H).

Suggested References/Resource

Professional Practice I

* British Columbia Ministry of Justice and Legislative Assembly. BC laws. <http://www.bclaws.ca>
	+ Employment Standards Act of BC <http://www.bclaws.ca/Recon/document/ID/freeside/00_96113_01>
	+ Freedom of Information and Protection of Privacy Act <http://www.bclaws.ca/civix/document/id/complete/statreg/96165_01>
	+ Health Professions Act of British Columbia/PN Regulation <http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01>
	+ Labour Relations Code <http://www.bclaws.ca/civix/document/id/complete/statreg/96244_01>
	+ Nurses (Licensed Practical) Regulation

<http://www.bclaws.ca/civix/document/id/complete/statreg/224_2015>

* Canadian Council for Practical Nurse Regulators (CCPNR). (2013). *Entry-to-Practice Competencies for Licensed Practical Nurses*. [https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-(EPTC)-LPNs.aspx](https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-%28EPTC%29-LPNs.aspx)
* Canadian Interprofessional Health Collaborative (CIHC). (2010). *A National Interprofessional Competencies Framework.* <https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf>
* Canadian Nursing Student Association. (2009). *Self-Care Practices among Nursing Learners*. <http://www.aeic.ca/self-care-practices-among-nursing-students/>
* College of Licensed Practical Nurses of British Columbia (CLPNBC) website: <https://www.clpnbc.org>
* Dahlkemper, T. (2013). *Anderson’s Nursing Leadership, Management, and Professional Practice for the LPN/LVN in Nursing School and Beyond*. 5th edition. Phil: F.A. Davis.
* Yoder-Wise, P., & Grant, L. (2015). *Leading and Managing in Canadian Nursing.* Toronto: Mosby/Elsevier.

Professional Practice II

* Aboriginal Nurses Association of Canada (ANAC), Canadian Association of Schools of Nursing (CASN), Canadian Nurses Association (CNA) (2009*). Cultural Competence and Cultural Safety in Nursing Education.* <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/first_nations_framework_e.pdf?la=en>
* British Columbia Ministry of Health. (2012). Advanced Care Planning. <http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning>
* Canadian Council for Practical Nurse Regulators (CCPNR). (2013). *Entry-to-Practice Competencies for Licensed Practical Nurses*. [https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-(EPTC)-LPNs.aspx](https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-%28EPTC%29-LPNs.aspx)
* Canadian Interprofessional Health Collaborative (CIHC). (2010). *A National Interprofessional Competencies Framework.* <https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf>
* Dahlkemper, T. (2013). *Anderson’s Nursing Leadership, Management, and Professional Practice for the LPN/LVN in Nursing School and Beyond*. 5th edition. Phil: F.A. Davis.
* Fraser Health Authority. (n.d.). *Advanced Health Care Planning*. Surrey, BC: Author. <http://www.fraserhealth.ca/health-info/health-topics/advance-care-planning/advance-care-planning>
* Hoffman‐Wold, G. (2011). *Basic Geriatric Nursing.* Toronto: Elsevier.
* Yoder-Wise, P., & Grant, L. (2015). *Leading and Managing in Canadian Nursing.* Toronto: Mosby/Elsevier.

Professional Practice III

* British Columbia Ministry of Justice and Legislative Assembly. BC Laws. <http://www.bclaws.ca>
	+ Age of Majority Act <http://www.bclaws.ca/civix/document/id/complete/statreg/96007_01>
	+ Child, Family and Community Service Act<http://www.bclaws.ca/civix/document/id/complete/statreg/96046_01>
	+ Health Professions Act of British Columbia<http://www.bclaws.ca/civix/document/id/complete/statreg/96183_01>
	+ Mental Health Act<http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01>
* Canadian Council for Practical Nurse Regulators (CCPNR). (2013). *Entry-to-Practice Competencies for Licensed Practical Nurses*. [https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-(EPTC)-LPNs.aspx](https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-%28EPTC%29-LPNs.aspx)
* Canadian Interprofessional Health Collaborative (CIHC). (2010). *A National Interprofessional Competencies Framework.* <https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf>
* First Nations Health Authority. (2016). *#itstartswithme – Creating a Climate for Change: Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in British Columbia.* <http://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf>
* First Nations Health Authority. (2016). *#itstartswithme – Cultural Safety and Humility: Key Drivers and Ideas for Change.* <http://www.fnha.ca/Documents/FNHA-Cultural-Safety-and-Humility-Key-Drivers-and-Ideas-for-Change.pdf>
* Island Health. Aboriginal Health: *For the Next Seven Generations for the Children eCourse*. PHSA Learning Hub. <https://learninghub.phsa.ca/Courses/7859/aboriginal-health-for-the-next-seven-generations-for-the-children>
* Yoder-Wise, P., & Grant, L. (2015). *Leading and Managing in Canadian Nursing.* Toronto: Mosby/Elsevier.

Professional Practice IV

* AIPHE. (2010). *The Interprofessional Health Education Accreditation Standards Guide.* <https://www.cihc.ca/files/resources/public/English/AIPHE%20Interprofessional%20Health%20Education%20Accreditation%20Standards%20Guide_EN.pdf>
* British Columbia Ministry of Justice and Legislative Assembly. BC Laws. <http://www.bclaws.ca>
* Pharmacy Operations and Drug Scheduling Act <http://www.bclaws.ca/civix/document/id/complete/statreg/9_98>
* Canadian Council for Practical Nurse Regulators (CCPNR). (2013). *Entry-to-Practice Competencies for Licensed Practical Nurses*. [https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-(EPTC)-LPNs.aspx](https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-%28EPTC%29-LPNs.aspx)
* Canadian Interprofessional Health Collaborative (CIHC). (2010). *A National Interprofessional Competencies Framework.* <https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf>
* Chan, A., Pang Mei Chi, S., Ching, S., & Lam, S. (2010). Interprofessional Education: The Interface between Nursing and Social Work. *Journal of Clinical Education. 19*, 168‐176.
* College of Licensed Practical Nurses of British Columbia (CLPNBC). (2014). *Professional Standards for* *Licensed Practical Nurses*. Burnaby: Author. <https://clpnbc.org/Documents/Practice-Support-Documents/Professional-Standards-of-Practice-for-Licensed-Pr.aspx>
* College of Licensed Practical Nurses of British Columbia (CLPNBC). (2017). *Scope of Practice: Standards, Limits and Conditions*. Burnaby: Author. <https://www.clpnbc.org/Documents/Practice-Support-Documents/Scope-of-Practice-ONLINE.aspx>
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Indigenous Learning Resources

Background

Including cultural competencies when working with and caring for Indigenous clients and families is a key deliverable for this project. It is well documented that the health status of Indigenous people in Canada is significantly lower than the average Canadian (CIHI, 2009). One strategy to address this state is by including Indigenous history, epistemology and cultural safety in the education of health professionals. The 2009 document entitled *Cultural Competence and Cultural Safety in Nursing Education*, jointly authored by the Aboriginal Nurses Association of Canada, the Canadian Association of Schools of Nursing and the Canadian Nurses Association has provided a foundation for the development of appropriate learning activities to be included in this curriculum.

Definitions

These definitions are taken from the Glossary of Terms, Practical Nurse Curriculum Guide (2011, revised 2017).

**Communication**: This concept entails effective and culturally safe communication among learners and faculty within the teaching/learning contexts; it also applies to nursing interactions with the First Nation, Inuit, and Métis peoples (Aboriginal Nurses Association of Canada, 2009).

**Cultural awareness:** The acknowledgement of differences between cultural groups (Aboriginal Nurses Association of Canada, 2009).

**Cultural humility:** A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience. Cultural humility builds mutual trust and respect and enables cultural safety. When health care professionals engage with First Nations peoples from a place of cultural humility, they are helping to create a safer health care environment where individuals and families feel respected. First Nations peoples are therefore more likely to access care when they need it and access care that is appropriate to their wellness beliefs, goals and needs. (First Nations Health Authority, 2016).

**Cultural safety:** An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care (First Nations Health Authority, 2016).

**Culturally sensitive care:** Care that affirms, respects and fosters cultural expression by others. Practical nurses must reflect on their personal cultural identity and practice in a manner that affirms the cultural beliefs and practices of others (CPNRE, 2010).

**Cultural sensitivity:** The recognition that the lived experiences of all people include aspects similar and different to our own and that our actions affect other people. It involves getting to know and understand other cultures and perspectives. Culturally sensitive approaches acknowledge that difference is important and must be respected (Dick et al., 2006).

**Historical trauma:** A cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma. These collective traumas are inflicted by a subjugating, dominant population. Examples of historical trauma include genocide, colonialism (e.g., Indian hospitals and residential schools), slavery and war. Intergenerational trauma is an aspect of historical trauma. (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 6).

**Inclusivity:** An intention of including people who might otherwise be excluded or marginalized, such as First Nation, Inuit and Métis peoples, those who are handicapped or learning disabled, or racial and sexual minorities. This requires increased awareness and insight as part of the engagement and relationship building process.

**Indigenous knowledge:** A knowledge system embedded in the cultural traditions of indigenous communities. It also includes understanding First Nations, Inuit and Métis ontology, epistemology, and explanatory models related to health and healing; and, First Nations, Inuit and Métis cosmologies (spirituality, range of religious beliefs, etc.) (Aboriginal Nurses Association of Canada, 2009).

**Indigenous people(s):** A collective name for the original peoples of North America and their descendants. The term “Aboriginal peoples” is often also used. The Canadian Constitution recognizes three groups of Aboriginal peoples: Indians (more commonly referred to as First Nations), Inuit and Métis. These are three distinct peoples with unique histories, languages, cultural practices and spiritual beliefs (Indigenous and Northern Affairs, Canada, 2016).

**Intergenerational trauma:** The psychological or emotional effects that can be experienced by people who live with trauma survivors. It refers to the coping and adaptation patterns developed in response to trauma that can be passed from one generation to the next (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 6).

**Post-colonial understanding:** The comprehension of colonization and its effect on the lives of Indigenous peoples. This includes the understanding of the relationship between residential schools and historic trauma transmission.

**Respect:** The show of consideration for all peoples, their family and communities; the act of esteeming another. Demonstrated by word and deed, it is fostered by attending to the whole person by involving the patient and family in decision making, providing family‐centred care, bearing witness, and adopting a broader perspective marked by cultural humility (Rushton, 2007). Respect for First Nation, Inuit and Métis cultural integrity is one of the guiding principles originating from the perspectives of Aboriginal communities. Respect is the show of consideration for First Nation, Inuit and Métis learners, their families, and communities for who they are, their uniqueness, and diversity (Aboriginal Nurses Association of Canada, 2009).

**Trauma-informed practice**: The integration of an understanding of trauma into all levels of care to avoiding retraumatizing or to minimize the individual’s experiences of trauma (BC Provincial Mental Health and Substance Use Planning Council, 2013, p. 19).

Overview

Nurse theorist Madeline Leininger asserts that “peoples of each culture can not only know and define the ways in which they experience and perceive their nursing care world but also relate these experiences and perceptions to their general health beliefs and practices” (George, 2011, p. 406). Cultural competency is recognized as an essential learning outcome for health care practitioners as students may encounter clients and families whose beliefs and assumptions differ from their disciplinary training (Barkley, 2010). In addition to acquiring cultural knowledge, Practical Nurse students must learn to recognize and appropriately address cultural bias in themselves, in others and in the process of health care delivery. Learning activities such as movie reviews, story lessons, dialogue circles, inquiries and learning rubrics help students to make visible their attitudes, stereotypes, and power dynamics that they may not have been aware of in the past. Jane Vella’s principles of effective adult learning such as needs assessment, safety, sound relationships, sequencing, praxis and teamwork are used to frame students’ learning (Vella, 2002, p. 4). Scaffolding and inquiry‐based learning are integrated to promote critical thinking to ready Practical Nurse students to work with complex situations (Benner, Sutphen, Leonard and Day, 2010).

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| --- |
| **OVERVIEW OF LEARNING RESOURCES****(REQUIRED RESOURCES IN BOLD)** |
| Level | ProfessionalPractice | ProfessionalCommunication | Variations in Health | Health Promotion | Pharmacology |
| I | Race**Learning Rubric 1: Learning about Diversity** | What is in a name? Bafa BafaCulture and Diversity**Place in Culture** | Meaning of Health **Approaching Traditional Knowledge** | **Health Trends** | Traditional medicines |
| II | **Learning Rubric 2: Cultivating Understanding** Weighty Blankets | Communicating with Indigenous Older Adults **Caring Interactions in End‐of‐Life Care** | Approaches for End‐of‐Life Care | **Determinants of Health** |  |
| III | **Learning Rubric 3: Fostering Partnerships in Care** | **Caring Interactions** | **Supporting Traditional Knowledge in Health and Healing** | Health Resources |  |
| IV | **Learning Rubric 4: Supporting****Diversity** | **Speaking Out for Cultural Safety** | Pain Management | Considerations of Health Access |  |

Learning Resources

The following chart lists the learning resources that are associated with each course. The competencies that the learning activities address are from the Cultural Competency Framework for Nursing Education. For each course, required learning resources are in **bold**.

|  |  |  |
| --- | --- | --- |
| **Course** | **Core Cultural****Competencies** | **Learning Resources** |
| Professional Practice I | Inclusivity | *Race – The Power of an Illusion.* Episode 1: “The Difference Between Us.” A movie to help students become aware of own perception.Accompanying website (online) with questions for faculty. |
| Professional Practice I | InclusivityMentoring/support | **Learning Rubric 1: *Learning about Diversity***Students are invited to examine their own assumptions, values, beliefs and biases.**Students’ self‐assessment.** |
| Professional Practice II | Post-colonial understandingMentoring/support | **Learning Rubric 2: *Cultivating Understanding*****Cultural Safety Module 1: Peoples’ experiences of colonization.**Students make connections between culturally safe practice and CLPNBC values.**Students’ self‐assessment of progress in cultural****competencies.** |
| Professional Practice II | RespectPost-colonial understandingMentoring/support | Weighty BlanketsA hands‐on activity to make visible effects of historical impact of colonization on individuals. |
| Professional Practice III | InclusivityPost-colonial understandingMentoring/support | **Learning Rubric 3: *Fostering Partnerships in Care*****Cultural Safety Module 3: Peoples’ experiences of colonization in health care.**Students identify ways to partner with Indigenous clients, families and communities to create culturally safe, person‐centred care plans.**Students’ self‐assessment of progress in cultural competencies.** |
| Professional Practice IV | InclusivityRespectPost-colonial understanding Indigenous KnowledgeMentoring/support | **Learning Rubric 4: *Supporting Diversity***Students conduct a literature search and create posts in forum on ethics and transcultural nursing.Students’ self‐ assessment of progress in cultural competencies. |
| Professional Communication I | RespectCommunicationMentoring/support | ***Place in Culture***Students develop awareness of how their “place in culture” shapes their communication. |
| Professional Communication I | InclusivityCommunication Mentoring/ support | Bafa Bafa Simulation ActivityA guided exercise for students to gain self‐awareness of own cultural bias and experience what it feels like to be the one person in a group who is different. They understand how easily stereotypes can be developed and what must be done to overcome them. |
| Professional Communication I | Indigenous knowledgeCommunicationMentoring/Support | What Is in a Name?Introduction of the importance of Spirit names and colours to identity formation, healing and balance.Students practice the art of listening and narration. |
| Professional Communication I | RespectCommunicationMentoring/Support | *Culture and Diversity*Students discuss the article “Nursing, Indigenous peoples and Cultural Safety: So what? Now what?” using a dialogue circle format. |
| Professional Communication II | RespectCommunicationMentoring/Support | ***Caring Interactions in End‐of‐Life Care***Use media clips to help students to decipher between helpful and unhelpful interactions when working with First Nations, Inuit and Métis clients and families |
| Professional Communication II | RespectPost-colonial understanding CommunicationMentoring/Support | *Communicating with Indigenous Older Adults*Recognizing the impact of colonization and its historical transmission, students examine verbal and non‐verbal approaches to convey respect and inclusivity in practice. |
| Professional Communication III | RespectCommunication Mentoring/support | ***Caring Interactions In Acute Care Settings***Students use scenarios and role play to gain understanding of elements necessary for culturally safe therapeutic communication while developing awareness of risk of unintended cultural harm to clients and families in commonly used assessment tools. |
| Professional Communication IV | RespectCommunicationMentoring/support | ***Speaking Out for Cultural Safety***Students practice using voice to advocate for cultural safety in practice setting. |
| Variations in Health I | RespectIndigenous Knowledge | ***Approaching Traditional Knowledge***Students learn about role of Traditional Healer, Elder and Medicine Person by exploring the tensions and augmentations of biomedical and holistic health beliefs models through review of the film *Spirit Doctors*.. |
| Variations in Health I | RespectIndigenous Knowledge | *Meaning of Health*Using case study, students explore the diverse meaning of health for First Nations, Inuit and Metis clients, families and communities.Invite Elder to speak about the importance of four corners. |
| Variations in Health II | RespectInclusivityIndigenous knowledge | *End‐of‐Life Care*Through role play, students learn about culturally sensitive approaches for end‐of‐life care of clients and families. |
| Variations inHealth III | RespectInclusivityIndigenous Knowledge | **Supporting Traditional Knowledge to Promote Health and Healing**Students conduct inquiry into traditional practices through community visits and engagement of Elders, present lessons learned in poster session. |
| Variations in Health III | RespectInclusivityIndigenous Knowledge | **Mental Health**Students learn of what Indigenous Elders consider as essential guidelines for mental health workers. Application of learning through concept map linking etiology, health beliefs models, determinants of health, cultural safety and nursing implications. |
| Variations in Health IV | RespectIndigenousknowledge | **Pain Management**Through readings and discussions (think‐pair‐share), students examine the effect of culture on pain and pain management. |
| Health Promotion I | Post-colonial understanding | **Health Trends**Students to conduct a search of local media clips (printed or digital) over the term to illuminate patterns of health issues identified for their local region. |
| Health Promotion II | Post-colonial understanding | **Determinants of Health**Building on information gathered in Health Trends, students apply determinants of health to identified health issue for Indigenous peoples. |
| Health Promotion III | InclusivityRespect | **Health Resources**Research websites/resources and database of Indigenous services related to health issues identified in Health Trends**.** |
| Health Promotion IV | InclusivityRespectPost-colonialunderstanding | **Considerations of Health Access**Using evidence (research article) to inform practice regarding health access of Indigenous women. |
| Pharmacology I | RespectIndigenousknowledge | **Traditional Medicines**Invite Traditional Healer(s) to speak on the topic of Indigenous medicines and practices. |

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Indigenous Teaching Learning Resources

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| Teaching Learning Resource: Health Trends | Recommended Activity **Cognitive Domain:** Understanding/Applying/Analyzing |
| **Course:** Health Promotion I | **Duration**: Spiral set 1 of 4**Preparation:** Moderate |
| **Indigenous Competencies**: Post‐Colonial Understanding |
| **Purpose:*** To help learners prepare for and engage in awareness development of health issues of Indigenous populations across the lifespan.
 |
| **Process:****In Preparation:**1. Teacher prepares learning by introducing health issues of Canadian Indigenous populations (metabolic, cardiac, socioeconomic)
2. Learners to watch the film *The Gift of Diabetes* (58 minutes) available online from National Film Board of Canada. <http://www.nfb.ca/film/gift_of_diabetes/>
3. Learners to collect three to five current media clips (newspaper articles, websites, etc.) related to Indigenous health in their local community.
4. Learners prepare a small report of each clip by responding to the questions below.

**In Class:**1. Learners bring media clips and summaries to class.
2. In groups of six, learners share and pool their media clips and note trends emerging from within group members (nutrition, oral health, diabetes, immunization, etc.).
3. Each learner to select ONE trend for further investigation (to take place in Health Promotion II, III, and IV).
 |
| **Summary for each media clip to include the following:*** What is the issue?
* Why is this issue in the media?
* How is this issue related to Indigenous health? Explain. Why did you pick this issue over others?
* Identify two questions that you would like to ask about this clip or issue. (No answer necessary.)
 |
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| Teaching Learning Resource: Determinants of Health | Recommended Activity **Cognitive Domain:** Understanding/Applying/Analyzing |
| **Course:** Health Promotion II | **Duration**: Spiral set 2 of 4 **Preparation**: Moderate |
| **Indigenous Competencies:** Post‐Colonial Understanding |
| **Purpose:*** To help learners understand the effects of determinants of health on Indigenous populations.
 |
| **Indigenous Determinants of Health**Diagram adapted from Morley & Schwenger, (2009), *Aboriginal Health Determinants and Chronic Disease.* |
| **Process:****In Preparation:**1. Learners access and read *Canada’s Response to WHO Commission on Social Determinants of Health.* <https://www.canada.ca/en/public-health/services/health-promotion/canada-s-response-who-commission-on-social-determinants-health/background.html>

**In Class:**1. Have learners identify the top five Indigenous determinants of health that most influenced their selected health trend (from Health Promotion I). See determinants of health diagram above.
2. Provide each learner with five sticky dots.
3. Write the Indigenous determinants of health on the flip chart.
4. Invite learners to place dots on the determinants that influenced their particular health trend. (Learners may place all five dots on one determinant or spread them out to five different determinants.)
5. When all learners are finished, look for patterns of determinants with the most dots.
6. In small groups, discuss the cause and effects of those health determinants on Indigenous health trends. Examine the role of social determinants of health on First Nations, Inuit and Métis clients, families and communities.
 |
| **References:**Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006). *Cultural Safety: Module 2: Peoples’ Experiences of Oppression.* <http://web2.uvcs.uvic.ca/courses/csafety/mod2/index.htm>Health Canada. *First Nations and Inuit Health*. <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health.html>Morley, M., & Schwenger, S. (2009). *Aboriginal Health Determinants and Stroke/Chronic Disease*. Health Nexus. <http://en.healthnexus.ca/sites/en.healthnexus.ca/files/resources/aboriginal_health_determinants_part2.pdf>Public Health Agency of Canada. Canada’s Response to WHO Commission on Social Determinants of Health. <https://www.canada.ca/en/public-health/services/health-promotion/canada-s-response-who-commission-on-social-determinants-health/background.html>Ralston, A. *Nursing 205 – Introduction to First Nations Health,* Module 1 – Units 3 & 4 – *Determinants of Health*. Accessed from BCcampus, Sharable Online Learning Resources Repository. Resource under BC Commons License. |

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| Teaching Learning Resource: Health Resources | Recommended Activity **Cognitive Domain**: Applying/Analyzing/Evaluating |
| **Course:** Health Promotion III | **Duration:** Spiral set 3 of 4 **Preparation:** Moderate |
| **Indigenous Competencies:** Inclusivity, Respect, Mentoring and Support |
| **Purpose:*** To make visible the range of health resources available to support the health of Indigenous populations.
* To assist learners in review of Indigenous health resources from perspectives of cultural competence and accessibility.
 |
| **Process:****In Preparation:**1. Learners conduct inquiry into Indigenous health resources (from local community and/or government) that address the health trend/issue identified in Health Promotion I and II.

**In Class:**1. Learners in groups of six share information on their inquiry into Indigenous health resources.
2. Once all group members have shared, learners will collaboratively create a list of five criteria to determine the accessibility and cultural competence of the various resources. Prioritize the criteria with the most important one on top. Consider factors such as cultural relevancy, literacy competency, Indigenous preferred learning styles, Indigenous determinants of health, technology competency, time perception, etc.
3. Select the three resources that best meet the criteria established.
4. Discuss questions below.
5. Each group to report out significant findings.
 |
| **Consider the following questions:**1. What rationale or evidence did you use to select your criteria?
2. How did you prioritize your criteria? Did all group members agree? Were there any differences?
3. From whose perspective were these criteria being based on?
4. In what ways are these health resources culturally inclusive, culturally respectful and culturally congruent?
5. How is accessibility and mobilization of health resources connected to health promotion?
 |
| **Sample Worksheet for Learners**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Criteria | Title of Resource 1 | Title of Resource 2 | Title of Resource 3 | Title of Resource 4 | Title of Resource 5 | Title of Resource 6 |
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| **References:**Canadian Council on Learning. (2009). *State of Aboriginal Learning in Canada:* *A Holistic Approach to Measuring Success*. <http://www.afn.ca/uploads/files/education2/stateofaboriginalholisticframework.pdf>Canadian Women’s Health Network. (2001). *Aboriginal Midwifery in Canada: Blending Traditional and Modern Forms*. <http://www.cwhn.ca/node/39589>Health Canada. (2014). *First Nations and Inuit: Healthy Pregnancy and Babies.* <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/family-health/healthy-pregnancy-babies.html>Health Canada. (2014). *First Nations and Inuit: First Nations Mental Wellness Continuum Framework – Summary Report*. <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/reports-publications/health-promotion/first-nations-mental-wellness-continuum-framework-summary-report.html>Provincial Health Services Authority, Perinatal Services BC. (2006). *Aboriginal Resources: BC’s Aboriginal Maternal Health Project* (draft). <http://www.perinatalservicesbc.ca/health-professionals/professional-resources/aboriginal-resources> |

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| Teaching Learning Resource: Considerations of Health Access | Optional Activity **Cognitive Domain:** Understanding/Applying/Analyzing |
| **Course:** Health Promotion IV | **Duration**: Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Indigenous Knowledge |
| **Purpose:*** To assist learners in using evidence to inform their practice of working with Indigenous women.
 |
| **Process:****In Preparation:**1. Learners to read the following:

Van Herk, K., Smith, D., & Andrew, C. (2011). Identity Matters: Aboriginal Mothers’ Experiences of Accessing Health Care. *Contemporary Nurse, 37*(1), 57‐68. doi:10.5172/conu.2011.37.1.057**In Class:**1. Learners in groups of five. Assign each learner in the groups a section of the article in which they will be the “expert” of that section.
2. Learners summarize their section into salient points and respond to the questions in the Sample Reading Circle Responsibility (see below).
3. Learners share their responses with other members of the group.
4. Move to a large group, and have learners discuss the article as a whole and apply findings of the article to their potential practice.
5. Teachers pull through concept of evidence‐informed practice and cultural influence of Indigenous women’s use of pregnancy and parenting resources.
 |
| **Sample Reading Circle Responsibility****Learner 1:** Read pages 57–59 (up to end of background) and answer the following questions: 1. Why is this study being done?
2. What is the purpose of the study?

**Learner 2**: Read pages 59–61 (up to end of limitations) and answer the following questions:1. Who were the participants of the study?
2. What methods of data gathering were used?
3. How are the methods culturally congruent?

**Learner 3:** Read pages 61–63 (up to end of Western models of mothering) and answer the following questions:1. What were the main findings?
2. Do you agree or isagree?
3. In what ways do the findings support your knowledge of cultural safety?

**Learner 4:** Read pages 63–65 (up to end of Indigenous women leading and transforming care) and answer the following questions:1. What were the main findings?
2. Do you agree or disagree?
3. In what ways do the findings support your knowledge of cultural safety?

**Learner 5:** Read pages 65–67 (starting with implications for nursing) and answer the following questions:1. What new ideas or validation of ideas came out of this study?
2. How does this study contribute to your evidence‐informed practice of promoting health for First Nations, Inuit and Métis peoples?
 |
| **References:**Davis, B., & Logan, J. (2008). *Reading Research: A User‐Friendly Guide for Nurses and Other Health Professionals.* Toronto: Elsevier Canada.Van Herk, K., Smith, D., & Andrew, C. (2011). Identity Matters: Aboriginal Mothers’ Experiences of Accessing Health Care. *Contemporary Nurse, 37*(1), 57‐68. doi:10.5172/conu.2011.37.1.057 |

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| Teaching Learning Resource: Traditional Medicines | Optional Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Pharmacology I | **Duration:** Single session **Preparation:** Moderate |
| Indigenous Competencies: Respect, Indigenous Knowledge |
| **Purpose:*** To help learners appreciate the meaning and values of traditional modalities and medicines in health and healing of First Nations, Inuit and Métis clients, families and communities.
 |
| **Process:****In Preparation:**1. Learners to read the following:

Wieman, C. (2006). Western Medicine Meets Traditional Healing. *CrossCurrents, 10*(1), 10‐11.1. Invite learners to reflect on the following quote from Cook (2005):

A Royal Commission on Indigenous Peoples widely consulted Indigenous people in Canada. The Commission’s 1996 Report advocated 4 cornerstones of Indigenous health reform, one of which was “the appropriate use of traditional medicine and healing techniques [that] will assist in improving outcomes…” It reported that many expressed the sentiment that “the integration of traditional healing practices and spirituality into medical and social services is the missing ingredient needed to make those services work for Aboriginal people.”1. Learners to visit the World Health Organization website to review traditional and complementary medicine: <http://who.int/medicines/areas/traditional/en/>

**In Class:**1. Watch the video *Indigenous Plant Diva* (nine minutes). “Wyss reveals the remarkable healing powers of plants growing among the sprawling urban streets of downtown Vancouver.” [http://www.cultureunplugged.com/play/2819/Indigenous‐Plant‐Diva](http://www.cultureunplugged.com/play/2819/Indigenous%E2%80%90Plant%E2%80%90Diva)
2. Create two posters (or on white board), one with the heading “What I know about Indigenous medicines and practices” and the other with “What I would like to know more of.”
3. Provide learners with Post‐it Notes and invite them to indicate their current knowledge base and curiosity about traditional modalities and medicines. Read some of them out to indicate common interests.
4. Invite Traditional Healers/Elders to speak on the topic of Indigenous medicines and practices.
5. Break learners into small discussion groups. Invite guests to circulate or join the discussions.
 |
| **Sample Questions** 1. What did you learn?
2. How will you apply this knowledge in practice?
3. What practice issues do you have about the use of traditional modalities and medicines?
4. How is the CLPNBC practice resource for complementary and alternative health care applicable to your practice?
5. To support your clients’ decision of traditional medicines, what implications will it have in your care plan?
6. In the event of differing value systems of Indigenous clients and health care workers, from who, what, and where can you get further clarification?
 |
| **References:**College of Licensed Practical Nurses of British Columbia (CLPNBC). (2017). *A Resource for Complementary & Alternative Health.* <https://www.clpnbc.org/Documents/Practice-Support-Documents/Practice-Resources/A-Resource-for-Complementary-and-Alternative-Healt.aspx>Cook S. (2005). Use of Traditional Mi’kmaq Medicine among Patients at a First Nations Community Health Centre. *Canadian Journal of Rural Medicine, 10*(2), 95‐9. First Nations Health Authority. *Traditional Healing Resources.* <http://www.fnha.ca/what-we-do/traditional-healing>Selywn, J. (Director), & Kamala, T. (Producer). (2009). *Indigenous Plant Diva* [DVD]. National Film Board of Canada. [http://www.cultureunplugged.com/play/2819/Indigenous‐Plant‐Diva](http://www.cultureunplugged.com/play/2819/Indigenous%E2%80%90Plant%E2%80%90Diva)Wieman, C. (2006). Western Medicine Meets Traditional Healing. *CrossCurrents, 10*(1), 10‐11.World Health Organization. *Traditional and Complementary Medicine.* <http://who.int/medicines/areas/traditional/en/> |

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| Teaching Learning Resource: Bafa Bafa | Optional Activity **Affective Domain**: Respond/Value |
| **Course:** Professional Communication I | **Duration:** Single session, best done in a three- to four-hour block **Preparation**: High |
| **Indigenous Competencies:** Inclusivity, Mentoring and Support |
| **Purpose:*** A guided simulation exercise for students to gain self‐awareness of their own cultural biases and experience what it feels like to be the one person in a group who is different.
* To help learners gain awareness of how easily stereotypes develop and what they can do to overcome them.
 |
| **Process:****In Preparation:**(This activity uses the concept of experiential learning – please refer to references on experiential learning.)1. Review product information, facilitation notes and detailed lesson plan (see Reference section below).
2. Required: two large classrooms, preferably not connected to each other. In each room, arrange chairs in circle leaving large space in centre of circle.
3. Required: a minimum of two facilitators who have experienced the game personally; assign roles as outlined in facilitation notes.

**In Class:**1. Inform learners of the purpose of the exercise and the need to adhere to rules of simulation to achieve maximum benefits.
2. Ensure adequate time for debriefing; debriefing notes included in simulation kit (minimum one hour, use of white board).
3. Learners to reflect on experience in journal.
 |
| **Sample Journal Prompts**1. What happened?
2. Why was this simulation part of your learning?
3. What did you experience?
4. What were you most surprised at?
5. What did you notice about yourself and others during the simulation?
 |
| **References:**Fowler, S., & Pusch, M. (2010). Intercultural Simulation Games: A Review (of the United States and Beyond). *Simulation & Gaming, 41*(1), 94‐115. doi: 10.1177/1046878109352204Kaminski, J., & Currie, S. (2009). Experiential Knowledge Overview. *First Nations Pedagogy Online.* http://firstnationspedagogy.ca/experiential.htmlPersell, C., & Gerdes, J. (2008). Introsocsite: Introduction to Sociology: Resources for Teachers: Detailed Lesson Plan for Bafa Bafa . New York University. <http://www.nyu.edu/classes/persell/aIntroNSF/LessonPlans/BAFABAFALesson%20Plan.htm>Simulation Training Systems. (n.d.). Product Information for BaFa BaFa Simulation Game. <http://www.simulationtrainingsystems.com/business/bafa.html> |

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| Teaching Learning Resource: Culture and Diversity | Optional Activity **Affective Domain:** Receive/Respond/Value |
| **Course:** Professional Communication I | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Communication, Mentoring and Support |
| **Purpose:*** To create an environment (dialogue circle) where there is shared learning, exchange and co‐ creation of knowledge.
* To help learners appreciate the importance of trust, respect and reciprocity in relationship building.
* To explore ways to facilitate culturally safe communication with First Nations, Inuit and Métis clients, families, and communities.
 |
| **Process:****In Preparation:**1. Learners to read the Stout & Downey (2006) article (see References below) and choose one or more quotes or a portion of the article that they would like to have further dialogue/inquiry on and prepare a list of three to five open‐ended questions related to the quotes or section they have chosen.

**In Class:****Option A: Dialogue Groups**1. In small dialogue groups (ideally, four learners), learners each take a turn being the group dialogue facilitator (15 to 20 minutes, depending on time availability) using their selected quotes and questions. Allow approximately five minutes for transition between learner facilitations. Within each group, assign a bumper guard, timekeeper, skeptic and recorder (see below for role descriptions).

**Option B: Talking Circles**1. Please see General Process in Circle Talks http://firstnationspedagogy.ca/circletalks.html (activity could be adapted to online application).
2. When dialogue circles or Circle Talks are complete, teacher to pull out main points from each dialogue group and note emerging patterns of culture and diversity themes.
3. Review with learners the concept of developing trust, respect and reciprocity as essential steps of engagement in dialogue (see reflection questions below).
4. Explore with learners ways to facilitate trusting relationships in working with First Nations, Inuit and Métis clients, families and communities.
* Variations: Ask learners to turn in quotes, question preparations (if used), and responses/reflections as assignment.
 |
| **Roles of Dialogue Circle (Option A):****Bumper Guard** – Keeps the discussion on track and focused, and encourages balance in members’ voices, not having one member talk too much or too little.**Timekeeper** – Maintains and monitors time so that the group moves along without one person monopolizing the time. Each person will have 15 to 20 minutes to share their quotes and questions.**Skeptic** – Plays the role of devil’s advocate by posing challenges to different points of view. **Recorder**– Keeps notes of the salient points of dialogue.**Facilitator** – All learners in group will take turn being the facilitator of the dialogue circle, presenting their chosen quote and questions.**Circle Talk (Option B):**Follow slide and learning activity resource from *First Nations Pedagogy Online* <http://firstnationspedagogy.ca/circletalks.html>**Reflection Questions (Option A and B)**1. In what ways did your group members support you? How did that made you feel? What behaviours did that enable you to do when you were in your group?
2. How did you support your group members? What does the term “reciprocity” mean? Why is that important in relationship building?
3. What factors contributed to your sense of safety when you were with your group members?
4. Discuss the connections between safety and voice. How did the Dialogue Circle or Circle Talk enable balance in voice?
5. The concept of Dialogue Circle or Circle Talk is sometimes used in Indigenous family meetings. What are the benefits and challenges of this method of communication in practice?
6. What foundations of relational practice and cultural awareness will assist in the development of trusting relationships when working with First Nations, Inuit and Métis clients, families and communities?

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| **References:**Brookfield, S., & Preskill, S. (2005). *Discussion as a Way of Teaching: Tools and Techniques for Democratic Classrooms* (2nd ed.). San Francisco: Jossey‐Bass.Canadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. Kaminski, J., & Currie, S. (2009). Circle Talks. *First Nations Pedagogy Online*. <http://firstnationspedagogy.ca/circletalks.html>Stout, M., & Downey, B. (2006). Nursing, Indigenous Peoples and Cultural Safety: So What? Now What? *Contemporary Nurse, 22*(2), 327‐332.Weimer, M. (2002). *Learner‐Centered Teaching: Five Key Changes to Practice*. San Francisco: Jossey‐Bass. |

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| Teaching Learning Resource: What’s in a Name? | Optional Activity **Affective Domain**: Respond/Value |
| **Course:** Professional Communication I | **Duration**: Single session (preferably the first week of class)**Preparation:** Low |
| **Indigenous Competencies:** Indigenous Knowledge, Inclusivity, Mentoring and Support |
| **Purpose:*** To begin building safety in class to facilitate future exploration of values, beliefs and attitudes. To provide example for learners that they are the ones to set own level of self‐disclosure.
* To practice skill of “noticing” as non‐judgmental and non‐evaluative observations.
* To practice the art of listening and narration.
* To establish common ground experience.
* To introduce concept of cultural safety.
 |
| **Process:****In Preparation:**1. Learners to access the following site, Your Name and Colours: <https://neaoinfo.files.wordpress.com/2014/07/colours.pdf>
2. Arrange for Elder be a guest in the classroom.

**In Class:**1. As a welcome activity for learners to get to know each other better, explain the purpose of the activity, emphasizing relationship building and cultural safety.
2. Bridge‐In: across centuries and cultures, people have taken much thought and consideration when naming their babies. Ask learners to provide examples of their experience.
3. The ritual and honour of naming babies have significant meaning in many cultures. Invite learners to spend five to 10 minutes each to think about the sample questions below.
4. Learners will introduce themselves using the information provided. When all introductions are completed, discuss with learners the following:
	1. Importance of a person’s name to his or her individuality, self‐concept and empowerment.
	2. The Elder’s perspectives of the importance of Spirit names and colours to promote healing, balance and protection against sickness and diseases.
	3. The power of storytelling in conveying information and promoting understanding.
	4. The importance of getting to “know” in establishing relationship and trust building.
	5. The concept of culture – in the classroom, in the profession, in First Nations, Inuit and Métis communities.
	6. The concept of safety – in development of trust, empowerment and health.
 |
| **Sample Questions:**1. What is your name?
2. Who named you?
3. What is the story behind the name?
4. To your understanding, what is the meaning of your name?
5. What are the implications of your name and family history?
6. How does your name reflect your identity, individuality and culture?
 |
| **References:**Anishnawbe Health Toronto, (n.d.). *Your Name and Colours.* <https://neaoinfo.files.wordpress.com/2014/07/colours.pdf>Jacob, S. R. (2008). Cultural Competency and Social Issues in Nursing And Health Care. In B. Cherry, & S. R. Jacob (Eds.), *Contemporary Nursing: Issues, Trends and Management* (pp. 207‐233). St. Louis, MO: Mosby.Pharris, M. D. (2009). Inclusivity: Attending to Who Is in the Center. In S. D. Bosher, & M. D. Pharris (Eds.), *Transforming Nursing Education: The Culturally Inclusive Environment* (pp. 3‐26). New York: Springer. |

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| Teaching Learning Resource: Place in Culture | Recommended Activity **Affective Domain**: Receive/Respond/Value |
| **Course:** Professional Communication I | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Communication, Mentoring and Support |
| **Purpose:*** To help learners gain awareness of how their place in culture shapes their communication and decisions.
 |
| **Process:****In Preparation:**1. Invite learners to participate in the activity: What is this thing called culture? Activity from Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006). *Cultural Safety: Module 2: Peoples’ experiences of oppression.* <http://web2.uvcs.uvic.ca/courses/csafety/mod2/las.htm>

Learners to record their responses in journal entries.1. Learners to visit the following site:*Language and Culture: Hidden aspects of communication* <http://anthro.palomar.edu/language/language_6.htm>
2. Learners to consider cultural practices overview of Indigenous peoples. <http://firstnationspedagogy.ca/culture.html>

**In Class:**1. Have learners break into small groups and discuss questions associated with “What is this thing called culture” activity.
2. Discuss with learners the connections between place in culture and communication.
 |
| **Sample Questions to Connect Culture and Communication**1. Many forms of communication are connected with culture: for example, greeting gestures such as handshakes, eye contact, storytelling. How relevant and appropriate are these forms of non‐verbal communication with First Nations, Inuit and Métis peoples?
2. How does your place in the culture continuum shape how you see culture? To what extent do you assume others share the same cultural practices as you?
3. Take a moment to identify communication processes (verbal and non‐verbal) that are associated with your place in culture (e.g., choice of vocabulary, speech volume, tone of voice, use of space, use of time, use of stories to share perspectives, layers of clothing, knocking on doors).
4. What modifications might be necessary for you to create a culturally safe nursing environment when interacting with Indigenous clients, families and communities?
 |
| **References:**Canadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf?la=en>Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006). *Cultural Safety: Module 2: Peoples’ Experiences of Oppression.* <http://web2.uvcs.uvic.ca/courses/csafety/mod2/las.htm>Kaminski, J., & Currie, S. (2009). Cultural Practices Overview. *First Nations Pedagogy Online.* <http://firstnationspedagogy.ca/culture.html>O’Neil, D. (2009). *Language and Culture: Hidden Aspects of Communication*. Retrieved from <http://anthro.palomar.edu/language/language_6.htm>Stout, M., & Downey, B. (2006). Nursing, Indigenous Peoples and Cultural Safety: So What? Now What? *Contemporary Nurse, 22*(2), 327‐332. |

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| Teaching Learning Resource: Caring Interactions in End­of­Life Care | Optional Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Professional Communications II | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Communication, Mentoring and Support |
| **Purpose:*** To help learners develop culturally safe communication in end‐of‐life care for Indigenous peoples.
 |
| **Process:****In Preparation:**1. Learners watch the following YouTube clip: *Communication within the Family* (8 minutes) <https://youtu.be/1LAkV-ofnL4>

**In Class:**1. Select from the following series of Aboriginal (Canada) Palliative Care videos from Canadian Virtual Hospice. These series portray the do’s and don’ts of communication. Pause clips as necessary to facilitate discussions (discussion questions embedded in video clips).

**Variation:** learners may choose to reflect on own prior to discussion in class.1. *Responding to Aboriginal Diversity*(6 minutes) <https://youtu.be/vIO0kQknEpU>
	* + Assist learners to compare and contrast the communication approaches between the first and second scenarios.
		+ Assist learners to clarify “teaching points” embedded within the video.
* *Appropriate Family Support* (5 minutes) <https://youtu.be/jlvjOzhVb-M>
	+ - Assist learners to identify verbal and non‐verbal communication the family member (mother) used to convey her message/concerns.
		- Assist learners to identify the following behaviours of the practitioner in the video clip:
			* Use of open-ended questions, not making assumptions based on cultural background.
			* Working with the family member as partner in seeking health care solutions.
			* Use of exploratory questions to determine priority in care.
1. Upon completion of class discussion, ask learners to fill in the following one-minute paper (below) and hand in. Follow up with clarification for next class if necessary.
 |
| **One-Minute Paper**1. What was the most important point made in class today?
2. What unanswered questions do you still have?
 |
| **References:**Angelo, T., & Cross, K. (1993). *Classroom Assessment Techniques: A Handbook for College Teachers* (2nd ed.). San Francisco: Jossey‐Bass.Canadian Hospice Palliative Care Association. (2008). *Aboriginal Resource Commons.* <http://www.chpca.net/resource-commons/aboriginal-resource-commons.aspx>Canadian Virtual Hospice. (2003–2010). *Communication within the Family*. [YouTube video].<https://youtu.be/1LAkV-ofnL4> Canadian Virtual Hospice. (2003–2010). Responding to Aboriginal Diversity. [YouTube video]. <https://youtu.be/vIO0kQknEpU>Canadian Virtual Hospice. (2003–2010)*. Tools for practice – Aboriginal*. [http://www.virtualhospice.ca/en\_US/Main+Site+Navigation/Home/For+Professionals/For+Professionals/Tools+for+Practice/Aboriginal.aspx](http://www.virtualhospice.ca/en_US/Main%2BSite%2BNavigation/Home/For%2BProfessionals/For%2BProfessionals/Tools%2Bfor%2BPractice/Aboriginal.aspx)Canadian Virtual Hospice (2008–2010). *Appropriate Family Support*. [YouTube video]. <https://youtu.be/jlvjOzhVb-M>Longboat, D. (2002). *Ian Anderson Program in End‐of‐Life Care: Module 10: Indigenous Perspectives on Death and Dying*. University of Toronto. <http://www.cpd.utoronto.ca/endoflife/Modules/Indigenous%20Perspectives%20on%20Death%20and%20Dying.pdf> |

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| Teaching Learning Resource: Communicating with Indigenous Older Adults | Optional Activity **Affective Domain**: Receive/Respond/Value |
| **Course:** Professional Communication II | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Post-colonial Understanding, Communication, Mentoring and Support |
| **Purpose:*** To create an environment where there is shared learning, exchange and co‐creation of knowledge.
* To help learners develop a culturally safe therapeutic relationship with First Nations, Inuit and Métis clients, families, and communities through awareness of colonization and its historical impact.
 |
| **Process:****In Preparation:**1. Learners to access the following website:Public Health Agency of Canada, Division of Aging and Seniors. (2009). *Reaching Out: A Guide to Communicating with Aboriginal Seniors.* <http://publications.gc.ca/collections/Collection/H88-3-20-1998E.pdf>
2. Learners to access the following online interactive module:*Cultural Safety: Module 1: Peoples’ Experiences of Colonization.* <http://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm> Provide at least one week notice to enable ample time to work through module.

**In Class:**1. In small groups, learners work through the “what does this mean in practice” questions within the module 1 website, focusing on professional communication.
2. Invite Elder to provide teachings, insights and perspectives on culturally safe, caring interactions.
 |
| **Reflection Questions:**1. Recognizing the impact of colonization and its historical transmission on First Nations,

Inuit and Métis older adults, what might be some barriers to communication with older adults?1. What non‐verbal approaches might be appropriate for a nurse to convey respect and inclusivity in practice?
2. What verbal approaches might be appropriate for a nurse to convey respect and inclusivity in practice?
3. What multiple thinking must a nurse use to practice culturally safe, caring interactions?
4. What might be some challenges within the practice setting that prevent culturally safe, caring interactions? What are some alternatives?
5. What resources or services are available in your local community to assist in providing culturally safe communication with First Nations, Inuit and Métis clients and families?
 |
| **References:**Brookfield, S., & Preskill, S. (2005). *Discussion as a Way of Teaching: Tools and Techniques for Democratic Classrooms* (2nd ed.). San Francisco: Jossey‐Bass.Canadian Nurses Association. (2011)*. Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006). Cultural Safety: Module 1: Peoples’ Experiences of Colonization. <http://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm>Public Health Agency of Canada, Division of Aging and Seniors. (2009). *Reaching Out: A Guide to Communicating with Aboriginal Seniors.* <http://publications.gc.ca/collections/Collection/H88-3-20-1998E.pdf> |

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| Teaching Learning Resource: Caring Interactions in Acute Care Settings | Recommended Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Professional Communication III | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies**: Respect, Communication, Mentoring and Support |
| **Purpose:*** To create an environment where there is a culture of shared learning, exchange and co‐creation of knowledge for learners.
* To provide opportunities for learners to build communication approaches that are culturally sensitive and respectful when working with First Nations, Inuit and Métis clients and families.
 |
| **Process:****In Preparation:**1. Learners to read the following articles:
* Caron, N. (2006). Caring for Aboriginal patients: The Culturally Competent Physician. *Royal College Outlook, 3*(2), 19–23.
* Pullen, R. (2007). Tips for Communicating with a Patient from Another Culture. *Nursing, 37*(10), 48‐49.
* First Nations Health Authority. (2016). *#itstartswithme – Cultural Safety and Humility: Key Drivers and Ideas for Change.* <http://www.fnha.ca/Documents/FNHA-Cultural-Safety-and-Humility-Key-Drivers-and-Ideas-for-Change.pdf>

**In Class:**1. Working in small groups, learners to discuss and/or role play the following scenarios (sample scenarios below).
2. Debrief in large group.
 |
| **Sample Scenarios:**1. Discuss how a nurse may obtain vital clinical information from a First Nations, Inuit and Métis patient when the patient does not understand the intent of the question because of cultural or language barriers. Consider various assessment tools that are often used in acute care settings which are based on the biomedical model. Consider the cultural congruency of such tools and how a nurse might use effective communication skills to navigate through such assessments.
2. “True wellness includes not only the physical, but also the mental, emotional and spiritual elements” (Caron, 2006, p. 21). Culturally safe assessment questions take time to formulate.
* Prepare a list of culturally safe questions that will address these elements as part of your nursing assessment.
* What verbal and non‐verbal communication will you use?
* What verbal and non‐verbal communication will be your data?
1. You are on a surgical unit. Illustrate enabling and disruptive nursing interactions/behaviours when responding to a family member’s requests for analgesic for your client prior to a dressing change. Describe your rationale for interactions/behaviours with your client and with the client’s family members. What framework or communication principles guided your practice? Why?
2. You are working with an older adult on a medical floor. Your client mentions using use traditional medicine for his previous aliments. Prepare a dialogue where a nurse explores traditional healing modalities and medicines with a patient during his stay in the acute‐care setting. He is sharing a room with another male who is not of First Nations, Inuit or Métis descent.
3. You are the team leader and working with two unregulated providers who are not familiar with culturally safe care for First Nations peoples. One of your patients is a First Nations teenager from a rural setting who has not been in a hospital before. What communication strategies will you share with your team members?
 |
| **References:**Canadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. Caron, N. (2006). Caring for Aboriginal patients: The Culturally Competent Physician. *Royal College Outlook, 3*(2), 19‐23. Cass, A., Lowell, A., Christie, M., Snelling, P., Flack, M., Marrnganyin, B., & Brown, I. (2002). Sharing the True Stories: Improving Communication between Aboriginal Patients and Healthcare Workers. *The Medical Journal of Australia, 176*(10), 466 – 70.Pullen, R. (2007). Tips for Communicating with a Patient from Another Culture. *Nursing, 37*(10), 48‐49. |
| Teaching Learning Resource: Speaking Out for Cultural Safety | Recommended Activity **Affective Domain:** Receive/Respond/Value |
| **Course:** Professional Communication III | **Duration:** Single session **Preparation**: Moderate |
| **Indigenous Competencies:** Respect, Communication, Mentoring and Support |
| **Purpose:*** To create an environment where there is shared learning, exchange and co‐creation of knowledge.
* To provide opportunities for learners to formulate respectful communication approaches in advocating for culturally safe care of First Nations, Inuit and Métis clients and families.
 |
| **Process:****In Preparation:**1. Learners to access and work through the section of “Concepts – Experiences of Health and Health Care: Using Power Constructively.” *Cultural Safety: Module 3: Peoples’ experiences of colonization in relation to healthcare.* <http://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm>

**In Class:**1. Working in small groups of three, provide time for learners to work through the “Standing Your Ground” activity, found under the Activities section of the module.
2. Provide time for learners to work on the “Cultural Safety: A way forward?” exercise in the Activities section of the module.
3. Address the “What does this mean in practice?” section of the module.
 |
| **Sample Reflection Questions:** 1. What part of this exercise surprised you most? Why?
2. What part of this exercise was most challenging for you? What part of this exercise was most rewarding for you?
3. What have you learned about yourself? About professional communication?
 |
| **References:**Canadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006). *Cultural Safety: Module 3: Peoples’ Experiences of Colonization in Relation to Health Care*. <http://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm> |

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| Teaching Learning Resource: Race | Optional Activity **Affective Domain:** Respond/Value/Organize |
| **Course:** Professional Practice I | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Inclusivity |
| **Purpose:*** To develop learners’ awareness of own attitudes, biases and assumptions of race.
 |
| **Process:****In Preparation:**1. Invite learners to individually reflect and answer the following sample pre‐activity reflection before coming to class.

**In Class:**1. “Race is not based on biology, but race is rather an idea that we ascribe to biology.” Have learners discuss the meaning of this statement.
2. Watch *Race: The Power of an Illusion,* Episode 1: The Difference between Us: <http://www.dailymotion.com/video/x3zfck8>
3. Refer to California Newsreel website (below) for discussion guides and online facilitator guides.

Invite learners to answer the post‐activity questions. Discuss learners’ responses in relations to First Nations, Inuit and Métis people. Invite learners to journal about class discussions. |
| **Sample Pre‐Activity Reflections:**1. What does the term “race” mean to you?
2. How does it affect you? How does it affect your place in the world?
3. How does your background (gender, ethnicity, education, etc.) shape the lens that you see through?

**Sample Post‐Activity Reflections:** 1. What surprised you?
2. What did you discover about yourself, your views and values?

What does the term “race” mean to you now? |
| **References:**Adelman, L. (Executive Producer). (2003). *Race: The Power of an Illusion* Episode 1: The Difference between Us California Newsreel. http://www.dailymotion.com/video/x3zfck8 |

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| Teaching Learning Resource: Learning Rubric 1: Learning about Diversity | Recommended Activity**Cognitive:** Understanding/Applying |
| **Course:** Professional Practice I | **Duration:** Spiral set 1 of 4**Preparation:** Moderate |
| **Indigenous Competencies:** Inclusivity, Mentoring and Support |
| **Purpose:*** To help learners gain awareness of their own learning needs in context of culturally safe care with First Nation, Inuit and Métis clients, families and communities.
* To help learners with self‐assessment and reflection in making visible their own assumptions, values, beliefs and biases.
 |
| **Process:** **In Class:**1. Watch video *Recognizing Bias* (6 minutes), available from BCcampus. Discuss how biases influence our worldviews, decisions and communication.
2. As a class, discuss the Indigenous competencies (Inclusivity, Post‐Colonial Understanding, Respect, Indigenous Knowledge and Communication). See examples of cultural safety of health care practices on pages 9 to 11 of *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers AND Educators*. <http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf>
3. Learners working in small groups can be assigned one of the five competencies. Learners to provide examples of behaviours of a culturally unaware nurse, developing nurse and a culturally safe nurse of the assigned competency. Use creativity to share examples.
4. Invite learners to journal using the following stems. Learners are requested to revisit/revise entries each term of the PN program.
* I believe the ultimate purpose of cultural competence and cultural safety in nursing education is…
* I believe this purpose can be achieved by… I believe my role is…
* I believe the factors that inhibit or enable this purpose to be achieved include…
* Other values/beliefs that I hold about providing culturally safe care with First Nations, Inuit and Métis clients, families and communities are…
 |
| **Take home:**1. Have learners individually review the rubric and conduct an authentic self‐assessment. There are no wrong answers. Learners to date their entries so they can recognize their progression within the term.

**Variations:**1. Learners hand in rubric upon completion.
2. Learners place evidence and artefacts of competencies in professional portfolio.
 |
| **References:**Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing and Canadian Nurses Association. (2009). *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nation, Inuit and Metis Nursing*. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/first_nations_framework_e.pdf?la=en>Browne, A. J., Varcoe, C., Smye, V., Reimer‐Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural Safety and the Challenges of Translating Critically Oriented Knowledge in Practice. *Nursing Philosophy, 10*(3), 167‐179. doi: 10.1111/j.1466‐769X.2009.00406.xCanadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf?la=en>Fluckiger, J. (2010). Single Point Rubric: A Tool for Responsible Student Self‐Assessment. *Delta Kappa Gamma Bulletin, 76*(4), 18‐25.Jamison, J., & Balcaen, P. *Recognizing Bias* [Video]. Accessed from BCcampus, Sharable Online Learning Resources Repository. Resource under the BC Commons License.McCormack, B., Manley, K., & Robert, G. (2004). *Practice Development in Nursing*. United Kingdom: Blackwell Publishing.National Aboriginal Health Organization. (2008). *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators.* <http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf> |

**Learning Rubric 1: Learning about Diversity**

| **Not Yet** (areas that need work) | **Culturally Safe** | **Evidence**(how you have met the competencies) | **Advanced** (areas that go beyond basics) |
| --- | --- | --- | --- |
|  | **Inclusivity:*** Identify, acknowledge and analyze one’s considered emotional response to the many histories and contemporary environment of First Nations, Inuit and Métis peoples and offer opinions respectfully
* Acknowledge and analyze the limitations of one’s knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding the health and health practices of First Nations, Inuit and Métis peoples.
* Describe examples of ways to respectfully engage with, and contribute to First Nations, Inuit and Métis communities as a prospective care provider.
* Demonstrate authentic, supportive and inclusive behaviour in all exchanges with First Nations, Inuit and Métis individuals, health care workers, and communities.
* Additional entries (as needed)
 |  |  |
|  | **Post-colonial Understanding:** * Describe the connection between historical and current government practices toward First Nations, Inuit and Métis peoples.
* Describe the resulting intergenerational health outcomes, and determinants of health that impact First Nations, Inuit and Métis clients, families, and communities.
* Outline the concept of inequity of access to health care/health information for First Nations, Inuit and Métis peoples and the factors that contribute to it.
* Identify ways of readdressing inequity of access to health care/health information with First Nations, Inuit and Métis clients, families and communities.
* Articulate how the emotional, physical, social and spiritual determinants of health and well-being for First Nations, Inuit and Métis peoples impact their health.
* Additional entries (as needed)
 |  |  |
|  | **Respect:*** Understand that unique histories, cultures, languages and social circumstances are manifested in the diversity of First Nations, Inuit and Métis peoples.
* Understand that First Nations, Inuit and Métis peoples will not access a health care system when they do not feel safe doing so and where encountering the health care system places them at risk for cultural harm.
* Identify key principles in developing collaborative and ethical relationships.
* Describe types of Indigenous healers/traditional medicine people and health professionals working in local First Nations, Inuit and/or Métis communities.
* Demonstrate how to appropriately enquire whether First Nations, Inuit or Métis clients are taking traditional herbs or medicines to treat their ailment and how to integrate that knowledge into their care.
* Additional entries (as needed)
 |  |  |
|  | **Indigenous Knowledge:*** Demonstrate ways to acknowledge and value Indigenous knowledge with respect to the health and wellness of First Nations, Inuit and Métis clients, families and communities.
* Recognize the diversity, as a care provider, of Indigenous health knowledge and practices among First Nations, Inuit and/or Métis clients, families or communities.
* Identify and describe the range of healing and wellness practices, traditional and non‐traditional, present in local First Nations, Inuit and Métis communities.
* Additional entries (as needed)
 |  |  |
|  | **Communication:*** Identify the centrality of communication in the provision of culturally safe care, and engage in culturally safe communication with First Nations, Inuit and Métis clients, families and communities.
* Demonstrate the ability to establish a positive therapeutic relationship with First Nations, Inuit and Métis clients and their families, characterized by understanding, trust, respect, honesty and empathy.
* Identify specific populations that will likely require the support of trained interpreters; and demonstrate the ability to use these services when providing care to individuals, families and communities.
* Additional entries (as needed)
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| Teaching Learning Resource: Learning Rubric 2: Cultivating Understanding | Recommended Activity **Cognitive:** Understanding/Applying |
| **Course:** Professional Practice II | **Duration::** Spiral set 2 of 4 **Preparation:** Moderate |
| **Indigenous Competencies:** Inclusivity, Post‐Colonial Understanding, Mentoring and Support |
| **Purpose:*** To help learners with progress of own learning needs for Indigenous competencies.
* To help learners with ongoing self‐assessment and reflection to enhance Indigenous learning and culturally safe nursing practice.
* To help learners with awareness of historical colonization and its impact on health of First Nations, Inuit and Métis peoples.
 |
| **Process:****In Preparation:**1. Learners to visit the following online interactive module on “cultural safety”: *Module 1: Peoples’ Experiences of Colonization.* Please provide ample time for students to work through the module.

<http://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm> 1. Read the Introduction, including purposes of modules.
2. Visit the colonial history section in Concepts section.
3. Participate in private reflection in Activities.
4. Attend to Self‐Care Suggestions as needed.

**In Class:**1. Learners (in small groups) create a visual presentation linking culturally safe practice with one of the CLPNBC Professional Standards (2014).

Standard 1: Professional, Legal and Ethical Practice. Standard 2: Competency-based Practice.Standard 3: Client-focused Provision of Service.Standard 4: Ethical Practice.1. Invite learners to journal using the following stems. Learners are requested to revisit/revise entries each term of the PN program.
* I believe the ultimate purpose of cultural competence and cultural safety in nursing education is…
* I believe this purpose can be achieved by…
* I believe my role is…
* I believe the factors that inhibit or enable this purpose to be achieved include…
* Other values/beliefs that I hold about providing culturally safe care with First Nations, Inuit and Métis clients, families and communities are…
 |
| **Take home:**1. Making visible their evidence of learning. There are no wrong answers.

**Variations:**1. Learners hand in rubric upon completion.
2. Learners place evidence and artefacts of competencies in professional portfolio.
 |
| **References:**Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing and Canadian Nurses Association. (2010). Cultural Competency and Cultural Safety Curriculum for Aboriginal Peoples. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/first_nations_framework_e.pdf?la=en>Browne, A. J., Varcoe, C., Smye, V., Reimer‐Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural Safety and the Challenges of Translating Critically Oriented Knowledge in Practice. *Nursing Philosophy 10*(3), 167‐179. doi: 10.1111/j.1466‐769X.2009.00406.xCanadian Nurses Association. (2011)*. Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf?la=en>College of Licensed Practical Nurses of British Columbia (CLPNBC). (2014). *Professional Standards for Licensed Practical Nurses*. Burnaby: Author. <https://clpnbc.org/Documents/Practice-Support-Documents/Professional-Standards-of-Practice-for-Licensed-Pr.aspx>Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V. & Voyageur, E. (2006). *Cultural Safety: Module 1: Peoples’ Experiences of Colonization.* <http://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm>Fluckiger, J. (2010). Single Point Rubric: A Tool for Responsible Student Self‐Assessment. *Delta Kappa Gamma Bulletin, 76*(4), 18‐25.McCormack, B., Manley, K., & Robert, G. (2004). *Practice Development in Nursing*. United Kingdom: Blackwell Publishing. |

**Learning Rubric 2: Cultivating Understanding**

| **How I will****revise to****better meet****competency** | **Culturally Safe** | **How I know I****have met the****competency** | **How I went****beyond the****competency** |
| --- | --- | --- | --- |
|  | **Inclusivity:*** Identify, acknowledge and analyze one’s considered emotional response to the many histories and contemporary environment of First Nations, Inuit and Métis peoples and offer opinions respectfully.
* Acknowledge and analyze the limitations of one’s knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding the health and health practices of First Nations, Inuit and Métis peoples.
* Describe examples of ways to respectfully engage with, and contribute to, First Nations, Inuit and Métis communities as a prospective care provider.
* Demonstrate authentic, supportive and inclusive behavior in all exchanges with First Nations, Inuit and Métis individuals, health care workers and communities.
* Additional entries (as needed)
 |  |  |
|  | **Post-colonial Understanding:** * Describe the connection between historical and current government practices toward First Nations, Inuit and Métis peoples.
* Describe the resulting intergenerational health outcomes, and determinants of health that impact First Nations, Inuit and Métis clients, families and communities.
* Outline the concept of inequity of access to health care/health information for First Nations, Inuit and Métis peoples and the factors that contribute to it.
* Identify ways of readdressing inequity of access to health care/health information with First Nations, Inuit and Métis clients, families and communities.
* Articulate how the emotional, physical, social and spiritual determinants of health and well-being for First Nations, Inuit and Métis peoples impact their health.
* Additional entries (as needed)
 |  |  |
|  | **Respect:*** Understand that unique histories, cultures, languages, and social circumstances are manifested in the diversity of First Nations, Inuit and Métis peoples.
* Understand that First Nations, Inuit and Métis peoples will not access a health care system when they do not feel safe doing so and where encountering the health care system places them at risk for cultural harm.
* Identify key principles in developing collaborative and ethical relationships.
* Describe types of Indigenous healers/traditional medicine people and health professionals working in local First Nations, Inuit and/or Métis communities.
* Demonstrate how to appropriately enquire whether First Nations, Inuit or Métis clients are taking traditional herbs or medicines to treat their ailment and how to integrate that knowledge into their care.
* Additional entries (as needed)
 |  |  |
|  | **Indigenous Knowledge:*** Demonstrate ways to acknowledge and value Indigenous knowledge with respect to the health and wellness of First Nations, Inuit and Métis clients, families and communities.
* Recognize the diversity, as a care provider, of Indigenous health knowledge and practices among First Nations, Inuit and/or Métis clients, families or communities.
* Identify and describe the range of healing and wellness practices, traditional and non‐traditional, present in local First Nations, Inuit and Métis communities.
* Additional entries (as needed)
 |  |  |
|  | **Communication:*** Identify the centrality of communication in the provision of culturally safe care, and engage in culturally safe communication with First Nations, Inuit and Métis clients, families and communities.
* Demonstrate the ability to establish a positive therapeutic relationship with First Nations, Inuit and Métis clients and their families, characterized by understanding, trust, respect, honesty and empathy.
* Identify specific populations that will likely require the support of trained interpreters, and demonstrate the ability to use these services when providing care to individuals, families and communities.
* Additional entries (as needed)
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| Teaching Learning Resource: Weighty Blankets | Optional Activity **Affective Domain:** Receive/Respond/Value |
| **Course:** Professional Practice II | **Duration:** Single session **Preparation:** High |
| **Indigenous Competencies**: Respect, Communication, Mentoring and Support |
| **Purpose:*** To make visible the effects of residential schools on First Nations, Inuit and Métis people.
 |
| **Process:****In Preparation:**1. Learners to visit the website *Where Are the Children? Healing the Legacy of Residential Scho*ols: <http://www.wherearethechildren.ca/en/exhibit/stories.html>. In particular, listen to the shared stories of peoples who were in residential schools Provide at least two or three days’ notice to ensure ample time for students to work through exhibits and stories.
2. Teachers to bring in beach towels or blankets (five to 10) and a plant or small tree in a pot.
3. Arrange room so that there is a large open space for learners to form a circle.

**In Class:**1. Learners to individually write down on Post‐it Notes the feelings that were associated with people of residential schools (one Post‐it Note per feeling).
2. Invite learners to place their Post‐it Notes on the white board and group similar feelings together.
3. Taking the groupings with the largest numbers of notes, and label towel or blanket with associated feelings (e.g., shame, anger)
4. Bring in a plant or small tree in a pot (note that plant or tree may be damaged in process). The plant or small tree represents individuals who were in residential schools.
5. Have learners talk about feelings that they put on Post‐it Notes and place associated towel or blanket on top of the plant or tree.
6. Keep on layering the towels and blankets on the plant or tree until all finished.
7. Have one minute of silent reflection time.
8. Now, invite learners to remove one layer of blanket or towel at a time, stating the gifts that the learners/future health providers have to offer (e.g., listening, partnerships) until all have been removed.
9. Debrief the exercise. (Be sure to leave plenty of time for discussion.)
 |
| **Sample Debrief Questions:**1. What just happened?
2. What happened to the plant or tree?
3. If the plant or tree were to signify life, what did the blankets or towels do? What did you take away from this activity?
4. How will you make a difference?
 |
| **References:**Brookfield, S. & Preskill, S. (2005). *Discussion as a Way of Teaching: Tools and Techniques for Democratic Classrooms* (2nd ed.). San Francisco: Jossey‐Bass.Legacy of Hope Foundation. (2009). *Where Are the Children? Healing the Legacy of the Residential Schools*. <http://www.wherearethechildren.ca>Stout, M., & Downey, B. (2006). Nursing, Indigenous Peoples and Cultural Safety: So What? Now What? *Contemporary Nurse, 22*(2), 327‐332. |

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| Teaching Learning Resource: Learning Rubric 3: Fostering Partnerships in Care | Recommended Activity **Cognitive:** Understanding/Applying |
| **Course:** Professional Practice III | **Duration:** Spiral set 3 of 4 **Preparation:** Moderate |
| **Indigenous Competencies:** Inclusivity, Communication, Post‐Colonial Understanding, Mentoring and Support |
| **Purpose:*** To help learners with progress of own learning needs for Indigenous competencies.
* To help learners with ongoing self‐assessment and reflection to enhance Indigenous learning and culturally safe nursing practice.
* To help learners in understanding their own professional responsibility in creating effective health care partnerships with Indigenous peoples through recognition of Indigenous epistemology and respect for traditional knowledge in healing.
 |
| **Process:****In Preparation:**1. Learners to visit the following online interactive module on cultural safety: *Module 3: Peoples’ Experiences of Colonization in Health Care*. <http://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm>. Please provide ample time for learners to work through the module.
	1. Read the Introduction, including purposes of modules.
	2. Visit the Concepts: Supporting Inclusive Healing Process section.
	3. Attend to Self‐Care Suggestions as needed.

**In Class:**1. Listen to the “Father in Hospital” clip as Roger John describes how flexibility in the hospital helped his family (in Concepts: Supporting Inclusive Healing Process section).
2. Discuss ways that learners can incorporate Indigenous ways of knowing and being into care plans.
3. Identify how partnering with Indigenous and traditional knowledge will create culturally safe, person‐centred care plans.
4. Have learners consider the following questions in their decision-making process (questions adapted from *Cultural Competency and Cultural Safety Curriculum for Aboriginal Peoples*, p. 21).
	* Did I involve the client in planning his or her care?
	* Did the plan address my client’s needs and expectations? How would I know this?
	* What ways of knowing did I use in planning the care with my client?
	* Was my nursing care effective for the client?
	* What evidence‐informed practice did I use? How did I know it was relevant to the care needed by the client?
5. Invite learners to journal using the following stems. Learners are requested to revisit/revise entries each term of the PN program.
* I believe the ultimate purpose of cultural competence and cultural safety in nursing education is…
* I believe this purpose can be achieved by…
* I believe my role is…
* I believe the factors that inhibit or enable this purpose to be achieved include…
* Other values and beliefs that I hold about providing culturally safe care with First Nations, Inuit and Métis clients, families and communities are…
 |
| **Take home:** 1. Have learners individually review the rubric and conduct an authentic self‐assessment, making visible their evidence of learning. There are no wrong answers.

**Variations:**1. Learners hand in rubric upon completion.
2. Learners place evidence and artifacts of competencies in professional portfolio.
 |
| **References:**Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing and Canadian Nurses Association (2010). *Cultural Competency and Cultural Safety Curriculum for Aboriginal Peoples*. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/first_nations_framework_e.pdf?la=en>Canadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing*. Ottawa: Author. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf?la=en>College of Licensed Practical Nurses of British Columbia (CLPNBC). (2014). *Professional Standards for Licensed Practical Nurses*. Burnaby: Author. <https://clpnbc.org/Documents/Practice-Support-Documents/Professional-Standards-of-Practice-for-Licensed-Pr.aspx>Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006*). Cultural Safety: Module 3: Peoples’ Experiences of Colonization In relation to Health Care.*<http://web2.uvcs.uvic.ca/courses/csafety/mod3/notes3.htm>Fluckiger, J. (2010). Single Point Rubric: A Tool for Responsible Student Self‐Assessment. *Delta Kappa Gamma Bulletin, 76*(4), 18‐25.McCormack, B., Manley, K., & Robert, G. (2004). *Practice Development in Nursing*. United Kingdom: Blackwell Publishing. |

**Learning Rubric 3: Fostering Partnerships in Care**

| **How I will****revise to****better meet****competency** | **Culturally Safe** | **How I know I****have met the****competency** | **How I went****beyond the****competency** |
| --- | --- | --- | --- |
|  | **Inclusivity:*** Identify, acknowledge and analyze one’s considered emotional response to the many histories and contemporary environment of First Nations, Inuit and Métis peoples and offer opinions respectfully.
* Acknowledge and analyze the limitations of one’s knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding the health and health practices of First Nations, Inuit and Métis peoples.
* Describe examples of ways to respectfully engage with, and contribute to First Nations, Inuit and Métis communities as a prospective care provider.
* Demonstrate authentic, supportive and inclusive behavior in all exchanges with First Nations, Inuit and Métis individuals, health care workers and communities.
* Additional entries (as needed)
 |  |  |
|  | **Post-colonial Understanding:** * Describe the connection between historical and current government practices toward First Nations, Inuit and Métis peoples.
* Describe the resulting intergenerational health outcomes, and determinants of health that impact First Nations, Inuit and Métis clients, families and communities.
* Outline the concept of inequity of access to health care/health information for First Nations, Inuit and Métis peoples and the factors that contribute to it.
* Identify ways of readdressing inequity of access to health care/health information with First Nations, Inuit and Métis clients, families and communities.
* Articulate how the emotional, physical, social and spiritual determinants of health and well-being for First Nations, Inuit and Métis peoples impact their health.
* Additional entries (as needed)
 |  |  |
|  | **Respect*** Understand that unique histories, cultures, languages, and social circumstances are manifested in the diversity of First Nations, Inuit and Métis peoples.
* Understand that First Nations, Inuit and Métis peoples will not access a health care system when they do not feel safe doing so and where encountering the health care system places them at risk for cultural harm.
* Identify key principles in developing collaborative and ethical relationships.
* Describe types of Indigenous healers/traditional medicine people and health professionals working in local First Nations, Inuit and/or Métis communities.
* Demonstrate how to appropriately enquire whether First Nations, Inuit or Métis clients are taking traditional herbs or medicines to treat their ailments and how to integrate that knowledge into their care.
* Additional entries (as needed)
 |  |  |
|  | **Indigenous Knowledge:*** Demonstrate ways to acknowledge and value Indigenous knowledge with respect to the health and wellness of First Nations, Inuit and Métis clients, families and communities.
* Recognize the diversity, as a care provider, of Indigenous health knowledge and practices among First Nations, Inuit and/or Métis clients, families or communities.
* Identify and describe the range of healing and wellness practices, traditional and non‐traditional, present in local First Nations, Inuit and Métis communities.
* Additional entries (as needed)
 |  |  |
|  | **Communication:*** Identify the centrality of communication in the provision of culturally safe care, and engage in culturally safe communication with First Nations, Inuit and Métis clients, families and communities.
* Demonstrate the ability to establish a positive therapeutic relationship with First Nations, Inuit and Métis clients and their families, characterized by understanding, trust, respect, honesty and empathy.
* Identify specific populations that will likely require the support of trained interpreters, and demonstrate the ability to use these services when providing care to individuals, families and communities.
* Additional entries (as needed)
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| Teaching Learning Resource: Learning Rubric 4: Supporting Diversity | Recommended Activity **Cognitive:** Understanding/Applying/Analyzing |
| **Course:** Professional Practice IV | **Duration:** Spiral set 4 of 4 **Preparation**: Moderate |
| **Indigenous Competencies:** Inclusivity, Communication, Respect, Mentoring and Support |
| **Purpose:*** To help learners develop inquiry as a process for learning.
* To help learners with ongoing self‐assessment and reflection to enhance Indigenous learning and culturally safe nursing practice.
* To help learners examine ethical considerations in honouring diversity in their professional practice.
 |
| **Process:****In preparation:**1. Learners to access and read through the section of “Concepts – Professional and Personal Responsibility to Build Strength and Capacity. Small is Beautiful: What You Can Do.”*Cultural Safety: Module 3: Peoples’ Experiences of Colonization in Relation to Health Care*. <http://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm>. (Activity 4 – “Cultural Safety: A way forward?” will be done in Professional Communication IV class.)
2. Learners to conduct a literature search of at least two journal articles using the search terms “trans‐cultural nursing” and “ethics” or “social justice.”
3. Prepare a post using the information from the two articles and module. The posts may be done online (if available or alternatively, done as an in class activity).

**Online or in class:**1. At a minimum, learners are to:
	1. Post ONE entry online or in class.
	2. Respond to at least THREE posts online or in class.

Discuss potential misalignment of culturally safe nursing care and institutional policies, procedures and practices. What are some alternatives? 1. Invite learners to journal using the following stems. Learners are requested to revisit/revise entries each term of the PN program.
* I believe the ultimate purpose of cultural competence and cultural safety in nursing education is…
* I believe this purpose can be achieved by…
* I believe my role is…
* I believe the factors that inhibit or enable this purpose to be achieved include…
* Other values/beliefs that I hold about providing culturally safe care with First Nations, Inuit and Métis clients, families and communities are…
 |
| **Take home:**1. Have learners individually review the rubric and conduct an authentic self‐assessment, making visible their evidence of learning. There are no wrong answers.

**Variations**:1. Learners hand in rubric upon completion.
2. Learners place evidence and artefacts of competencies in professional portfolio.
 |
| **References:** Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing and Canadian Nurses Association. (2010). *Cultural Competency and Cultural Safety Curriculum for Aboriginal Peoples.* <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/first_nations_framework_e.pdf?la=en>Bishop, A. (2003). *Becoming an Ally: Breaking the Cycle of Oppression in People* (2nd ed.).Halifax: Fernwood Publishing. Accessed June 23, 2011 from <http://www.becominganally.ca/index.htm>Canadian Nurses Association. (2011). *Position Statement: Promoting Cultural Competence in Nursing.* Ottawa: Author. <https://www.canadian-nurse.com/sitecore%20modules/web/~/media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf?la=en>Dick, S., Duncan, S., Gillie, J., Mahara, S., Morris, J., Smye, V., & Voyageur, E. (2006). *Cultural Safety: Module 3: Peoples’ Experiences of Colonization in Relation to Health Care*. Retrieved from <http://web2.uvcs.uvic.ca/courses/csafety/mod3/notes3.htm>Fluckiger, J. (2010). Single Point Rubric: A Tool for Responsible Student Self‐Assessment. *Delta Kappa Gamma Bulletin, 76*(4), 18‐25.McCormack, B., Manley, K., & Robert, G. (2004). *Practice Development in Nursing*. United Kingdom: Blackwell Publishing. |

**Learning Rubric 4: Supporting Diversity**

| **How I will****revise to****better meet****competency** | **Culturally Safe** | **How I know I****have met the****competency** | **How I went****beyond the****competency** |
| --- | --- | --- | --- |
|  | **Inclusivity:*** Identify, acknowledge and analyze one’s considered emotional response to the many histories and contemporary environment of First Nations, Inuit and Métis peoples and offer opinions respectfully.
* Acknowledge and analyze the limitations of one’s knowledge and perspectives, and incorporate new ways of seeing, valuing and understanding the health and health practices of First Nations, Inuit and Métis peoples.
* Describe examples of ways to respectfully engage with, and contribute to First Nations, Inuit and Métis communities as a prospective care provider.
* Demonstrate authentic, supportive and inclusive behavior in all exchanges with First Nations, Inuit and Métis individuals, health care workers and communities.
* Additional entries (as needed)
 |  |  |
|  | **Post-colonial Understanding:** * Describe the connection between historical and current government practices toward First Nations, Inuit and Métis peoples.
* Describe the resultant intergenerational health outcomes, and determinants of health that impact First Nations, Inuit and Métis clients, families, and communities.
* Outline the concept of inequity of access to health care/health information for First Nations, Inuit and Métis peoples and the factors that contribute to it.
* Identify ways of readdressing inequity of access to health care/health information with First Nations, Inuit and Métis clients, families, and communities.
* Articulate how the emotional, physical, social and spiritual determinants of health and well-being for First Nations, Inuit and Métis peoples impact their health.
* Additional entries (as needed)
 |  |  |
|  | **Respect*** Understand that unique histories, cultures, languages and social circumstances are manifested in the diversity of First Nations, Inuit and Métis peoples.
* Understand that First Nations, Inuit and Métis peoples will not access a health care system when they do not feel safe doing so and where encountering the health care system places them at risk for cultural harm.
* Identify key principles in developing collaborative and ethical relationships.
* Describe types of Indigenous healers/traditional medicine people and health professionals working in local First Nations, Inuit and/or Métis communities.
* Demonstrate how to appropriately enquire whether First Nations, Inuit or Métis clients are taking traditional herbs or medicines to treat their ailments and how to integrate that knowledge into their care.
* Additional entries (as needed)
 |  |  |
|  | **Indigenous Knowledge:*** Demonstrate ways to acknowledge and value Indigenous knowledge with respect to the health and wellness of First Nations, Inuit and Métis clients, families and communities.
* Recognize the diversity, as a care provider, of Indigenous health knowledge and practices among First Nations, Inuit and/or Métis clients, families or communities.
* Identify and describe the range of healing and wellness practices, traditional and non‐traditional, present in local First Nations, Inuit and Métis communities.
* Additional entries (as needed)
 |  |  |
|  | **Communication:*** Identify the centrality of communication in the provision of culturally safe care, and engage in culturally safe communication with First Nations, Inuit and Métis clients, families and communities.
* Demonstrate the ability to establish a positive therapeutic relationship with First Nations, Inuit and Métis clients and their families, characterized by understanding, trust, respect, honesty and empathy.
* Identify specific populations that will likely require the support of trained interpreters, and demonstrate the ability to use these services when providing care to individuals, families and communities.
* Additional entries (as needed)
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| Teaching Learning Resource: Approaching Traditional Knowledge | Recommended Activity **Cognitive Domain:** Understanding |
| **Course:** Variations in Health I | **Duration:** Single session **Preparation**: Low |
| **Indigenous Competencies:** Respect, Indigenous Knowledge |
| **Purpose:*** To help learners value the importance and protocols of Elders in sharing traditional knowledge and wisdom.
* To help learners explore traditional knowledge and holistic health approaches of Indigenous peoples.
 |
| **Process:****In Preparation:**1. Learners access and read:

*Approaching a Traditional Healer, Elder or Medicine Person* [http://www.aht.ca/images/stories/TEACHINGS/ApproachingElderHealer.pdf](file:///C%3A%5CUsers%5CRuth%5COneDrive%5CBackup%20of%20Feb-2_DRAFT%20PN%20SUPPLEMENT%20with%20DS%20and%20MG%20review_RW%20EDIT.wbk)1. Learners watch YouTube videos:
* *For the Next 7 Generations: The Grandmothers Speak:* <http://youtu.be/GKGXpK8LXR4>
* *Happy Mother’s Day from the 13 Grandmothers of the World:* [http://youtu.be/Vpp7ZU‐Qgnc](http://youtu.be/Vpp7ZU%E2%80%90Qgnc)

**In Class:**1. Invite Elders to provide perspectives and teachings. Demonstrate and explain the protocols of welcoming Elders into the learning community. (In the References below, see podcasts of Elder Ellen White [Kwalasulwat] and Elder Geraldine Manson [Tstassiacan] in *Voices of the Snuneymuxw First Nation*.)
2. Discuss with learners the role of Elders in sharing of traditional knowledge and wisdom. (See Importance of Elders Overview resource below.)
3. Explore the role of Elders in promoting holistic health within the biomedical health beliefs model.
4. Watch the film *Spirit Doctors* (40 minutes), summarized here:

***Spirit Doctors***Mary and Ed Louie are committed to practices that keep them accountable to the spirit world, their people and Mother Earth. During the filming of this unique documentary, the sound recordist is diagnosed with throat cancer. He chooses to be treated with modern medicine, but he also looks to Mary and Ed for help. The couple decide to allow Don’s doctoring to be recorded in order to teach others. Filmed in the lush interior of British Columbia and the city of Vancouver.1. Learners work in small groups, using the concept map below (or alternative), indicate the potential augmentations as well as the tensions of the biomedical and holistic health beliefs models.
2. Where is the learners’ current health beliefs model situated in the diagram? Ask learners to draw a stick figure indicating their current position. Where do they see Indigenous clients, families and communities situated? What needs to happen in order for learners to provide holistic, person‐centred care?
 |
| HEALTH BELIEFSBIOMEDICALHOLISTIC |
| **References:**Anishnawbe Health Toronto. (n.d.) *Approaching a Traditional Healer, Elder or Medicine Person*. http://aht.ca/approaching‐a‐traditional‐healer‐elder‐or‐medicine‐personBurke, M. (Director), & Thompson, B. (Producer). (2005). *Spirit Doctors* [Video]. National Film Board of Canada. <https://www.nfb.ca/film/spirit_doctors/>Kaminski, J. & Currie, S. (2009). Importance of Elders Overview. *First Nations Pedagogy Online.* <http://firstnationspedagogy.ca/elders.html>National Aboriginal Health Organization. (2005)*. Sacred Ways of Life: Traditional Knowledge.* Ottawa: Author.*Voices of the Snuneymuxw First Nation.* (2007). <http://www.snuneymuxwvoices.ca/english/podcasts.asp> |

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| Teaching Learning Resource: Meaning of Health | Optional Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Variations in Health I | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Indigenous Knowledge |
| **Purpose:*** To assist learners in understanding the complexity of cultural approaches in supporting health for Indigenous peoples.
 |
| **Process:****In Preparation:**1. Invite learners to bring in an object from home that represents their understanding of what health is (e.g,. a flower with each petal representing a different aspect of health).
2. Learners to read information on culture and ethnicity in their fundamental nursing texts.

**In Class:**1. Learners in groups of four or five explain to other group members about their object and meaning behind it.
2. Ask learners to notice similarities and differences in what each person’s meaning of health is.
3. Invite learners to imagine if they were from a different culture how their meaning of health would vary? Why?
4. Access the case study “Does Betty Two‐Trees Need an Advocate?” in Kozier et al. (p. 244) OR the video *Lost Songs* (24 minutes) from the National Film Board of Canada.
5. Invite learners to reflect on the following questions and open up discussion with large class.
 |
| **Sample Questions:**1. What is your understanding of the situation?
2. What values do Indigenous cultures associate with health and being healthy? Why is it important to consider Indigenous perspectives on health care?
3. How do Indigenous peoples perceive Canada’s health care system?
4. Indigenous peoples’ understanding of health and well‐being emphasize the “interconnectedness between the individual and their environment and between the mind, body, and spirit” (Hales & Lauzon, 2010, p. 4). What are the challenges of holistic health in the mainstream health care system?
5. To strive for person‐centred and relationship‐centred care, what needs to happen?
 |
| **Resources:**Alberta, C. (Director). Moyah, E., & Krepakevich, J. (Producers). (1999). *Lost Songs* [DVD].National Film Board of Canada. <http://www2.nfb.ca/boutique/XXNFBibeCCtpItmDspRte.jsp?formatid=33408&lr_ecode=collection&minisite=10000&respid=22372>Hales, D., & Lauzon, L. (2010). *An Invitation to Health* (2nd Cdn. ed.). Toronto: Nelson Education.Kozier, B., Erb, G., Berman, A., Burke, K., Bouchal, D., & Hirst, S. (2000). *Fundamentals of Nursing: The nature of nursing practice in Canada* (Canadian ed.). Toronto: Prentice Hall. |

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| Teaching Learning Resource: End­of­Life Care | Optional Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Variations in Health II | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Indigenous Knowledge |
| **Purpose:*** To assist learners in recognizing cultural perspectives to end‐of‐life care for Indigenous peoples.
 |
| **Process:****In Preparation:**1. Learners to read the following online module:Longboat, D. (2002*). Ian Anderson Program in End‐of‐Life Care: Module 10: Indigenous Perspectives on Death and Dying.* University of Toronto. <http://www.cpd.utoronto.ca/endoflife/Modules/Indigenous%20Perspectives%20on%20Death%20and%20Dying.pdf>

**In Class:**1. Learners working in small groups of five or six role-play the scenario described in the module (physician, nurse, Mrs. Nahdee, daughter and observers).
2. Select and adapt from list of questions accompanying the module in a class discussion.
3. Learners to reflect on their experience in their journal using the following prompts (below).
 |
| **Sample Reflection Prompts:**1. How will you partner with your interprofessional team members to provide culturally safe care to your end‐of‐life client, families and communities?
2. What knowledge and/or gaps exist within your team? How will you share your resources?
3. Identify nursing practices in end‐of‐life care that may require adaptation to be culturally sensitive.
4. How might culturally diverse client and family members express suffering, grief, anger and loss? How will you respond?
5. How will you evaluate the effectiveness of your end‐of‐life care when working with Indigenous clients, families and communities?
 |
| **References:**Canadian Hospice Palliative Care Association. (2008). *Aboriginal Resource Commons.* <http://www.chpca.net/resource-commons/aboriginal-resource-commons.aspx>Canadian Virtual Hospice. (2003‐2010). *Tools for practice – Aboriginal.* [http://www.virtualhospice.ca/en\_US/Main+Site+Navigation/Home/For+Professionals/For+Professionals/Tools+for+Practice/Aboriginal.aspx#id\_f42be229a54a25eb5725c552d22fbb91](http://www.virtualhospice.ca/en_US/Main%2BSite%2BNavigation/Home/For%2BProfessionals/For%2BProfessionals/Tools%2Bfor%2BPractice/Aboriginal.aspx#id_f42be229a54a25eb5725c552d22fbb91)Longboat, D. (2002). *Ian Anderson Program in End‐of‐Life Care: Module 10: Indigenous perspectives on death and dying and dying*. University of Toronto. <http://www.cpd.utoronto.ca/endoflife/Modules/Indigenous%20Perspectives%20on%20Death%20and%20Dying.pdf> |

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| Teaching Learning Resource: Supporting Traditional Knowledge to Promote Health and Healing | Recommended Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Variations in Health III | **Duration:** Multiple sessions (may be adapted as an assignment)**Preparation:** High |
| **Indigenous Competencies:** Respect, Indigenous Knowledge |
| **Purpose:*** To help learners appreciate the value of traditional knowledge in promoting health and healing of Indigenous peoples.
 |
| **Process:****In Preparation (class one):**1. Learners to read the following,
	1. Struthers, R., Eschiti, V., & Patchell, B. (2004). Traditional Indigenous Healing: Part I. *Complementary Therapies in Nursing & Midwifery*, 10, 141–149.
2. Working in small groups, assign or have learners select one of the following traditional knowledge topics to conduct inquiry on. List of topics to include but not be limited to:
	* + Tobacco.
		+ Sage.
		+ Cedar.
		+ Sweet grass.
		+ Sweats.
		+ Sacred items and bundles.
		+ Feast and giveaways.
		+ Fasting.
		+ Traditional healing.
		+ Care of body after death and dying (spiritual needs).
		+ Traditional foods, toiletries and constitution.
		+ Body parts/tissues/substances (e.g., placenta after birth).
		+ Healing songs/prayers.
		+ Smudging ceremonies.
3. Encourage learners to attend community/institutional events such as Indigenous Days, soup and bannock lunches, Indigenous education workshops, Indigenous community centers, Friendship Centres, etc. to gather teachings (provide class/practice time for visits). Remind students of Indigenous protocol during visits and seek permission/approval from local authorities.
4. Learners to prepare a gathering to share their inquiry to address the following:
	* + Description of healing modality/practice.
		+ Purpose or effects on health and healing.
		+ Role of nurse in supporting modality/practice.
		+ Further inquiry or questions for investigation.
		+ References/resources.
5. Have learners create an invitation to the gathering and send out to community event organizers (where they visited), student bodies, nurses, students’ families, etc.

**Gathering (class two):*** 1. Create space for gathering and presentations.
	2. Invite Elders to participate and to provide lived experiences.
	3. During the gathering, invite learners to practice appropriate protocol and collect health and healing stories from visitors.

**Debrief (class three):**1. Encourage learners to provide feedback on process as well as lessons learned (see below).
 |
| **Lessons Learned:*** What did you learn?
* What suggestions do you have?
* What should we (nurses) be paying attention to?
 |
| **References:**Anishnawbe Health Toronto. (n.d.). *Traditional Teachings Brochures.* <http://aht.ca/circle-of-life/teachings>National Aboriginal Health Organization. (2008). *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators*. Retrieved from <http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf>Struthers, R., Eschiti, V., & Patchell, B. (2004). Traditional Indigenous healing: Part I. *Complementary Therapies in Nursing & Midwifery, 10,* 141‐149.  |

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| Teaching Learning Resource: Mental Health | Optional Activity **Cognitive Domain:** Understanding |
| **Course:** Variations in Health III | **Duration:** Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Inclusivity, Indigenous Knowledge |
| **Purpose:*** To help learners explore and adapting principles that are considered effective and appropriate for mental health workers who work with Indigenous clients and families.
 |
| **Process:****In Preparation:*** + 1. Learners to read the following:Postl, B. (1997). It’s time for action. *Canadian Medical Association Journal, 157*(2), 1655‐1656.
1. Learners to access and read through the section of “Concepts – Focus on Mental Health.” *Cultural Safety: Module 3: Peoples’ Experiences of Colonization in Relation to Health Care*. <http://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm>
2. Invite learners to visit various websites associated with Indigenous mental health.

**In Class:**1. Share with learners the study by Mehl‐Madrona (2009) revealing 12 common points as guideposts for mental health workers who wish to work with Indigenous peoples (see below).
2. Invite Elder to discuss the importance of holistic approach to mental health interventions for Indigenous peoples.
3. Working in groups, learners to create a concept map of their role in mental health support of Indigenous peoples to include the Mehl‐Madrona’s (2009) 12 common points and implications for nursing care (listed below).
 |
| Discussions with traditional healing Elders from the United States and Canada raised the following 12 common points that were unanimously accepted as guideposts for training mental health workers who wish to work with Indigenous people:1. Teach students the importance of listening.
2. Teach students a relational model of the self.
3. Solutions must be internally derived.
4. People are spontaneously self‐healing.
5. The healer should be selfless of intent.
6. Healers need to be passionate about their work.
7. Healers have to maintain some independence from political structures.
8. Teach students the importance of faith, hope and the power of the activated mind.
9. Empowerment is different from treatment.
10. Teach students the importance of community.
11. Only Creator can give prognoses.
12. All healing is ultimately spiritual healing.

Source: Mehl‐Madrona, L. (2009). |
| **References:**Health Canada. (2017). *First Nations and Inuit Health Mental Health and Wellness.* <https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/health-promotion/mental-health-wellness.html>Mehl‐Madrona, L. (2009). What Traditional Indigenous Elders Say about Cross‐Cultural Mental Health Training. *EXPLORE: The Journal of Science and Healing, 5*(1), 20‐29.Mussell, B., Cardiff, K., & White, J. (2004). *The Mental Health and Well‐Being of Aboriginal Children and Youth: Guidance for New Approaches and Services*. The Sal'i'shan Institute and The University of British Columbia. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.455.9214&rep=rep1&type=pdf> Postl, B. (1997). It’s Time for Action. *Canadian Medical Association Journal*, *157*(2), 1655–1656.Smye, V., & Mussell, B. (2001). *Aboriginal Mental health: ‘What Works Best.’* University of British Columbia: Mental Health Evaluation & Community Consultation Unit. <https://www.sfu.ca/carmha/publications/aboriginal-mental-health-what-works-best.html> |

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| Teaching Learning Resource: Pain Management | Optional Activity **Cognitive Domain:** Understanding/Applying |
| **Course:** Variations in Health IV | **Duration**: Single session **Preparation:** Moderate |
| **Indigenous Competencies:** Respect, Indigenous Knowledge |
| **Purpose:*** To help learners recognize the effects of culture on pain perception, responses and management.
 |
| **Process:****In Preparation:**1. Learners to read the following:
* D’Arcy, Y. (2009). The Effect of Culture on Pain. *Nursing Made Incredibly Easy! 7*(3), 5‐7. doi: 10.1097/01.NME.0000350931.12036.c7
* Latimer, M., et al. (2014). Understanding the Impact of the Pain Experience on Aboriginal Children’s Wellbeing: Viewing through a Two-Eyed Seeing Lens. *First Nations Child and Family Review, 9*(1), 22–37. <http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/viewFile/183/216>

**In Class:**1. Think‐pair‐share: Learners individually respond to questions (see below). Pair learners to share responses. Then, two pairs of learners get together to form a group of four.
2. Learners present findings to other groups in class.
 |
| **Sample Questions:**1. Describe the different natures of pain (physical, emotional, etc). Describe the relationship between ethnic background and pain. Discuss ethnic differences in pain perception and pain responses.
2. Explain how a nurse’s own culture, personal bias, values and beliefs may alter the interpretation of patients’ pain experience.
3. What might some variations be in assessment of pain when caring for First Nations, Inuit and Métis peoples? What are the verbal cues? What are the non‐verbal cues?
4. Which pain assessment tool would you use? Why?
5. What might some variations of nursing interventions be in management of pain when caring for First Nations, Inuit and Métis peoples? Pharmaceutical? Traditional? Alternative? Interprofessional?
 |
| **References:**D’Arcy, Y. (2009). The Effect of Culture on Pain. *Nursing Made Incredibly Easy! 7*(3), 5‐7. doi: 10.1097/01.NME.0000350931.12036.c7Kelly, L. (2007). End‐of‐Life Issues for Aboriginal Patients: A Literature Review. *Canadian Family Physician, 53*(9), 1459‐1465.Latimer, M., et al. (2014). Understanding the Impact of the Pain Experience on Aboriginal Children’s Wellbeing: Viewing through a Two-Eyed Seeing Lens. *First Nations Child and Family Review, 9*(1), 22–37. <http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/viewFile/183/216> |

WorkSafeBC Resources

* Be Sure...Be Safe: Safety in the Health Care Workplace (Discussion Guide) <https://www.worksafebc.com/en/resources/health-safety/books-guides/be-sure-be-safe>
* Controlling Exposure: Protecting Workers from Infectious Diseases <https://www.worksafebc.com/en/resources/health-safety/books-guides/controlling-exposure-protecting-workers-from-infectious-disease>
* Dementia: Understanding Risks and Preventing Violence <https://www.worksafebc.com/en/resources/health-safety/books-guides/dementia-understanding-risks-and-preventing-violence>
* Handle with Care: Patient Handling and the Application of Ergonomics (MSI) Requirements <https://www.worksafebc.com/en/resources/health-safety/books-guides/handle-with-care-patient-handling-application-ergonomics-musculoskeletal-msi-requirements>
* Identifying Risk Factors of Falls among BC’s Health Care Workers <https://www.worksafebc.com/en/resources/about-us/research/identifying-risk-factors-for-falls-among-bcs-health-care-workers>
* Patient Handling: Reducing the Risks [https://www.worksafebc.com/en/resources/health-safety/hazard-alerts/patient-handling-reducing-the-risks](https://www.worksafebc.com/en/resources/health-safety/hazard-alerts/patient-handling-reducing-the-risks?lang=en&origin=s&returnurl=https%3A%2F%2Fwww.worksafebc.com%2Fen%2Fsearch%23q%3DHigh%2520risk%2520manual%2520handling%2520of%2520patients%2520in%2520health%2520care%2520%26sort%3Drelevancy%26f%3Alanguage-facet%3D%5BEnglish%5D)
* Patient Handling in Small Facilities: A Companion Guide to Handle with Care <https://www.worksafebc.com/en/resources/health-safety/books-guides/patient-handling-in-small-facilities-a-companion-guide-to-handle-with-care>
* Preventing Violence in Health Care: Five Steps to an Effective Program <https://www.worksafebc.com/en/resources/health-safety/books-guides/preventing-violence-in-health-care-five-steps-to-an-effective-program>
* Working with Dementia: Safe Practices for Caregivers Video Discussion Guide <https://www.worksafebc.com/en/resources/health-safety/books-guides/working-with-dementia-safe-work-practices-for-caregivers>

COMPETENCY MAP

The PPNP Competency Map connects the required entry-level competencies of Practical Nurse graduates to the courses in which learning occurs as part of the educational process. The Competency Map integrates the Entry-to-Practice Competencies for Licensed Practical Nurses (CCPNR, 2013), the Canadian Practical Nurse Registration Examination Blueprint 2017–2021 (CPNRE, 2017), A National Interprofessional Competency Framework (CIHC, 2010), Professional Standards for Licensed Practical Nurses (CLPNBC, 2014), Practice Standards (CLPNBC, various years), CLPNBC Scope of Practice: Standards, Limits and Conditions (CLPNBC, 2016), competencies required by WorkSafe BC, the Cultural Competence and Cultural Safety in Nursing Education (ANAC-CASN-CNA, 2009) the Truth and Reconciliation Commission: Calls to Action (TRC, 2015) and Cultural Safety and Cultural Humility Key Drivers and Ideas for Change (FNHA, 2016).

The Competency Map assumes that particular competencies will be continued throughout multiple courses reflecting a spiral curriculum. Learner knowledge gained through theory courses is expected to be applied in both a simulated setting in the Integrated Nursing Practice courses and then further consolidated in the Consolidated Practice Experience.

**CONTEXT OF CHANGES**

The Competency Map in the original edition of the Practical Nursing Curriculum Guide was developed based on the Nurses (Licensed Practical) Regulation of the day. Under that act, LPNs had NO autonomous practice; they were required to practise under the direction of a medical practitioner or a nurse practitioner, or under the supervision of a registered nurse attending the patient. LPNs could provide any nursing services consistent with his or her training and education, based on:

* CLPNBC’s Baseline Competencies document of the day.
* The CPNRE Blueprint of the day.
* The CIHC Interprofessional Competencies Framework of the day.
* The ANAC-CASN-CNA Cultural Competence & Safety Competencies of the day.

Since then, a new regulation has come into force. Today, the Nurses (Licensed Practical) Regulation (2015):

* Authorizes autonomous LPN practice.
* Authorizes nine health professionals to issue orders that LPNs can carry out.
* Authorizes that health professionals licensed to practice in BC, Alberta, Yukon and Northwest Territories can issue orders to BC LPNs.
* Authorizes specific restricted activities that LPNs can carry out without and with an order/
* No longer addresses the concepts of direction and supervision.
* Authorizes CLPNBC to establish standards, limits and conditions for LPN practice of both restricted and non-restricted activities.

CLPNBC no longer has a Baseline Competencies document. Instead there exists a CLPNBC Standards of Practice Framework to guide LPN practice in BC. The Practice Framework covers:

* Professional Standards.
* Practice Standards.
* Scope Standards.

As well:

* The CPNRE Blueprint was updated.
* The Entry-to-Practice Competencies for LPNs document was developed by CCPNR.
* The CIHC Interprofessional Competencies Framework was updated.
* The ANAC-CASN-CNA Cultural Competence and Safety Competencies were updated.
* The Truth and Reconciliation Commission’s Calls to Action was developed.
* The FNHA Cultural Safety and Humility Competencies were developed.

All of these documents have been applied to guide the development of this new Competency Map.

| **GUIDELINES:**CCPNR Entry-to-Practice Competencies (ETPC) - [LINK](https://www.clpnbc.org/Documents/Practice-Support-Documents/Entry-to-Practice-Competencies-%28EPTC%29-LPNs.aspx)CPNRE Examination Blueprint (CPNRE) - [LINK](http://www.cpnre.ca/documents/2017-2021%20CPNRE%20Blueprint%20-%20FINAL_Apr2016.pdf)CIHC National Interprofessional Competencies Framework (CIHC) - [LINK](https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf) CLPNBC Professional Standards (CLPNBC-PRO)- [LINK](https://www.clpnbc.org/Documents/Practice-Support-Documents/Professional-Standards-of-Practice-for-Licensed-Pr.aspx) CLPNBC Practice Standards (CLPNBC-PRAC) - [LINK](https://www.clpnbc.org/Practice-Support-Learning/Practice-Standards) CLPNBC Scope of Practice (CLPNBC-SCOPE) – [LINK](https://www.clpnbc.org/Documents/Practice-Support-Documents/Scope-of-Practice-ONLINE.aspx) ANAC-CASN-CNA Cultural Competence & Safety (ANAC) - [LINK](https://cna-aiic.ca/~/media/cna/page-content/pdf-en/first_nations_framework_e.pdf) Truth & Reconciliation Calls to Action (TRC) - [LINK](http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf) FNHA Cultural Safety and Humility (FNHA) – [LINK](http://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf) and [LINK](http://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf) | Professional Practice (Levels I–IV) | Professional Communication (Levels I–IV) | Variations in Health (Levels I–IV) | Health Promotion (Levels I–IV) | Pharmacology (Levels I & II) | Integrated Nursing Practice (Levels I–IV) | Consolidated Practice Experience (Levels I–IV) | Final Practice Experience |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PROFESSIONAL PRACTICE** |  |  |  |  |  |  |  |  |
| **CLPNBC-PRO Responsibility and Accountability** |  |  |  |  |  |  |  |  |
| The licensed practical nurse maintains standards of nursing practice and professional conduct established by CLPNBC. | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| **ETPC & CPNRE PROFESSIONAL PRACTICE** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Are responsible and accountable for their own decisions and actions.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| 1. Develop the therapeutic nurse-client relationship.
 | 🗸 | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| 1. Demonstrate leadership in all aspects of practice.
 | 🗸 | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| 1. Demonstrate and model professional behaviour.
 | 🗸 | 🗸 |  |  | 🗸 | 🗸 | 🗸 | 🗸 |
| **CIHC - DOMAIN CLARIFICATION** |  |  |  |  |  |  |  |  |
| Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and achieve patient/client/family and community goals. | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| **ETHICAL PRACTICE** |  |  |  |  |  |  |  |  |
| **CLPNBC-PRO Ethical Practice** |  |  |  |  |  |  |  |  |
| The licensed practical nurse understands, upholds and promotes the ethical standards of the nursing profession. | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| **ETPC & CPNRE ETHICAL PRACTICE** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Apply an ethical framework to nursing practice.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| 1. Advocate for client’s rights and responsibilities.
 | 🗸 | 🗸 |  | 🗸 | 🗸 |  | 🗸 | 🗸 |
| **LEGAL PRACTICE** |  |  |  |  |  |  |  |  |
| **ETPC & CPNRE LEGAL PRACTICE** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Adhere to legal requirements of practical nursing practice.
 | 🗸 |  |  |  | 🗸 |  | 🗸 | 🗸 |
| 1. Maintain client confidentiality in written, oral and electronic communication.
 | 🗸 | 🗸 |  |  |  |  | 🗸 | 🗸 |
| 1. Adhere to legal requirements regarding documentation.
 | 🗸 | 🗸 |  |  | 🗸 | 🗸 | 🗸 | 🗸 |
| **FOUNDATIONS OF PRACTICE** |  |  |  |  |  |  |  |  |
| **ASSESSMENT** |  |  |  |  |  |  |  |  |
| **CLPNBC-PRO Competency-Based Practice** |  |  |  |  |  |  |  |  |
| The licensed practical nurse applies appropriate knowledge, skills, judgment and attitudes consistently in nursing practice. |  |  | 🗸 |  |  | 🗸 | 🗸 | 🗸 |
| **ETPC & CPNRE - ASSESSMENT** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Complete comprehensive health assessments of clients throughout the lifespan.
 |  |  | 🗸 | 🗸 |  | 🗸 | 🗸 | 🗸 |
| 1. Complete comprehensive assessments.
 |  |  | 🗸 | 🗸 |  | 🗸 | 🗸 | 🗸 |
| **FOUNDATIONS OF PRACTICE** |  |  |  |  |  |  |  |  |
| **PLANNING AND IMPLEMENTATION** |  |  |  |  |  |  |  |  |
| **ETPC & CPNRE - PLANNING and IMPLEMENTATION** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Plan and implement evidence-informed nursing interventions based on assessments findings, client preferences and desired outcomes.
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| 1. Set priorities and develop time-management skills for meeting responsibilities.
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| 1. Facilitate the involvement of clients in their care plan.
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| 1. Facilitate health education.
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| 1. Contribute to a culture of safety.
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| 1. Formulate decisions consistent with client needs and priorities.
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| **CIHC - PATIENT/CLIENT/FAMILY/COMMUNITY-CENTRED CARE** |  |  |  |  |  |  |  |  |
| Learners/practitioners seek out, integrate and value, as a partner, the input and the engagement of the patient/client/family/community in designing and implementing care/services. |  | 🗸 |  | 🗸 |  | 🗸 | 🗸 | 🗸 |
| **FOUNDATIONS OF PRACTICE** |  |  |  |  |  |  |  |  |
| **EVALUATION** |  |  |  |  |  |  |  |  |
| **ETPC & CPNRE FOUNDATIONS OF PRACTICE – EVALUATION** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Perform ongoing evaluation throughout delivery of care.
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| **COLLABORATIVE PRACTICE** |  |  |  |  |  |  |  |  |
| **CLPNBC-PRO - Client-Focused Provision of Service** |  |  |  |  |  |  |  |  |
| The licensed practical nurse provides nursing services and works with others in the best interest of clients. |  | 🗸 |  | 🗸 |  | 🗸 | 🗸 | 🗸 |
| **ETPC & CPNRE - COLLABORATIVE PRACTICE** |  |  |  |  |  |  |  |  |
| Practical nursing students: |  |  |  |  |  |  |  |  |
| 1. Initiate, maintain and terminate collaborative relationships with clients.
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| 1. Communicate collaboratively with the client and other members of the health-care team.
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| 1. Demonstrate leadership within the health care team.
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| **CIHC - TEAM FUNCTIONING** |  |  |  |  |  |  |  |  |
| Learners/practitioners understand the principles of teamwork dynamics and group/team processes to enable effective interprofessional collaboration. | 🗸 | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| **CIHC - COLLABORATIVE LEADERSHIP** |  |  |  |  |  |  |  |  |
| Learners/practitioners understand and can apply leadership principles that support a collaborative practice model. | 🗸 | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| **COLLABORATIVE PRACTICE** |  |  |  |  |  |  |  |  |
| **CIHC - INTERPROFESSIONAL COMMUNICATION** |  |  |  |  |  |  |  |  |
| Learners/practitioners from different professions communicate with each other in a collaborative, responsive and responsible manner. | 🗸 | 🗸 |  | 🗸 |  | 🗸 | 🗸 | 🗸 |
| **CIHC - INTERPROFESSIONAL CONFLICT RESOLUTION** |  |  |  |  |  |  |  |  |
| Learners and practitioners work together with all participants, including patients/clients/families, to formulate, implement and evaluate care/services to enhance health outcomes. | 🗸 | 🗸 |  | 🗸 |  | 🗸 | 🗸 | 🗸 |
| **CLPNBC PRACTICE STANDARDS** |  |  |  |  |  |  |  |  |
| **Boundaries in the Nurse-Client Relationship** |  |  |  |  |  |  |  |  |
| Boundaries in the Nurse-Client Relationship Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs use professional judgment to determine the appropriate boundaries of a therapeutic relationship with each client. The nurse — not the client — is always responsible for establishing and maintaining boundaries.
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| 1. LPNs are responsible for beginning, maintaining and ending a relationship with a client in a way that ensures the client’s needs are first.
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| 1. LPNs do not enter into a friendship or a romantic relationship with clients.
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| 1. LPNs do not enter into sexual relations with clients.
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| 1. LPNs are careful about socializing with clients and former clients, especially when the client or former client is vulnerable or may require ongoing care.
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| 1. LPNs maintain the same boundaries with the client’s family and friends as with the client.
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| 1. LPNs help colleagues to maintain professional boundaries and report evidence of boundary violations to the appropriate person.
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| 1. At times, a LPN must care for clients who are family or friends. When possible, overall responsibility for care is transferred to another health care provider.
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| 1. At times, a LPN may want to provide some care for family or friends. This situation requires caution, discussion of boundaries and the dual role with everyone affected and careful consideration of alternatives.
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| 1. LPNs in a dual role make it clear to clients when they are acting in a professional capacity and when they are acting in a personal capacity.
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| 1. LPNs have access to privileged and confidential information, but never use this information to the disadvantage of clients or to their own personal advantage.
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| 1. LPNs disclose a limited amount of information about themselves only after they determine it may help to meet the therapeutic needs of the client.
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| 1. LPNs may touch or hug a client with a supportive and therapeutic intent and with the implicit or explicit consent of the client.
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| 1. LPNs do not communicate with or about clients in ways that may be perceived as demeaning, seductive, insulting, disrespectful or humiliating. This is unacceptable behaviour.
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| 1. LPNs do not engage in any activity that results in inappropriate financial or personal benefit to themselves or loss to the client. Inappropriate behaviour includes neglect and/or verbal, physical, sexual, emotional and financial abuse.
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| 1. LPNs do not act as representatives for clients under powers of attorney or representation agreements.
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| 1. Generally, LPNs do not exchange gifts with clients. Where it has therapeutic intent, a group of nurses may give or receive a token gift. Nurses return or redirect any significant gift. Nurses do not accept a bequest from a client.
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| **Communicable Diseases: Preventing Nurse-to-Client Transmission** |  |  |  |  |  |  |  |  |
| Communicable Diseases Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs have a professional, ethical and legal duty to provide their clients with safe care, including protecting them from the risk of infection.
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| 1. LPNs are aware of the risks and dangers of transmitting infections to clients.
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| 1. LPNs follow “routine practices and additional precautions” for infection control for all clients at all times.
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| 1. LPNs who are involved in exposure-prone procedures must know whether they have a blood-borne pathogen themselves so they can take appropriate measures to protect patients from any risk of transmission.
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| 1. LPNs who have a communicable disease themselves consider methods and risks of transmission and take steps to prevent passing the infection to clients.
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| **Conflict of Interest** |  |  |  |  |  |  |  |  |
| Conflict of Interest Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs identify and seek to avoid actual, potential or perceived conflicts of interest.
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| 1. LPNs avoid any behaviours including promoting private or business interests that place their personal gain ahead of their professional responsibilities
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| 1. LPNs handle all types of conflict of interest by identifying the problem, discussing it with the appropriate people and managing it ethically.
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| 1. LPNs fully and accurately disclose, to the appropriate persons, any relationships, affiliations, financial interests or personal interests that may create a conflict of interest.
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| 1. LPNs follow their regulatory college’s bylaws when they advertise or promote professional services or products.
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| 1. LPNs recognize the potential for gifts of any value to affect objectivity and use professional judgment when considering their acceptance.
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| 1. LPNs only accept funds from commercial sources in the form of an unrestricted grant paid to the organization sponsoring the professional activity.
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| **Consent** |  |  |  |  |  |  |  |  |
| Consent Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs recognize, respect and promote clients’ rights to be informed about their health care.
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| 1. LPNs respect clients’ rights to make decisions about their own health care and to give, refuse or revoke consent.
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| 1. LPNs meet legal and ethical obligations when obtaining client consent.
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| 1. LPNs determine the client’s capacity to give consent. If necessary, LPNs identify the person who is authorized to make health care decisions on the client's behalf.
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| 1. LPNs obtain consent before providing health care, unless it is not required by legislation. LPNs are not responsible for obtaining consent for health care provided by another health care provider.
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| 1. LPNs provide sufficient, specific and evidence-based information in a timely and appropriate manner, considering the client’s abilities, age, culture, language and preferences.
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| 1. LPNs provide clients with information they are competent to provide, including information a reasonable person would require to make a decision about:
* The condition for which the health care is proposed.
* The nature of the proposed health care.
* The risks and benefits of the proposed health care.
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| 1. LPNs tell clients about any health care before it is done, regardless of a client’s capacity to give consent.
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| 1. LPNs recognize that consent may be given verbally, in writing or through behaviour that implies consent.
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| 1. LPNs are aware of the difference in power between themselves and clients, and do not use that power to influence the client’s decision.
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| 1. LPNs respect the right of clients to seek further information or another opinion, and to involve others in the decision- making and consent process.
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| 1. LPNs help clients understand that they have the right to refuse or revoke consent at any time and for any reason.
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| 1. LPNs provide a substitute decision-maker with the same information and respect they would a client.
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| 1. LPNs document if a client has given, refused or revoked consent.
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| **Dispensing Medications** |  |  |  |  |  |  |  |  |
| Dispensing Medications Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs dispense a medication when it is in the best interest of the client.
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| 1. LPNs dispense a medication only to a client under their care.
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| 1. LPNs only dispense a medication when it has been ordered by an authorized health professional; however, there are some exceptions:
* LPNs may dispense epinephrine to treat anaphylaxis.
* LPNs may dispense glucagon to treat hypoglycemia.
* LPNs may dispense a Schedule II drug to be given orally, intranasally or by intramuscular or subcutaneous injection.
* LPNs may dispense a Schedule III drug without an order.
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| 1. When a pharmacist has reviewed a medication’s pharmaceutical and therapeutic suitability, LPNs take steps to ensure its proper use.
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| 1. When a pharmacist has *not* reviewed a medication’s pharmaceutical and therapeutic suitability, LPNs take steps to ensure the medication’s pharmaceutical and therapeutic suitability, as well as its proper use.
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| 1. When taking steps to ensure pharmaceutical and therapeutic suitability, LPNs:
* Review the order for completeness and appropriateness.
* Review the client’s medication history and other personal health information.
* Consider potential drug interactions, contraindications, allergies, therapeutic duplications and any other potential problems (e.g., adverse side effects).
* Use current, evidence-based resources to support their decision-making.
* Consider the client’s ability to follow the medication regimen.
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| 1. When taking steps to ensure proper use, LPNs:
* Label the medication legibly with the:
* Client’s name, date of birth and personal health number or medical record number.
* Medication name, dosage, route and (where appropriate) strength.
* Directions for use.
* Quantity dispensed.
* Date dispensed.
* Initials of the LPN dispensing the medication.
* Name, address and telephone number of the agency that dispensed the medication.
* Any other information that is appropriate/specific to the medication.
* Package the medication in a way that is most appropriate for the client.
* Hand the medication directly to the client or delegate.
* Provide education to the client or delegate that includes:
* The purpose of the medication.
* The dosage regime, expected benefits, potential side effects, storage requirements and instructions required to achieve a therapeutic response.
* Written information about the medication.
* Advice on seeking follow-up care.
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| 1. LPNs document dispensing information on the client record each time a medication is dispensed, including:
* Client name, address, phone number, date of birth, gender and, when available, allergies and adverse reactions.
* Name of delegate to whom medication was provided, if applicable.
* Date dispensed.
* Name, strength and dosage of medication.
* Quantity dispensed.
* Duration of therapy.
* Directions to client.
* Signature and title of the person dispensing the medication.
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| **Documentation** |  |  |  |  |  |  |  |  |
| Documentation Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs are responsible and accountable for documenting on the health record the care they personally provide to clients. Except in an emergency, LPNs are not responsible for documenting care given by other health care providers.
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| 1. When caring for clients, LPNs document the nursing process (assessment, nursing diagnosis, planning, intervention and evaluation), including information or concerns reported to another health care provider and, when appropriate, the health care provider’s response.
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| 1. LPNs document all relevant information about the client in chronological order on the client’s health record. Documentation is clear, concise, factual, objective, timely and legible, and includes agency-approved abbreviations.
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| 1. LPNs document at the time they provide care or as soon as possible afterward, as delays affect the continuity of care, cloud the memory of events and increase the possibility of errors. LPNs do not document before giving care.
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| 1. LPNs correct any documentation error in a timely, honest and transparent manner. LPNs clearly mark any “late entries,” recording both the date and time of the late entry and of the actual event.
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| 1. LPNs indicate their accountability and responsibility by adding their signature and title, or initials, as appropriate, to each entry they make on the health record.
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| 1. LPNs carry out more comprehensive and frequent documentation when a client’s health is no longer stable and predictable.
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| 1. LPNs complete an incident report following incidents such as medication errors, falls or harm to staff, visitors or clients. The incident report is not part of the health record. LPNs record facts about any incident affecting the client on the client’s health record.
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| 1. LPNs have a role in safeguarding the privacy, security and confidentiality of health records. LPNs access a health record only when they have a professional need.
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| 1. Self-employed LPNs are responsible for maintaining client records for a legally determined number of years. If the client is a minor, or has a disability, special rules apply.
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| **Duty to Provide Care** |  |  |  |  |  |  |  |  |
| Duty to Provide Care Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs have a professional and legal obligation to provide their clients with safe, competent and ethical care.
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| 1. In an emergency, LPNs provide the best care they can, given the circumstances and their competence.
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| 1. LPNs do not abandon their clients. Abandonment occurs when the LPN has engaged with the client or has accepted an assignment and then discontinues care without:
2. negotiating a mutually acceptable withdrawal of service with the client, or
3. arranging for a suitable alternative or replacement services, or
4. allowing the employer a reasonable opportunity to provide for alternative or replacement services.
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| 1. LPNs may withdraw from care provision or refuse to provide care if they believe that providing care would place them or their clients at an unacceptable level of risk.
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| 1. LPNs recognize that informed, capable clients have the right to be independent, live at risk and direct their own care. Regardless of this right, LPNs do not comply with client wishes when doing so would require action contrary to the law, CLPNBC Standards of Practice or employer policy.
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| **Duty to Report** |  |  |  |  |  |  |  |  |
| Duty to Report Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs may report incompetent or impaired practice or unethical conduct to their supervisor, who will then report to the appropriate regulatory body. However, if the supervisor does not report, the LPN must make a direct report to the regulatory body.
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| 1. LPNs must report, in writing, to the appropriate regulatory body when they have good reason to believe that the public might be in danger because a health professional is practising when he or she:
* Is suffering from a mental or physical problem, an emotional disturbance, or an addiction to drugs or alcohol that impairs his or her ability to practice.
* Has a pattern of incompetent practice.
* Is alleged to have behaved unethically.
* Has been charged or convicted of a crime that may result in the public losing confidence in the profession or the health care system.
* Has been terminated or has resigned when there are unresolved practice concerns that the employer has not reported.
* Has engaged in sexual misconduct.
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| **Medication Administration** |  |  |  |  |  |  |  |  |
| Medication Administration Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs administer medications within the Regulation, CLPNBC standards, limits and conditions, employer policy and their individual competence.
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| 1. LPNs understand and recognize effects, side effects and interactions of medications and take action as necessary.
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| 1. LPNs adhere to the “rights” of medication administration. These include Right Medication, Right Client, Right Dose, Right Time, Right Route, Right Reason and Right Documentation.
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| 1. LPNs determine all client-specific orders are clear, complete, current, legible and clinically relevant for the client before administering any medication.
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| 1. LPNs act on clinical order sets when the authorized health professional has made those orders client-specific by reviewing them, adding the client’s name and customizing, signing and dating them.
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| 1. LPNs only act on verbal and telephone orders if there are no other reasonable options.
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| 1. Except in an emergency, LPNs only administer medications they themselves or a pharmacist has prepared for a specific client.
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| 1. LPNs verify that medication orders, pharmacy labels and medication administration records are complete and include:
* The name of the client.
* The name of the medication.
* The medication strength.
* The dosage, route and frequency.
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| 1. LPNs educate clients about the medications the clients are receiving.
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| 1. LPNs understand how medication errors and near misses can occur and take steps to prevent them
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| 1. When a medication error or near miss occurs at any point in the process of administering a medication, LPNs take appropriate steps to resolve and report it in a timely manner.
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| **Privacy & Confidentiality** |  |  |  |  |  |  |  |  |
| Privacy & Confidentiality Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs collect and access clients’ personal health information only for purposes that are consistent with their professional responsibilities.
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| 1. LPNs ensure that clients are aware of their rights and have consented to the collection, use and disclosure of their personal health information.
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| 1. LPNs safeguard information learned in the context of the nurse-client relationship and disclose this information outside of the health care team only with client consent or when there is an ethical or legal obligation to do so.
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| 1. When disclosure of confidential information is required, LPNs restrict the amount of information disclosed and the number of people informed.
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| 1. LPNs take action if others inappropriately access or disclose a client’s personal health information.
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| 1. LPNs comply with any legal obligation to disclose confidential information that is imposed by legislation or required under a warrant, court order or subpoena.
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| 1. LPNs disclose a client’s personal health information to the appropriate authority if there is a substantial risk of significant harm to the health or safety of the client or others.
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| 1. LPNs respect clients’ rights to access their own health records and to request a correction of information.
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| **Use of LPN Title** |  |  |  |  |  |  |  |  |
| Use of LPN Title Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs use their protected title in ways that comply with the Health Professions Act, the Nurses (Licensed Practical) Regulation, CLPNBC Bylaws and CLPNBC Standards of Practice.
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| 1. Registrants who are authorized to practise nursing use the abbreviation “LPN,” “LPN (L),” “LPN (I)” or “LPN (T)” when they document nursing care or provide nursing services.
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| 1. No one other than a CLPNBC registrant may use the protected titles or call himself or herself an LPN.
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| 1. Registrants who are working outside the scope of an LPN cannot use any of the protected titles.
 | 🗸 |  |  |  |  |  | 🗸 | 🗸 |
| 1. Registrants who hold non-practicing registration may use the title “Non-practicing Licensed Practical Nurse,” but they cannot practice nursing, even as a volunteer.
 | 🗸 |  |  |  |  |  | 🗸 | 🗸 |
| 1. Former registrants who are now retired may refer to themselves as a “retired Licensed Practical Nurse” but cannot use any nursing title and cannot provide nursing services even as a volunteer.
 | 🗸 |  |  |  |  |  | 🗸 | 🗸 |
| 1. Registrants cannot use their title to market products or services in a way that is false, inaccurate, misleading, unverifiable or contrary to the public interest.
 |  |  |  |  |  |  | 🗸 | 🗸 |
| 1. Registrants cannot use their title to advertise or sell products or services unless the product or service relates directly to the profession.
 |  |  |  |  |  |  | 🗸 | 🗸 |
| 1. Registrants cannot use their title to speak on behalf of CLPNBC unless expressly authorized.
 | 🗸 |  |  |  |  |  | 🗸 | 🗸 |
| 1. Self-employed LPNs follow the BC Registry Services process for seeking “Name Approval” if the name of their business includes the title “nurse.”
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| **Working with Health Care Assistants** |  |  |  |  |  |  |  |  |
| Working with Health Care Assistants (HCA) Practice Standard principles include: |  |  |  |  |  |  |  |  |
| 1. LPNs are responsible for assessing clients, making a nursing diagnosis, planning care and assigning care appropriately to HCAs.
 | 🗸 | 🗸 | 🗸 |  |  | 🗸 | 🗸 | 🗸 |
| 1. LPNs are responsible for knowing the HCA’s role description in their practice setting.
 | 🗸 | 🗸 |  |  |  |  | 🗸 | 🗸 |
| 1. LPNs only assign care to HCAs when the care is:
* Within the LPN scope of practice.
* Within the LPN’s individual competence.
* Permitted within employer policy.
* Within the HCA core competency profile.
* Within the HCA’s role description and training.

AND* Set out in a client’s care plan.
 | 🗸 | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| 1. Before assigning care to an HCA, the LPN assesses the client’s needs, makes a nursing diagnosis, determines the activity is within the HCA’s job description and identifies any potential risks.
 | 🗸 | 🗸 | 🗸 |  |  | 🗸 | 🗸 | 🗸 |
| 1. LPNs may provide training and ongoing support and guidance to HCAs if it is an employer expectation set out in the LPN’s job description.
 | 🗸 | 🗸 |  |  |  |  | 🗸 | 🗸 |
| 1. After an LPN assigns care to an HCA, the LPN continues to be responsible for assessing the outcomes of the care and for updating the overall plan of care.
 | 🗸 | 🗸 |  |  |  |  | 🗸 | 🗸 |
| **CLPNBC SCOPE OF PRACTICE** |  |  |  |  |  |  |  |  |
| **Standards for Acting without an Order**[**(List of Activities, pp. 10-15)**](https://www.clpnbc.org/Documents/Practice-Support-Documents/Scope-of-Practice-ONLINE.aspx) |  |  |  |  |  |  |  |  |
| Before carrying out any activity *without* an order, LPNs:  |  |  |  |  |  |  |  |  |
| * + - 1. Accept sole accountability for determining that the client’s condition requires performance of the activity.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| * + - 1. Assess client status and make a nursing diagnosis of a client condition that can be improved or resolved through LPN activities.
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| * + - 1. Verify that the activity is:
* Within the scope of practice for LPNs as set out in the Regulation.
* Consistent with CLPNBC’s standards, limits and conditions.
* Consistent with employer policy.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| * + - 1. Interpret and use current evidence from research and other credible sources to support both the activity and the decision to carry it out.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| * + - 1. Have the competence to:
* Determine if the client’s condition requires performance of the activity, having considered:
* The known risks and benefits to the client
* The predictability of outcomes of performing the activity
* Other relevant factors specific to the situation

 * Carry out the activity safely and ethically
* Manage the intended and unintended outcomes of the activity, having considered the safeguards and resources available in the circumstances to safely manage the intended and unintended outcomes of performing the activity.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| 1. Meet legal and ethical obligations for client consent.
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| **Standards for Acting with an Order**[**(List of Activities, p. 17-32)**](https://www.clpnbc.org/Documents/Practice-Support-Documents/Scope-of-Practice-ONLINE.aspx) |  |  |  |  |  |  |  |  |
| Before carrying out any activity *with* an order, LPNs:  |  |  |  |  |  |  |  |  |
| 1. Verify that the order is:
* Client-specific.

Made by a health professional authorized to give an order to an LPN. | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| 1. Verify that the activity is:
* Within the scope of practice for LPNs as set out in the Regulation
* Consistent with CLPNBC’s standards, limits and conditions.
* Consistent with employer policy.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| 1. Have the competence to:
* Carry out the activity safely and ethically.
* Manage the intended outcomes of the activity.
* Recognize unintended outcomes of the activity and implement the plan for dealing with these unintended outcomes.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| 1. Take appropriate action if the order does not seem to be evidence-based or if it does not appear to consider individual client characteristics or wishes.
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| 1. Meet legal and ethical obligations for client consent.
 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 | 🗸 |
| **ANAC Cultural Competence and Cultural Safety** |  |  |  |  |  |  |  |  |
| **Post-Colonial Understanding** |  |  |  |  |  |  |  |  |
| 1. Demonstrate compassionate, culturally safe, relationship-centred care with First Nation, Inuit, and Métis clients, their families or communities.
 | 🗸 |  |  |  |  |  | 🗸 | 🗸 |
| 1. Identify the determinants of health of Indigenous populations and use this knowledge to promote the health of First Nation, Inuit, and Métis clients, families, and communities.
 | 🗸 |  |  | 🗸 |  |  | 🗸 | 🗸 |
| **Communication** |  |  |  |  |  |  |  |  |
| 1. Demonstrate effective and culturally safe communication with First Nation, Inuit and Métis clients, their families and peers.
 |  | 🗸 |  |  |  |  | 🗸 | 🗸 |
| **Inclusivity** |  |  |  |  |  |  |  |  |
| 1. Demonstrate a commitment to engage in dialogue and relationship building with First Nation, Inuit and Métis peoples, cultures, and health practices.
 |  | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| **Respect** |  |  |  |  |  |  |  |  |
| 1. Identify health care approaches that places First Nation, Inuit, and Métis clients, families, and communities at risk for cultural harm, and describe measures to rectify these approaches.
 | 🗸 | 🗸 |  | 🗸 |  |  | 🗸 | 🗸 |
| 1. Demonstrate the skills of effective collaboration with both Indigenous and non-Indigenous health care professionals, traditional/medicine peoples/healers in the provision of effective health care for First Nation, Inuit, and Métis clients, families and communities.
 |  | 🗸 |  |  | 🗸 |  | 🗸 | 🗸 |
| 1. Describe approaches to optimize First Nation, Inuit, and Métis health through a just allocation of health care resources, balancing effectiveness, efficiency and access, employing evidence-based and Indigenous best practices.
 | 🗸 | 🗸 |  | 🗸 |  |  | 🗸 | 🗸 |
| 1. Contribute to the development, critical assessment of knowledge/practices, and their dissemination to improve the health of First Nation, Inuit, and Métis in Canada.
 |  |  |  |  |  |  | 🗸 | 🗸 |
| **Indigenous Knowledge** |  |  |  |  |  |  |  |  |
| 1. Describe First Nation, Inuit and Métis ontology, epistemology, cosmologies and explanatory models as they relate to health and healing; and the graduating student will describe First Nation, Inuit and Métis.
 |  |  |  | 🗸 |  |  | 🗸 | 🗸 |
| **Mentoring and supporting students for success** |  |  |  |  |  |  |  |  |
| 1. Will have experienced teaching/learning environments where he or she felt safe to freely express ideas, perspectives and critical thoughts.
 |  |  |  |  |  |  | 🗸 | 🗸 |
| 1. Will have experienced a supportive nursing program as they journey towards degree completion and their “place” as registered nurses within the profession.
 |  |  |  |  |  |  | 🗸 | 🗸 |
| **TRUTH & RECONCILIATION CALLS TO ACTION** |  |  |  |  |  |  |  |  |
| Item # 23 III. Demonstrate cultural competency within a variety of settings.  |  |  |  |  |  | 🗸 | 🗸 | 🗸 |
| Item # 24. Discuss Indigenous health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Indigenous rights, and Indigenous teachings and practices.  | 🗸 | 🗸 |  | 🗸 |  |  | 🗸 | 🗸 |
| Item # 24b. Applies knowledge of intercultural competency, conflict resolution, human rights, and anti-racism principles to practice. |  | 🗸 |  | 🗸 |  | 🗸 | 🗸 | 🗸 |
| **FNHA CULTURAL SAFETY AND CULTURAL HUMILITY** |  |  |  |  |  |  |  |  |
| 1. Recognize that cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.
 | 🗸 | 🗸 |  |  |  |  | 🗸 | 🗸 |
| 1. Recognize that cultural humility is a process of self-reflection to understand personal and systemic conditioned biases, and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a lifelong learner when it comes to understanding another’s experience.
 | 🗸 | 🗸 |  |  |  |  | 🗸 | 🗸 |
| 1. Recognize the impact of acculturation, assimilation and historical events on all interactions with Indigenous clients.
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| 1. Conduct client journey mapping to support ongoing improvement and learning.
 |  |  |  |  |  |  |  |  |
| 1. Explore local First Nations communities including history; modern and traditional governance and political structures; fishing, hunting and gathering activities; spiritual practices; tribal council affiliations; and role of Hereditary Leaders and Elders.
 |  |  |  | 🗸 |  |  | 🗸 | 🗸 |
| 1. Recognize traditional protocols and teachings of local First Nations communities.
 |  |  |  | 🗸 |  |  | 🗸 | 🗸 |
| 1. Incorporate cultural safety and humility skill development and/or assessment within clinical practice.
 |  | 🗸 |  |  |  | 🗸 | 🗸 | 🗸 |
| 1. Apply principles of cultural safety and humility courses with clients in a variety of settings.
 |  |  |  |  |  | 🗸 | 🗸 | 🗸 |
| 1. Discuss Brief Action Planning and Motivational Interviewing principles to assist in building wellness plans with Indigenous and other clients. (Brief Action Planning is an approach based on the principles of Motivational Interviewing, a method of client interviewing. It is invitational versus dictator and based on relationship.)
 |  |  |  |  |  |  |  |  |
| 1. Apply principles of trauma informed practice in a variety of settings.
 |  |  |  | 🗸 |  | 🗸 | 🗸 | 🗸 |