CRANSTON RIDGE MEDICAL CLINIC

CANADIAN EXPERIENCE PROGRAM FOR INTERNATIONALLY EDUCATED NURSES

CEPIEN Learner Manual

Canadian RN Practice • Basic Health Assessment • Clinical Skills • Communication • Professional Integration

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Controlled educational document — current CRNA requirements and CRMC policy always govern practice.

Document control

Topic	Standard
Document owner	CRMC Canadian Experience Program for Internationally Educated Nurses.
Audience	Fully registered RNs admitted to CEPIEN; approved preceptors and programme faculty.
Purpose	To support transition to Canadian RN practice through supervised experience, foundational clinical skills, basic health assessment, communication, documentation and professional integration.
Clinical approval	CRMC Medical Director or designated clinical lead and approved nursing programme leadership.
Review cycle	At least annually and sooner when CRNA standards, legislation, programme design or clinic policy changes.
Distribution	Learner edition. Assessment keys, examiner guidance and confidential personnel records are maintained separately.

Approved document

Approved for use within the CEPIEN programme. Revisions are managed through CRMC document control.

Purpose and limits of this manual

CEPIEN supports fully registered internationally educated nurses who are adapting existing nursing knowledge and experience to Canadian primary-care practice. It is a professional-integration programme delivered within the learner's current CRNA registration, individual competence, supervision arrangements and employer policy. [1,2]

The manual teaches a safe and repeatable method for basic nursing assessment, common clinical procedures, medication administration, communication, documentation, escalation, portfolio development and competency assessment. A listed skill may be performed only when the learner is legally authorized, educated, competent, supervised as required, and supported by current employer policy. [4,7-11]

CEPIEN health-assessment teaching emphasizes accurate data collection, foundational examination technique, recognition of unexpected findings, clear documentation, communication and timely escalation at entry-level RN depth.

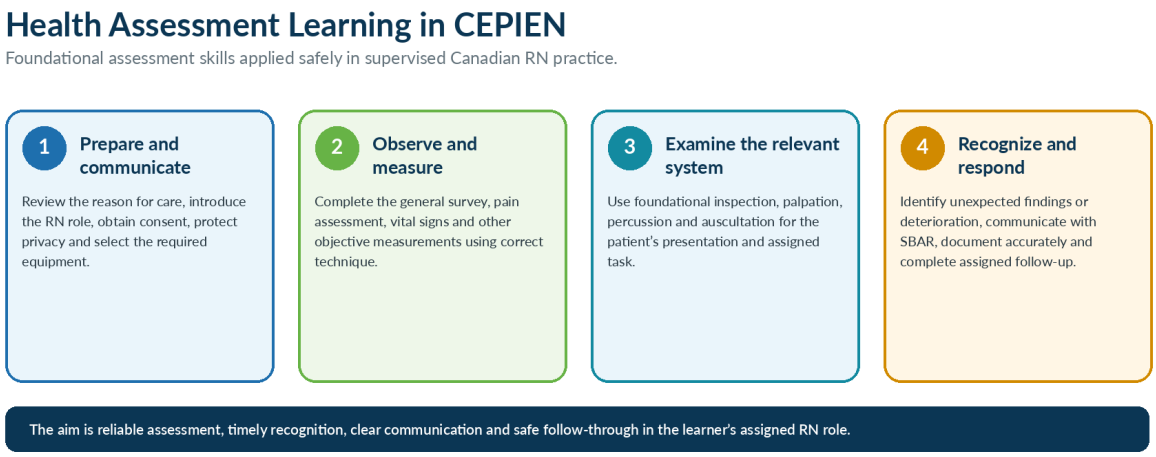

Figure 1. The four practical aims of health-assessment learning in CEPIEN.

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PART I — PROGRAMME IDENTITY AND LEARNER JOURNEY

What CEPIEN is, how learning is organized and how competency is demonstrated.

1. What CEPIEN provides

The Canadian Experience Program for Internationally Educated Nurses is a supervised professional-integration programme for RNs who already hold an active, unrestricted Alberta RN practice permit. Its goal is to provide structured Canadian nursing experience and help the learner demonstrate entry-level RN competence in the Alberta primary-care environment. [1,2]

Topic	Standard
Programme purpose	Structured Canadian nursing experience with theory, supervised clinical learning, feedback, portfolio evidence and competency assessment.
Learning approach	Orientation, deliberate practice, direct observation, reflection and repeated evidence across relevant primary-care contexts.
Learner identity	A registered nurse who brings prior education and experience and is adapting practice to local law, standards, workflows, communication and patient expectations.
Outcome	A documented programme decision that the learner has achieved the required competency level across the approved CEPIEN framework.
Programme boundaries	CEPIEN does not replace CRNA registration requirements or guarantee employment; any clinical activity remains subject to the learner's authorization, competence, supervision and employer policy.

Strength-based transition

International education and experience are assets. CEPIEN does not assume incompetence; it creates a transparent setting in which existing capability can be demonstrated and local practice gaps can be identified and addressed.

2. Programme at a glance

The current public programme page describes 480 practical hours over approximately 12 weeks and 133 hours of theoretical learning. It also identifies an initial 160-hour, four-week full-time immersion. The learner's issued Individual Schedule and current controlled programme policy govern the precise sequence, attendance pattern, course titles and assessment dates. [1]

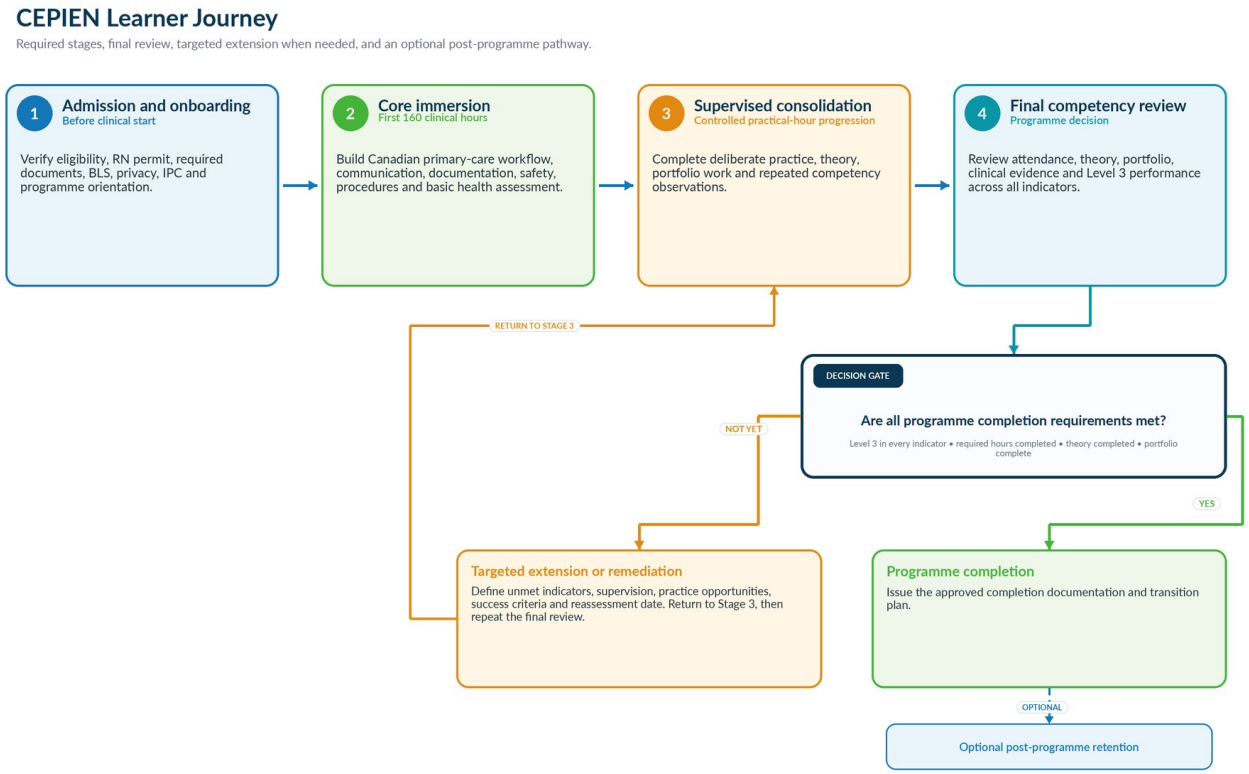

Figure 2. CEPIEN learner journey. Solid connectors show required stages and decision branches; the dashed connector identifies the optional post-programme pathway.

Component	Publicly described scope	Learner evidence
Practical experience	Up to 480 supervised hours in the clinic according to the issued schedule.	Attendance, clinical log, direct observation and competency sign-off.
Core immersion	The public page identifies an initial 160 full-time hours.	Orientation completion, foundational skills and early progress review.
Theory	Current public description: approximately 133 hours delivered through online learning.	Course completion records and integration into clinical reflection.
Portfolio	Electronic professional portfolio developed throughout the programme.	Credentials, competency evidence, feedback, reflection and learning plan.
Completion	Level 3 is required in every approved competency indicator.	Final framework, programme review and completion decision.
Optional retention	PCEPIENRP may provide continued supported practice after CEPIEN.	Separate current agreement and schedule.

3. Programme roles and supervision

Topic	Standard
Learner	Prepare, practise within scope, ask for help early, accept feedback, document accurately, complete assigned work and maintain portfolio evidence.
RN preceptor	Orient, supervise, demonstrate, observe, coach, assess and document performance within the preceptor's competence and authority.
Physician or NP	Provide patient-care consultation, accept escalation or transfer when appropriate, and support interprofessional learning.
Clinical manager / coordinator	Manage schedule, attendance, LMS records, competency framework, portfolio reviews, remediation and programme communication.
Medical Director / clinical lead	Provide clinical governance, emergency and procedural oversight, and approval of local clinical policies.
MOA and clinic team	Support safe workflow, appointments, messages, equipment, records and interprofessional integration without replacing nursing judgment.

4. Competency levels and completion

The CEPIEN framework uses three performance levels. The supplied framework requires Level 3 in all indicators before completion. [2]

Level	Operational interpretation	Supervision / evidence
1 — Requires ongoing assistance	The learner needs frequent prompting, demonstration or correction to complete the activity safely.	Direct supervision and a targeted learning plan.
2 — Progressing	The learner performs many elements correctly but still needs intermittent cueing, review or assistance.	Supervised practice, feedback and repeated observation.
3 — Meets programme expectation	The learner performs the entry-level activity safely, consistently and with appropriate judgment, communication and follow-through.	Multiple observations and evidence across relevant contexts.

Level 3 is not "expert" practice

Level 3 means the learner meets the approved CEPIEN entry-level expectation for that indicator. It does not imply advanced practice, independent procedural privilege in every setting, or competence beyond the situations assessed.

PART II — REGISTERED NURSING PRACTICE IN ALBERTA

Scope, professional roles, person-centred care, communication and documentation.

5. Scope of practice and individual competence

CRNA distinguishes the profession's scope of practice from an individual RN's scope. Individual practice is shaped by legislation, standards, employer policy, education, experience, current competence, patient needs and the practice environment. [4,7,9]

- ☐ **Before performing a skill, confirm:** Is it legally permitted for an RN?
- ☐ **Employer authority.** Does current CRMC policy permit it in this setting?
- ☐ **Education and competence.** Have I been taught, assessed and authorized to perform it?
- ☐ **Patient-specific safety.** Is this appropriate for this patient now?
- ☐ **Supervision.** Is the required preceptor or clinician available?
- ☐ **Follow-through.** Can I document, monitor and respond to the outcome?

Stop when any boundary is unclear

Do not proceed because a task is familiar from another country, was previously performed elsewhere, or has been informally requested. Pause, clarify the authority and obtain appropriate supervision.

6. The nine entry-level RN roles

Alberta and national entry-level competency frameworks organize RN practice through nine integrated roles: Clinician, Professional, Communicator, Collaborator, Coordinator, Leader, Advocate, Educator and Scholar. [5,6]

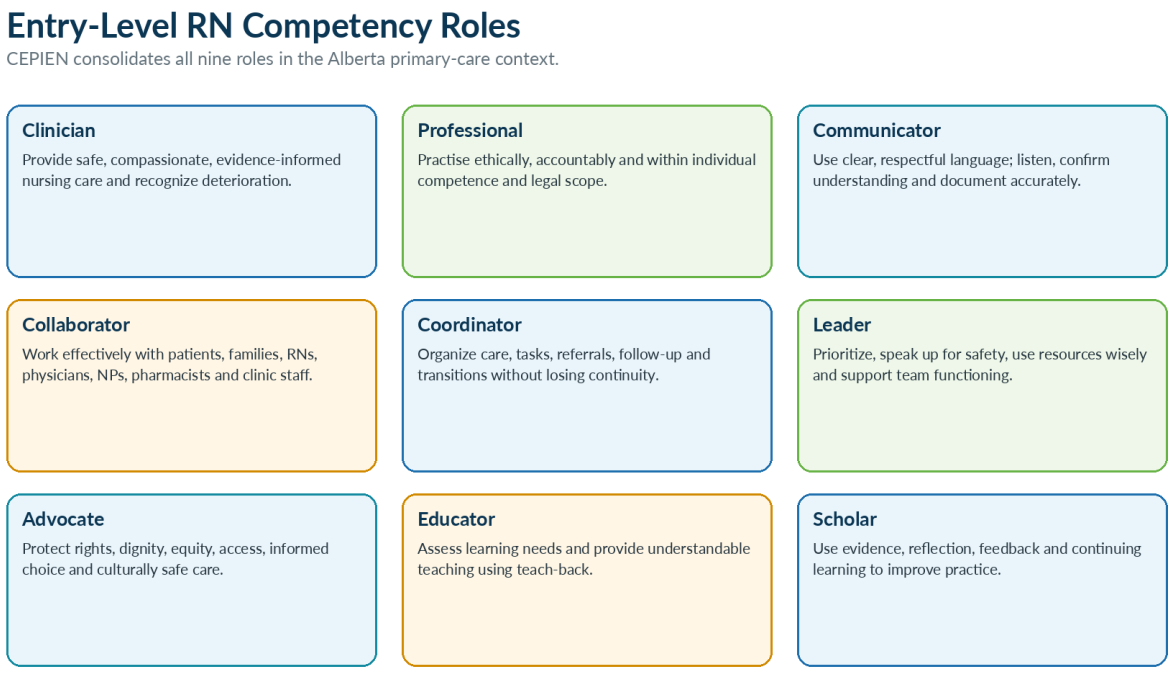

Figure 3. The nine entry-level roles applied throughout CEPIEN.

7. Person-centred and culturally safe care

Person-centred care respects the patient's values, goals, language, culture, identity, family context, autonomy and right to participate in decisions. Culturally safe practice requires reflection on power, bias, racism and assumptions, and is defined by the person receiving care—not only by the clinician's intentions. [12]

- **Introduce and explain.** Use name, title and role; explain what will happen and why.
- **Ask, do not assume.** Clarify preferred name, pronouns, language, decision-makers, cultural or spiritual needs and accessibility requirements.
- **Use qualified interpretation.** Do not rely on children or untrained family members for complex clinical interpretation except in a genuine emergency.
- **Seek consent.** Consent is a process: voluntary, informed, specific, capable and withdrawable. [18]
- **Use trauma-informed practice.** Offer choice, privacy, predictable steps and permission before touch.
- **Check understanding.** Use teach-back rather than asking only "Do you understand?"
- **Address inequity.** Identify cost, transport, housing, food, pharmacy, technology and follow-up barriers and involve the team.

8. Privacy, confidentiality and consent

Alberta's Health Information Act and professional standards govern collection, access, use, disclosure and safeguarding of health information. Access only what is required for the assigned role and patient care. [8,17]

- ☐ Confirm identity using the approved identifiers.
- ☐ Discuss care in a private environment whenever possible.
- ☐ Log out or lock the workstation when leaving it.
- ☐ Do not access the chart of a family member, friend, colleague or public figure without a care-related need.
- ☐ Verify recipients before sending messages, faxes, tasks or documents.
- ☐ Use only approved devices, platforms and photography processes.

- ☐ Remove identifying information from portfolio reflections unless programme policy expressly requires it.
- ☐ Document consent, refusal, substitute decision-maker involvement and interpreter use.

9. Communication, documentation and the EMR

Documentation must be timely, clear, accurate, objective and sufficiently complete to support continuity and accountability. Correct an error using the approved EMR process; never conceal or backdate a change. [8,19]

Documentation element	Minimum expectation
Subjective	What the patient or caregiver reports, including the presenting concern, relevant symptoms, history, medications, allergies and goals.
Objective	Vital signs, general appearance, assessment findings, procedures, specimens and observed response.
Assessment / nursing impression	Nursing interpretation within competence: expected or unexpected findings, risk, deterioration, needs and reason for escalation.
Plan / action	Nursing intervention, teaching, clinician notification, task, follow-up and patient instructions.
Task closure	Record who was notified, when, what was requested, the response and who retains responsibility.

Use objective language

Document what was observed and reported. Avoid labels such as “difficult,” “non-compliant” or “drug-seeking” without objective description and relevant context.

PART III — BASIC HEALTH ASSESSMENT

Foundational history and examination skills used to recognize needs, deterioration and the correct next step.

10. The basic nursing assessment and escalation algorithm

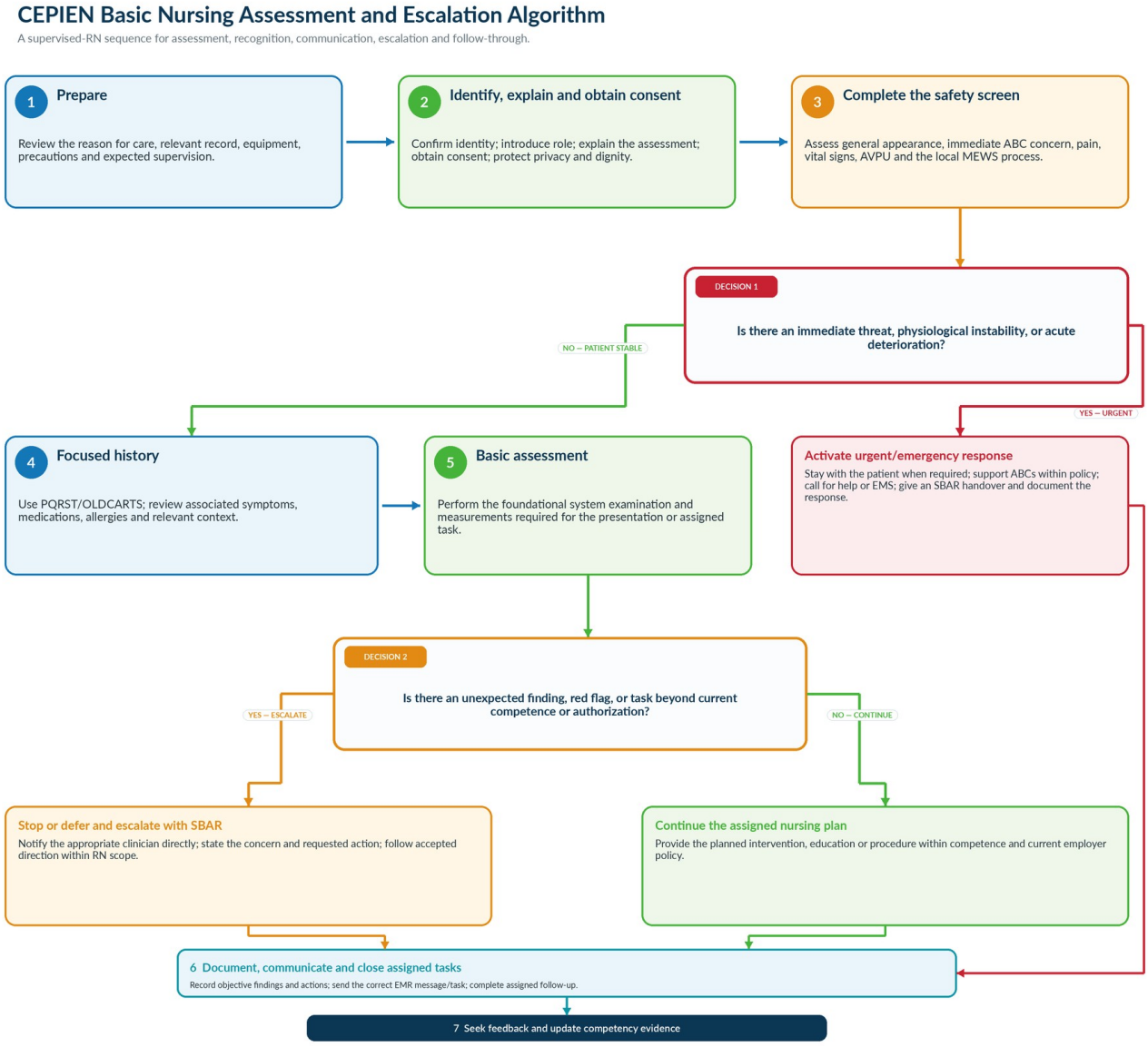

Figure 4. CEPIEN basic nursing assessment and escalation algorithm. Every connector represents a defined sequence or decision branch.

The algorithm begins with preparation, identity, explanation, consent and a safety screen. An immediate threat, unstable observation or acute deterioration moves directly to the urgent or emergency response. A stable patient proceeds to focused

history and the relevant basic assessment. If an unexpected finding, red flag, or activity beyond competence or authorization is identified, the learner stops or defers the activity and escalates with SBAR. Otherwise, the assigned nursing plan continues. Every pathway ends with objective documentation, communication, task closure, feedback and updated competency evidence. A basic assessment is not necessarily a complete head-to-toe examination; select the relevant system while maintaining a general survey and a low threshold to expand or escalate when findings are unexpected.

11. General survey, vital signs and MEWS

- ☐ **General appearance.** Distress, posture, work of breathing, colour, hygiene, interaction and mobility.
- ☐ **Identity and consent.** Confirm patient and explain the purpose of the observations.
- ☐ **Vital signs.** Blood pressure, pulse, respiratory rate, oxygen saturation, temperature and pain using correct equipment and technique.
- ☐ **Neurological responsiveness.** Use AVPU or the local approved tool.
- ☐ **MEWS.** Calculate and act according to current CRMC policy; do not memorize thresholds from old learning material.
- ☐ **Trend.** Compare with baseline, repeat unexpected readings manually or with correct equipment, and communicate deterioration.
- ☐ **Context.** Consider age, pregnancy, medication, activity, anxiety, pain and device limitations without dismissing abnormal findings.

Respiratory rate must be measured—not guessed

Count accurately before drawing conclusions from oxygen saturation or appearance. A normal SpO_2 does not exclude serious illness.

12. Focused history

- **Opening.** Begin with an open question and the patient's priority.
- **Symptom analysis.** Use PQRST or OLDCARTS: onset, provoking/palliating factors, quality, region/radiation, severity and time course.
- **Associated symptoms.** Ask relevant positives and negatives, including red flags.
- **Background.** Past medical and surgical history, medications, allergies and exact reaction, immunizations and recent care.
- **Context.** Function, occupation, family supports, smoking/substance use, pregnancy possibility and access barriers when relevant.
- **Close.** Summarize back to the patient, clarify discrepancies and identify what must be communicated.

13. Respiratory assessment

- ☐ Observe respiratory rate, pattern, depth, speech, position, accessory-muscle use, colour and work of breathing.
- ☐ Confirm SpO_2 quality and interpret with the whole clinical picture.
- ☐ Inspect chest symmetry and shape; assess expansion when indicated.
- ☐ Percuss and auscultate systematically, comparing equivalent areas bilaterally and including posterior bases.
- ☐ Describe air entry and sounds accurately: clear, reduced, crackles, wheeze, rhonchi, stridor or pleural rub.
- ☐ Recognize urgent features: severe distress, cyanosis, altered mental status, inability to speak/feed, chest pain, hemoptysis, markedly abnormal vital signs or clinician concern.
- ☐ Report findings and disposition; do not diagnose pneumonia, asthma or PE independently unless another approved role/policy applies.

14. Cardiovascular and peripheral vascular assessment

- ☐ Assess pulse rate, rhythm, volume and symmetry.
- ☐ Observe skin colour, temperature, capillary refill, edema, wounds and peripheral perfusion.

- ☐ Locate and describe peripheral pulses; compare sides.
- ☐ Inspect and palpate the precordium only as taught and appropriate.
- ☐ Auscultate systematically at the aortic, pulmonic, tricuspid and mitral areas; identify rate/rhythm and recognize that an abnormal sound requires clinician review.
- ☐ Recognize urgent features: chest pressure, syncope, shock, acute neurologic deficit, severe dyspnea, unilateral cold/pale limb, new severe edema or suspected DVT/PE.

15. Abdominal and renal assessment

- ☐ Ask about pain, nausea/vomiting, bowel and urinary symptoms, bleeding, pregnancy possibility, intake and previous surgery.
- ☐ Inspect before touching; note contour, movement, scars, distention and visible concern.
- ☐ Use the correct sequence: inspect, auscultate, percuss, then palpate.
- ☐ Palpate gently and observe for focal tenderness, guarding, rigidity, rebound or mass; stop if unsafe.
- ☐ Assess costovertebral-angle tenderness only when indicated and with appropriate technique.
- ☐ Recognize urgent features: peritonism, GI bleeding with instability, severe or escalating pain, persistent vomiting, pulsatile mass, ectopic-pregnancy concern, urinary obstruction or systemic illness.

16. Neurological screen and cranial nerves

- ☐ Assess level of consciousness, orientation, speech and behaviour.
- ☐ Use a rapid stroke screen according to current emergency policy.
- ☐ Compare pupils, facial movement, limb strength, sensation and coordination.
- ☐ Observe gait only when safe; protect the patient from falls.
- ☐ Perform selected cranial-nerve components as taught and relevant; do not turn a focused urgent screen into a lengthy exam.
- ☐ Recognize urgent features: sudden focal deficit, seizure with incomplete recovery, altered consciousness, thunderclap headache, meningism, acute ataxia or progressive weakness.

17. HEENT and eye assessment

- ☐ Inspect the head, face, mouth, pharynx and neck as relevant.
- ☐ Assess visual acuity when eye symptoms are present and the patient can participate.
- ☐ Observe pupils and extraocular movement; identify pain, photophobia, visual change or fixed/irregular pupils as urgent concerns.
- ☐ Inspect the external ear and use the otoscope only after training; begin with the less affected ear.
- ☐ Describe the ear canal and tympanic membrane rather than writing “ear normal.”
- ☐ Assess nose, sinuses, oral cavity, tonsils, lymph nodes and hydration as indicated.
- ☐ Escalate airway compromise, drooling, trismus, mastoid swelling, orbital signs, severe eye pain, reduced vision or chemical/penetrating injury.

18. Musculoskeletal, knee and fracture recognition

- ☐ Clarify mechanism, onset, function, previous injury, pain and ability to bear weight/use the limb.
- ☐ Inspect for deformity, swelling, bruising, redness and asymmetry.
- ☐ Assess tenderness, active movement and neurovascular status without forcing a painful or unstable joint.
- ☐ For the knee, observe gait, swelling, range of motion and focal tenderness; perform special tests only when taught and appropriate.
- ☐ Recognize suspected fracture/dislocation, open injury, neurovascular compromise, severe trauma, hot swollen joint, compartment-syndrome features or non-accidental-injury concern.
- ☐ Immobilize/support and escalate according to policy; do not delay urgent care for a routine clinic x-ray.

19. Skin, wounds and suspicious lesions

- ☐ Describe location, number, size, colour, border, shape, surface, distribution and evolution.

- ☐ Use correct lesion language: macule, papule, plaque, vesicle, pustule, nodule, scale, crust, erosion or ulcer.
- ☐ Assess warmth, tenderness, drainage, odor, fluctuance, surrounding erythema and systemic symptoms.
- ☐ For wounds, document dimensions, tissue, exudate, edges, surrounding skin, pain and dressing applied.
- ☐ Recognize rapidly progressive redness, necrosis, pain out of proportion, crepitus, severe drug rash, mucosal involvement, orbital/hand/genital infection or systemic toxicity.
- ☐ Use ABCDE/change principles to recognize a suspicious pigmented lesion and refer; CEPIEN does not train independent skin-cancer diagnosis.

PART IV — FOUNDATIONAL CLINICAL SKILLS

Procedures and medication-related skills listed in the CEPIEN framework, performed only under current authority and supervision.

20. Infection prevention and control

CRNA standards require routine practices and additional precautions based on point-of-care risk assessment. [11]

- ☐ Perform hand hygiene at the correct moments and use gloves only when indicated.
- ☐ Select PPE using the point-of-care risk assessment.
- ☐ Use aseptic or sterile technique according to the procedure.
- ☐ Clean/disinfect equipment and the environment using approved products and contact time.
- ☐ Dispose of sharps immediately without recapping.
- ☐ Manage blood/body-fluid exposure, needlestick or splash promptly through the current exposure pathway.
- ☐ Identify symptoms requiring additional precautions and protect vulnerable patients and staff.

21. Medication administration and injections

Medication administration is a restricted activity and must follow CRNA standards, current orders/directives, employer policy and individual competence. [9,10]

- ☐ **Verify the order.** Correct patient, indication, medication, dose, route, time/frequency, formulation and prescriber authorization.
- ☐ **Assess before giving.** Allergy/reaction, relevant vital signs, contraindications, hold parameters, weight and patient-specific risk.
- ☐ **Prepare safely.** Hand hygiene, calculation, independent double check where required, expiry, storage and aseptic technique.
- ☐ **Administer correctly.** Oral, intramuscular, subcutaneous or intradermal technique only after competency validation.
- ☐ **Monitor.** Observe therapeutic response and adverse reaction; know the emergency response.
- ☐ **Document.** Record medication, dose, route, site, time, lot/expiry when required, response and teaching.
- ☐ **Teach.** Explain purpose and expected effects in plain language and use teach-back.

CEPIEN does not add prescribing authority

Learners may administer medications and vaccines only under a valid order, directive or other legally supported process. They do not create or independently alter prescriptions through CEPIEN.

22. ECG acquisition and specimen handling

- **ECG.** Confirm identity and indication; prepare skin; place leads correctly; reduce artifact; label and transmit promptly; recognize technical failure and urgent symptoms. Acquiring an ECG is not equivalent to independently interpreting or ruling out ACS.
- **Specimens.** Use correct container, label at the bedside, verify identifiers, record collection time/source, maintain transport conditions and complete requisition details.

- **Chain of responsibility.** Know who receives results and what to do with critical or unexpected information. A learner does not assume result ownership beyond the assigned and supervised process.
- **Quality.** Repeat a compromised specimen or tracing when safe rather than submitting misleading data.

23. Wound care, suture removal and ear irrigation

Topic	Standard
Wound dressing	Assess wound and surrounding skin, pain, infection risk and current plan; cleanse and dress using approved products; document response and teaching.
Suture/staple removal	Confirm order/timing and wound approximation; stop for dehiscence, infection, retained material or unexpected pain; apply support strips when ordered/policy-supported.
Ear irrigation	Confirm indication, consent and contraindications; inspect both ears first; use approved temperature/pressure and equipment; stop for severe pain, bleeding, vertigo or neurologic symptoms; reassess after.
Escalation	Do not continue a procedure to “finish the task” when the patient deteriorates or findings are outside competence.

24. Pap testing and assistance with procedures

The CEPIEN framework lists Pap smear performance and assistance with nursing or primary-care procedures. These activities require explicit site authorization, appropriate education, patient consent, privacy, chaperone processes where applicable, specimen handling competence and direct supervision until competency is confirmed. [2,7,9]

- **Before.** Confirm indication/order, patient identity, consent, relevant history, equipment, privacy and infection-control requirements.
- **During.** Explain each step, preserve dignity, respond to pain or withdrawal of consent, and seek help for unexpected findings.
- **After.** Label specimens correctly, document the procedure and tolerance, provide instructions and ensure the appropriate clinician/result process is identified.
- **Limits.** Do not interpret abnormal cervical findings or independently diagnose; notify the responsible clinician according to policy.

PART V — TEAM PRACTICE, ESCALATION AND PROFESSIONAL DEVELOPMENT

Communication, telehealth, safety, portfolio, remediation and transition after CEPIEN.

25. SBAR and interprofessional communication

SBAR element	What to include
S — Situation	Identify yourself, patient, immediate concern, urgency and current stability.
B — Background	Relevant diagnosis/history, recent events, medication/allergy information and context.
A — Assessment	Vital signs/MEWS, focused findings, nursing impression and what has changed.
R — Recommendation / Request	State exactly what you need: immediate attendance, advice, order clarification, transfer, review or routine follow-up. Read back the agreed plan.

Escalation must be closed-loop

A task or message is not adequate for an emergency. Use direct verbal communication, confirm receipt, repeat back the plan and document the handover.

26. Telehealth, EMR tasks and continuity

- ☐ Confirm identity, location, callback number and immediate emergency plan at the start of a virtual/telephone encounter.
- ☐ Explain the limits of remote assessment and arrange in-person assessment when examination is needed.
- ☐ Use approved platforms and protect privacy in both locations.
- ☐ Route tasks/messages to the correct clinician with clear urgency, relevant findings and requested action.
- ☐ Do not assume a sent task has been read; use direct escalation for urgent concerns.
- ☐ Follow assigned tasks to closure and document the response.
- ☐ Avoid copying every team member unnecessarily; use the minimum necessary information and correct workflow.

27. Recognizing deterioration and emergency response

The learner's first responsibility is to recognize concern, call for help and follow the current CRMC emergency process. Diagnostic certainty is not required before escalation.

- ☐ Activate 911/EMS or the clinic emergency response for life-threatening concern.
- ☐ Use ABCDE and current BLS within certification and role.
- ☐ Obtain help, emergency equipment and vital signs without leaving an unstable patient alone.

- ☐ Administer oxygen, emergency medication or other intervention only under current policy, order/directive and competence.
- ☐ Provide a concise SBAR handover to EMS or the receiving clinician.
- ☐ Document time, observations, interventions, response and transfer.
- ☐ Complete the incident/debrief process and seek support after a distressing event.

Examples requiring immediate escalation

Severe respiratory distress, cyanosis, unresponsiveness, suspected stroke or acute coronary syndrome, uncontrolled bleeding, anaphylaxis, seizure with incomplete recovery, shock, severe trauma, rapidly worsening infection or any situation in which the nurse believes delay could cause serious harm.

28. Professionalism, feedback, conflict and personal security

- **Reliability.** Arrive prepared and on time; communicate absence or limitation promptly; complete records and assigned follow-up.
- **Professional identity.** Use the RN title accurately and do not imply advanced or prescriber authority.
- **Feedback.** Ask for specific observations, listen without defensiveness, clarify the expected change and demonstrate it in later practice.
- **Conflict.** Address concerns respectfully and directly when safe; use the programme escalation route for unresolved, discriminatory or patient-safety issues.
- **Speaking up.** Use graded assertiveness when concerned: clarify, state concern, identify risk and request action.
- **Security.** Know panic buttons, exits, duress codes, violence-prevention procedures, safe-room practice and lone-work rules.
- **Fitness to practise.** Report fatigue, illness, impairment or distress that could affect patient safety and seek support.

29. Portfolio and reflective practice

The CRMC portfolio guidance recommends current professional credentials, CV, registrations, academic records, specialty certificates, current BLS/ACLS where applicable, and a dedicated reflective section. [3]

- ☐ Updated CV and employment history
- ☐ CRNA permit and relevant regulatory correspondence
- ☐ Academic and language records
- ☐ BLS, WHMIS, immunization and other required certificates
- ☐ CEPIEN theory completion records
- ☐ Competency framework and assessor feedback
- ☐ Basic assessment and procedure logs using de-identified entries
- ☐ Reflective journal and learning plans
- ☐ Examples of patient education, communication or quality improvement
- ☐ Completion and remediation records
- ☐ Career plan and continuing-competence evidence

Reflection questions

What happened? What did I notice, assume or miss? Which standard or competency applies? What feedback did I receive? What will I practise or change? What evidence will show improvement?

30. Assessment, remediation and completion

Assessment should be based on observed performance across appropriate situations rather than one isolated event. A learner who has not yet reached Level 3 receives a specific learning plan, supervised practice and reassessment. Programme completion occurs only when all approved indicators are at the required level and outstanding administrative requirements are complete. [2]

Step	Action	Record
Identify	Describe the exact knowledge, skill, judgment, communication or professionalism gap.	Observation and learner discussion.
Protect	Increase supervision or pause the skill when patient safety requires.	Interim restriction or support plan.
Plan	Set learning activities, practice opportunities, timeframe and success criteria.	Written remediation plan.
Practise	Use demonstration, simulation, observation and feedback.	Practice log and feedback.
Reassess	Use a method matched to the gap and more than one observation when appropriate.	Reassessment result.
Decide	Confirm Level 3, extend remediation or apply the programme's unsuccessful-completion process.	Final programme decision.

31. Transition to employment and PCEPIENRP

CEPIEN completion supports employment readiness but does not guarantee a position. The learner remains responsible for CRNA renewal, currency of practice, continuing competence, liability protection, employer onboarding and maintaining competence. CRNA currently recognizes multiple routes to currency, including 450 practice hours in the previous two years or 1,125 hours in the previous five years, alongside other approved routes. [15,16]

The public CEPIEN page describes an optional Post-CEPIEN Retention Program. Its hours, fees, supervision, activities and termination terms must be stated in a current separate agreement. The learner should not rely on an older webpage or information sheet as the controlling contract. [1,20]

- ☐ Maintain an active practice permit and complete annual renewal requirements.
- ☐ Update the portfolio and continuing-competence plan.
- ☐ Seek references based on observed practice and programme policy.
- ☐ Prepare a Canadian-style CV and evidence-based interview examples.
- ☐ Clarify the scope, orientation and competency process of each new employer.
- ☐ Do not represent CEPIEN completion as specialization, prescribing authority or advanced-practice certification.

PART APPENDICES — LEARNER TOOLS AND PROGRAMME RESOURCES

Practical templates for learning and documentation; adapt only through approved document control.

Appendix A. Universal basic assessment checklist

- ☐ Identity, role, reason for contact and consent confirmed.
- ☐ Relevant record, medications, allergies and precautions reviewed.
- ☐ General appearance, pain and immediate ABC concern assessed.
- ☐ Full vital signs, AVPU and current local MEWS process completed when indicated.
- ☐ Focused history and relevant basic system assessment completed.
- ☐ Expected versus unexpected findings identified.
- ☐ Urgency and scope/competence limits considered.
- ☐ SBAR or correct EMR task/message used.
- ☐ Nursing action, patient teaching and follow-up documented.
- ☐ Feedback and competency evidence recorded when required.

Appendix B. Basic assessment quick map

System	Minimum basic components	Urgent examples
Respiratory	Rate/work, SpO_2, inspection, expansion, percussion/auscultation as indicated.	Severe distress, cyanosis, altered state, chest pain, inability to speak/feed.
Cardiovascular	Pulse, perfusion, edema, peripheral pulses, basic heart auscultation.	Shock, ACS concern, syncope, acute neuro deficit, cold pulseless limb.
Abdomen/renal	History, inspection, bowel sounds, percussion, gentle palpation, CVA tenderness when indicated.	Peritonism, severe pain, GI bleed with instability, ectopic/obstruction concern.
Neurological	Consciousness, speech, pupils, face/limbs, strength/sensation, gait if safe.	Sudden deficit, seizure with incomplete recovery, thunderclap headache.
HEENT/eye	Visual acuity when relevant, pupils/EOM, ear/otoscopy when trained, mouth/throat/neck.	Vision loss, severe eye pain, airway compromise, drooling, mastoid/orbital signs.
MSK	Mechanism, function, inspection, tenderness, movement, neurovascular status.	Deformity, open injury, neurovascular compromise, hot joint, severe trauma.
Skin/wound	Morphology, distribution, wound dimensions/tissue/exudate, surrounding skin.	Rapid progression, necrosis, pain out of proportion, systemic toxicity.

Appendix C. SBAR handover template

Topic	Standard
S — Situation	I am [name/role] calling about [patient]. The immediate concern is [...]. They are currently [stable/unstable].
B — Background	Relevant history, recent event/procedure, medications/allergies and context: [...].
A — Assessment	Vital signs/MEWS and focused findings: [...]. My nursing concern is [...].
R — Request	Please [attend now/review/order/advise/accept transfer] by [...]. Read-back: [...].

Appendix D. EMR task/message template

Topic	Standard
Subject	CEPIEN RN learner — [routine/urgent] — [patient issue] — [date]
Summary	Reason for contact, stability and key objective findings.
Action completed	Assessment/procedure/teaching/specimen/medication administration.
Concern	Unexpected finding, scope limit or follow-up need.
Request	Exact clinician action and timeframe, or “for awareness only.”
Closure	Response received, plan confirmed and responsibility documented.

Appendix E. Competency evidence record

Field	Learner entry / assessor entry
Competency indicator	
Date and clinical context	
Level observed: 1 / 2 / 3	
What the learner did well	
Specific improvement required	
Supervision/intervention required	
Learning action and timeframe	
Reassessment evidence	

Field	Learner entry / assessor entry
Assessor name/signature/date	

Appendix F. Portfolio checklist

- ☐ Cover page and professional profile
- ☐ Current CV
- ☐ CRNA permit and regulatory documents
- ☐ Academic qualifications and transcripts
- ☐ BLS/WHMIS/immunization and other required certificates
- ☐ CEPIEN theory records
- ☐ Competency framework and clinical log
- ☐ Assessment and remediation records
- ☐ De-identified reflective entries
- ☐ Quality-improvement or patient-education evidence
- ☐ Employment-readiness materials
- ☐ Continuing-competence plan

Appendix G. Theory curriculum map

The exact LMS course titles and sequence are controlled by the current CEPIEN syllabus. The learner should be able to connect theory to the following practice domains:

Domain	Learning emphasis
Canadian health system	Alberta primary care, team roles, patient pathways and regulated-profession responsibilities.
Professional regulation	Scope, standards, restricted activities, documentation, privacy, consent and continuing competence.
Communication	Therapeutic communication, professional English, SBAR, conflict, feedback and health literacy.
Clinical foundations	Vital signs, basic health assessment, deterioration, medication safety, IPC and common procedures.
Patient populations	Children, older adults, pregnancy, disability, mental health, equity and culturally safe care.
Digital practice	EMR, Netcare/approved systems, tasks, telehealth, cybersecurity and privacy.
Career integration	Portfolio, reflective practice, CV, interview preparation and employment expectations.

Appendix H. Learner onboarding checklist

- ☐ Active unrestricted CRNA RN permit verified
- ☐ Identity, admission and eligibility documents complete
- ☐ BLS and required certifications current

- ☐ Immunization and occupational-health requirements complete
- ☐ Background/vulnerable-sector screening complete
- ☐ WHMIS and IPC orientation complete
- ☐ Privacy, confidentiality and EMR access agreements signed
- ☐ Emergency, security and incident-reporting orientation complete
- ☐ Individual Schedule and theory access received
- ☐ Preceptor and escalation contacts confirmed
- ☐ Uniform, identification and attendance expectations understood
- ☐ Portfolio structure created

Appendix I. Programme governance and maintenance

Governance area	Approved standard	Maintenance responsibility
Programme schedule	The learner's Individual Schedule and current CEPIEN programme materials define the required hours, sequence and attendance expectations.	Programme leadership maintains one controlled schedule and updates learner-facing materials when programme delivery changes.
Theory curriculum	The current CEPIEN syllabus and LMS assignment list govern theory requirements and completion evidence.	Superseded course lists are archived and are not used for current learner assessment.
Fees and optional retention	Financial, employment and optional post-programme arrangements are governed by the applicable enrolment or retention agreement.	Programme administration maintains current financial and contractual terms separately from the clinical learner manual.
Level 3 standard	Programme completion requires Level 3 in every approved competency indicator together with completion of required hours, theory, portfolio and administrative requirements.	The CEPIEN assessment policy governs evidence thresholds, remediation, reassessment and appeal.
Registration and currency	Current CRNA requirements and the learner's practice permit govern registration, currency and continuing competence.	Programme leadership updates relevant materials when CRNA requirements or applicable legislation change.
Procedural privileges	Clinical skills are performed only within the learner's authorization, education, competence, supervision arrangement and current employer policy.	Competency sign-off confirms assessed performance but does not override regulatory or employer boundaries.
Document maintenance	This manual is an approved CEPIEN programme document managed through CRMC document control.	Review occurs at least annually and sooner when regulation, programme design, clinical policy or safety requirements change.

Appendix J. References — Vancouver style

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End of learner manual

Questions, errors, safety concerns or suggestions should be submitted through the current CEPIEN programme and CRMC governance process. Do not wait for the next scheduled review when a patient-safety concern is identified.