University of New England

School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

SECOND YEAR
HSNS 263 Nursing Practice: Focus on Integrated Care

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	Manning rural referral hospital
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	Shannon Weiley
PRECEPTOR CONTACT TELEPHONE:	0459323477
LOCATION (eg: town name):	Taree
WARD/UNIT:	Surgical
PLACEMENT DATES:	FROM 29 / 4 / 19 TO 10 / 5 / 19

For more information, additional copies of documents or questions related to your Clinical Record Book please contact the Clinical Office staff.

YOUR CLINICAL RECORD BOOK

Your Clinical Record Books have been designed to provide a permanent and progressive record of your achievement of the competencies for beginning professional practice. This record will provide you with guidance for your clinical development and will give you an opportunity to set clinical goals and monitor the achievement of these goals. Please refer to pp 71-74 of your Clinical Placement textbook for guidance (Levett-Jones, T and Burgeois, S 2015 'The Clinical Placement: An Essential Guide for Nursing Students" 3rd Edition Elsevier).

You are personally responsible for your Clinical Record Book and you are required to follow the following instructions:-

- Show your clinical book to your Clinical Partner/Facilitator when you commence your clinical placement to discuss your requirements for the placements.
- Keep this Clinical Record Book with you at all times during your clinical placements.
- Look after it.
- Keep it clear from food and drinks.
- Do not deface your Clinical Record Book in any way.
- Do not remove pages from your Clinical Record Book.
- Do not use whiteout/correction fluid under ANY circumstances
- **Follow carefully the instructions provided in the book to ensure that each document is correctly completed and signed by your designated Clinical Partner/Facilitator prior to leaving the facility.**
- Whilst on Clinical placement if no one is available to complete your clinical placement booklet, contact the Coordinator for Clinical/Field Learning or the Clinical Coordinator (Academic) and they will negotiate with the agency for a report to be completed and forwarded to this university.

This book is to be submitted in the Unit Moodle Site within one week of completion of the placement.

Students who do not submit the Clinical Record Book with the required documentation for each clinical placement may receive delayed or "Fail Incomplete" results for the unit to which the clinical placement relates.

CHECK LIST

DO THIS NOW

- ☑ Write your name, contact telephone number and student number on the front cover of this book.
- ☑ Fill in your *Placement Details* for the forthcoming placement.
- ☑ Complete your goals for this placement online.

DO THIS EVERY DAY

- ☑ Complete your ***Daily Attendance Time Sheet*** and have your Clinical Partner/Facilitator sign it.

DO THIS BEFORE YOU LEAVE THE PLACEMENT

- ☑ Make sure your ***Daily Attendance Time Sheet*** is completed and signed.
- ☑ Make sure your Clinical Partner/Facilitator has signed your ***Procedures Check List*** for procedures performed during this placement.
- ☑ Ensure your Clinical Partner/Facilitator has completed and signed your ***National Clinical Assessment Schedule (NCAS).***
- ☑ Check that you have achieved the ***Clinical Objectives*** set for this placement (where possible).
- ☑ Review your ***Personal Goals*** set for this placement; date those you have achieved. Ask your Clinical Partner/Facilitator to help you identify goals for your next placement (if applicable).

AT THE CONCLUSION OF THIS PLACEMENT

- ☑ **Submit your completed Clinical Record Book into the HSNS263 Assessment task in Moodle.**
- ☑ **You MUST keep your original clinical record book as it may be called on for auditing purposes.**
- ☑ **Students are reminded that they will require access to their ORIGINAL books for their portfolio. The Clinical Office will NOT be able to provide access to uploaded versions of their book.**

CONTACT INFORMATION

The Clinical Office

Work Integrated Learning Manager	Tania Robb
Contact details:	Phone: 6773 3680 Email trobb@une.edu.au
	Rhiannon Morgan-Wright
Placement Assistants:	Alisa Gray Kellie Lockyer
Contact details:	Phone: 6773 4388 Email nursingplacements@une.edu.au

Students are reminded to contact the Clinical Office Staff via the AskUNE system.

If we are unable to answer your call please leave your name, brief description of message, contact details and time you called and we will return your call as soon as possible.

Emergency/Crisis Support:	1300 661 927
Text Support	0488 884 196
Clinical Coordinator (Academic):	Fiona Barrett
Contact details:	Email: fcpnursing_academic@une.edu.au Phone: 6773 4388 Mobile: 0407 414 577
Mail:	The Clinical Office School of Health University of New England Armidale NSW 2351

UNE Student Nurse Clinical Assessment

INSTRUCTIONS FOR CLINICIANS
It is a UNE requirement that students must demonstrate sound clinical performance in order to complete their nursing theory units. Clinical Partners/Facilitators are requested to assess each student on the following:

Individual Nursing Skills
All compulsory assessment/skills assessments for this unit of study are included within this book. They are also outlined on the Procedure Achievement Summary (p9) "Compulsory Skills to be completed this placement".

Additionally you are asked to document (**sign/initial and date**) the development of clinical psychomotor skills on the Procedure Achievement Summary Form.

Any additional skills that are within the student's scope of practice that the student may have an opportunity to be assessed against, may be assessed using the individual skill assessments from the Tollefson text book.

Nursing Competency Assessment Schedule (NCAS)

The NCAS is a comprehensive validated evaluation tool that provides for a more standardised approach to assessment of nursing knowledge and skills in the clinical environment. This tool is used to assess students against the Registered Nurse Standards for Practice (2016).

This assessment tool is to be completed at the following times:

- At the time any issues are identified
- At the end of each clinical rotation, if in more than one area, to provide students with interim (formative) feedback;
- At the halfway point ***for any placement of 4 weeks duration*** to provide students with interim (formative) feedback;
- At the completion of the clinical placement (final/summative).

Completing the Assessment
Please refer to the NCAS Support Guide for assistance in completing this tool. Students are to be assessed regarding their ability to work towards achieving Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards.

It is expected that all Clinical Partners/Facilitators will review student's clinical goals at the beginning of the placement and assist the students to achieve or revise the goals where possible.

It is a requirement of the Nursing and Midwifery Board Australia (NMBA), that where the focus of the student's clinical experience is nursing practice, assessments and documentation relating to the students practice of nursing be completed and signed by a Registered Nurse at all times.

Scope of Practice

Students at this level are allowed to perform the skills listed below with Preceptor/Facilitator supervision.

COMPULSORY ASSESSMENT

- Regulatory/Statutory Competencies (NCAS) pp12-13
- Employer Competency; The initial and ongoing nursing assessment of a client/patient (NCAS) pp23-26
- Employer Competency; Caring for a client/patient requiring wound management (NCAS) pp27-29
- Employer Competency; Managing medication administration (NCAS) pp30-32
- Employer Competency; Managing the Care of a Client/Patient (NCAS) pp33-35
- Employer Competency; Monitoring and Responding to Changes in a Client/Patients condition (NCAS) 36-38
- Participation in basic documentation/charting (Tollefson) p39
- Clinical handover (Tollefson) p40
- Communicates in English (Procedure Achievement Summary) p9
- Communicates with others (Procedure Achievement Summary) p9

Fundamental assessments copy from Tollefson textbook

(as outlined on Procedure Achievement Summary (pp9-10)

Infection Control

- Standard precautions
- Hand washing and completion of NSW Health Hand Hygiene Certificate
- Aseptic technique/Wound care
  - Dry Dressing
  - Complex wounds - drain, suture or clip removal (including shortening of drains)
  - Complex wounds - wound irrigation
  - Complex wounds - packing a wound
  - Collection of specimens (MSU, CSU and Faeces)
  - Insertion/removal/maintenance of an IDC
  - Removal of IV Cannula

Patient Care

- Effective patient communication
- Assisting patients with nutritional needs (excluding patients with swallowing difficulties)
- Assisting with personal hygiene across the lifespan (mouth care, shaving, hair care and nail care, eye care)
- Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)
- Assisting with elimination needs (toileting, bed pans, urinals, commodes)
- Care and maintenance of indwelling catheter
- Assisting with mobility and use of mobility aids
- Pressure area care
- Range of motion, deep breathing and coughing exercises
- Assisting with lifting and positioning of patients using safe manual handling techniques
- Basic CPR
- Bed making
- Care of the body after death
- Respiratory interventions - Oxygen therapy
  - Suctioning
- Management of a person with a tracheostomy

Assessment

- Recording and interpreting of vital signs, blood glucose levels, urinalysis, height and weight across the lifespan, including basic pain assessment
- Admission of the patient across the lifespan and provision of support for next of kin, parent(s) or carer(s)
- Pre-operative and post-operative care
- Pain Assessment
- Respiratory assessment
    - Spirometry
- Cardiac assessment
    - Conduct and interpret an electrocardiogram
- Renal assessment

Documentation

- Document and interpret a care plan and integrated patient notes
- Recording and monitoring fluid balance charts

Medication Administration (adults and children)

- Calculate and administer doses of oral, topical and PR medications
- Administration of medications via a nebuliser
- Administration and management of oxygen therapy
- Calculation and administration of parenteral (injectable) medications (IMI, S/C,IVI)
- Monitor IV infusions (calculate rates of flow)
- Changing of IV/SC infusions
- Management of blood transfusions (****after completion of blood safe elearning package***)

The University of New England has provided both theoretical and/or practical classes on the skills described in this list.

Students are now prepared to perform these skills with Registered Nurse supervision. ***IMPORTANT NOTE: Students must comply with NSW Health and Institutional guidelines and protocols for the administration of medications and be supervised by an RN at all times when administering medications.***

DAILY ATTENDANCE TIME SHEET 80hrs Required

Day	Date	Time Start	Preceptor/ Facilitator Signature	Printed Name and Designation (RN) – must be RN	Time Finish	Preceptor/ Facilitator Signature	Printed Name and Designation (RN) – must be RN	TOTAL HOURS (not including meal breaks)	Preceptor/ Facilitator Signature	Printed Name and Designation (RN) – must be RN
Monday	29/4	0800		S Weiley RN	1630		S. Weiley RN	8		S. Weiley RN
Tuesday	30/4	1300		Elizabeth Samuels RN	2130		Elizabeth Samuels RN	8		Elizabeth Samuels RN
Wednesday	1/5	1200		S Weiley RN	2030		S. Weiley RN	8		S Weiley RN
Thursday	2/5	1300		J green RN	2130		J green RN	8		J green
Friday	3/5	0900		S Weiley RN	1530		S Weiley RN	8		S Weiley
Saturday										
Sunday										
Monday	6/5/19	0700		S Weiley RN	1530		S Weiley RN	8		S Weiley RN
Tuesday	7/5/19	0700		J. May RN	1530		J. May	8		J May.
Wednesday	8/5/19	0700		S Weiley RN	1530		S Weiley RN	8		S Weiley RN
Thursday	9/5/19	0700		S Weiley RN	1530		S Weiley RN	8		S Weiley RN
Friday	10/5/19	0700		S Weiley RN	1530		S Weiley RN	8		S Weiley RN
Saturday										
Sunday										
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

STUDENT DECLARATION: I declare that the hours documented are a true reflection of the hours worked. (Student Signature).....

SICK DAY/S MUST BE DOCUMENTED ON TIME SHEET – Please include Medical Certificates

NB: Medical Certificates **must** be from a medical doctor. Pharmacy Certificates or invoices are not acceptable.

PROCEDURE ACHIEVEMENT SUMMARY

A Registered Nurse is requested to sign and date the procedures in the appropriate column.

	Safe Practice Demonstrated		Needs more Supervised Practice	
COMPULSORY SKILLS TO BE COMLETED EACH PLACEMENT	**RN Signature**	**Date**	**RN Signature**	**Date**
Regulatory/Statutory Competencies (NCAS) p12-13	[signature]	10/5/19		
The initial and ongoing nursing assessment of a client/patient (NCAS) p23-26	[signature]	3/5/19		
Caring for a client/patient requiring wound management (NCAS) p27-29	[signature]	9/5/19		
Managing medication administration (NCAS) p30-32	[signature]	8/5/19		
Managing the care of a client/patient (NCAS) p33-35	[signature]	8/5/19		
Monitoring and responding to changes in a client/patient condition (NCAS) p36-38	[signature]	3/5/19		
Participation in basic documentation/charting (Tollefson text) p39	[signature]	3/5/19		
Clinical handover (Tollefson text) p40	[signature]	9/5/19		
Communicates effectively in English	[signature]	2/5/19		
Communication with others	[signature]	2/5/19		
FUNDAMENTAL ASSESSMENTS *(copy competency from Tollefson text and upload completed assessment with your Clinical Record Book)*				
Infection Control				
Standard precautions	[signature]	2/5/19		
Hand hygiene (Tollefson text p12)	[signature]	2/5/19		
Aseptic technique/Wound care				
- Dry Dressing technique (Tollefson text p377)	[signature]	9/5/19		
- Complex wounds - drain, suture or clip removal (including shortening of drains) (Tollefson text p383)				
- Complex wounds - wound irrigation (Tollefson text p388)				
- Complex wounds - packing a wound (Tollefson text p393)				
- Collection of specimens (MSU, CSU and Faeces)				
- Insertion/removal/maintenance of an IDC				
- Removal of IV Cannula				
Patient Care				
Effective patient communication	[signature]	3/5/19		
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)				
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, eye care) (Tollefson text p282)				
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower) (Tollefson text p276)				
Assisting with elimination needs (toileting, bed pans, urinals, commodes) (Tollefson text p172)				
Assisting with mobility and use of mobility aids (Tollefson text p292)				
Pressure area care (Tollefson text p297)				
Positioning a dependent patient (Tollefson text p288)				

	Safe Practice Demonstrated		Needs more Supervised Practice	
	RN Signature	Date	RN Signature	Date
Range of motion, deep breathing and coughing exercises				
Assisting with lifting and positioning of patients using safe manual handling techniques				
Basic CPR				
Bed making	[signature]	31519		
Care of body after death				
Respiratory interventions				
- Oxygen therapy via Nasal Cannula or various masks (Tollefson text p308)				
- Suctioning (Tollefson text p328)				
Management of a person with a tracheostomy				
Assessment				
Recording and interpreting of blood pressure; temperature, pulse and respiration (TPR) measurements (Tollefson text p204, 209)	[signature]	31519		
Recording and interpreting of height, weight and waist circumference measurement (Tollefson text p197)				
Recording and interpreting of blood glucose measurement (Tollefson text p223)				
Admission of the patient across the lifespan and provision of support for next of kin, parent(s) or carer(s)				
Pre-operative care (Tollefson text p254)				
Post-operative care (Tollefson text p269)				
Pain assessment				
Respiratory assessment - Spirometry				
Cardiac assessment - Conduct and interpret a 12 lead electrocardiogram (Tollefson text p54-59)				
Renal assessment				
Documentation				
Document and interpret a basic care plan and integrated patient notes	[signature]	9/5/19		
Recording and monitoring fluid balance charts				
Medication Administration (adults and children)				
Calculate and administer doses of oral, topical and PR medications (Tollefson text p148-164)	[signature]	8/5/19		
Administration of medication via a nebuliser				
Administration and management of oxygen therapy				
Administration of parenteral (injectable) medications (IMI, S/C) (Tollefson text p174)				
Administration of parenteral (injectable) medications (IV) Tollefson text p185-192				
Monitor IV infusions (calculate rates of low)				
Changing of IC/SC infusions - maintenance fluid only				
Management of blood transfusions ***(on completion of bloodsafe learning package)***				

ADDITIONAL ACTIVITIES

e.g. Attended In-service Wound care, involved in Simulation, Ground Rounds

→ attended Nursing grand rounds on the management of local anesthetic toxicity.

→ attended cultural awareness presentation/seminar.

→ attended a presentation on the management, monitoring and administration of electrolytes in the acute care setting.

Nursing Competency Assessment Schedule-NCAS

Registered Nurse Standards for Practice (NMBA 2016)

INTERIM	FINAL
	✓

Please insert your initials

TRIMESTER 1 / YEAR 2

Standard 1 to 7 (RN assessor- Please place your **initials** in the appropriate column)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)	Not Assessed
Standard 1 (Please place your ***initials*** in the appropriate column)						
Thinks critically and analyses nursing practice	✓					
Standard 2 (Please place your ***initials*** in the appropriate column)						
Engages in therapeutic and professional relationships	✓					
Standard 3 (Please place your ***initials*** in the appropriate column)						
Maintains the capability for practice	✓					
Standard 4 (Please place your ***initials*** in the appropriate column)						
Comprehensively conducts assessments		✓				
Standard 5 (Please place your ***initials*** in the appropriate column)						
Develops a plan for nursing practice	✓					
Standard 6 (Please place your ***initials*** in the appropriate column)						
Provides safe, appropriate and responsive quality nursing practice	✓					
Standard 7 (Please place your ***initials*** in the appropriate column)						
Evaluates outcomes to inform nursing practice	✓					

How would you rate the overall performance of this student during this clinical practicum ***(please initial)*** :

Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent ☒

Nursing and Midwifery Board of Australia (NMBA) 2016, *Registered Nurse Standards for Practice*.
Modified from: Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', *Journal of Nursing Education*, vol. 22(9), pp. 376-381.

Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skillful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Scoring guide:

- ONLY ***initial*** (not assessed) if the student has not had an opportunity to be exposed to and therefore demonstrate the standard.
- Any item not assessed should not be scored.
- You should only ***initial*** one column for each of the one to seven descriptors
- Evaluate the student's performance against the ***minimum*** standard level expected for a beginning/entry level registered nurse.

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection)

During my 3 weeks of clinical placement I have gained an extensive amount of knowledge and experience through my clinical practice. I have found myself to be more confident around my patients and am able to provide them with my best possible care. I have enjoyed working on a surgical ward and observing and involving myself on how the ward runs. It has allowed me to expand my knowledge and capabilities in nursing whilst working in a supportive learning environment.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical placement? ***(please initial)***

Unsatisfactory ☐ Satisfactory ☐ Good ☒ Excellent ☐

Comments by RN: (please ***initial***)

INTERIM	FINAL

Well done on a successful placement. You have actually progressed extremely quickly in this second week. I have seen you reflect, provide clinical reasoning and apply critical thinking to situations as opposed to performing nursing tasks in isolation. I have enjoyed watching your growth in such a short period of time. You should be proud of your effort and achievements. Hopefully I get to work with you again in the future. Best of luck ☺ You are going to make a great RN.

Continue on a separate sheet if necessary

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 10/5/19

Clinical facilitator: *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 10/05/19

Guidance for both the -

- **Assessor to verify that the student has met the standard and**
- **Student to have a clearer understanding of what is expected.**

STANDARD 1:
THINKS CRITICALLY AND ANALYSES NURSING PRACTICE

RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.
The registered nurse:

1.1 accesses, analyses, and uses the best available evidence, that includes research findings, for safe, quality practice
1.2 develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice
1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures
1.4 complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions
1.5 uses ethical frameworks when making decisions
1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations, and
1.7 contributes to quality improvement and relevant research.

OBSERVATIONS
Knows when to utilise policy-procedure & best evidence
Has capability to engage with systems to locate evidence in practice
Demonstrates competence in practice, reflects on practice and acknowledges own scope
Problem solving evident in the students decisions & actions
Questions nursing actions but is not 'hamstrung' by over analysis
Considers own (and others) scope when delegating
QUESTIONS
Why/what/when/how are you doing….?
Articulates theory supporting their practice
Participates in quality improvement activities
What's hospital accreditation mean and why is quality assessment important you?
Knows actions to initially take to assess client/patient
Use of resources to support Evidence Based Practice
Can give examples of best practice
Consultation with Multidisciplinary/Interdisciplinary Health Care Team (M/IDHCT)
MEASUREMENTS
Reviews client/patient notes and uses appropriate model
Uses assessment tools uses; (i.e. falls/pressure) 'wound trace', 'Braden score' etc.
Identifies hospital/agency bench-marking
Displays sound clinical knowledge base through data interpretation
Carries out the task successfully and appropriately

STANDARD 2:
ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS

RN practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships.
The registered nurse:

2.1 establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships
2.2 communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights
2.3 recognises that people are the experts in the experience of their life
2.4 provides support and directs people to resources to optimise health-related decisions
2.5 advocates on behalf of people in a manner that respects the person's autonomy and legal capacity
2.6 uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes
2.7 actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care
2.8 participates in and/or leads collaborative practice, and
2.9 reports notifiable conduct of health professionals, health workers and others.

OBSERVATIONS	
Uses appropriate language	Interaction is engaging
Communicates effectively with the team both nursing and multi-disciplinary (attitude & demeanor)	Empathetic & knowledgeable practice within social context
When clients/patients are unwell is the level of care/basic needs being met (within reason?);	Ability to problem solve and direct clients/patients appropriately
Behaves in a manner that makes peers & colleagues and patients/clients comfortable and is non-threatening;	Appropriate level of quality of working, communication (written & verbal) and relationships with other professionals
Listens and responds appropriately	Handover info is accurate and timely
Recovery model used, with the clients/patients journey	Agrees/adheres with treatment plans for care from all Inter Disciplinary Health Care Team
Evidence of cultural & racial respect	Professional role articulated clearly
Student initiates conversation/interactions appropriately (valuing-privacy/safety/quietness) and adjusts strategies as required in different situations based on ongoing evaluation	Able to identify policy/procedure and Evidence Based Practice/Protocols (EBP) illustrating safe and pertinent ways of working;
Confidentiality is appropriate	Continuity of care/communication;
Clear advocacy evident	Shows knowledge of clinical nursing practice;
Appropriate communication and dress for the context	Enhancing & growing communication skills repertoire;
Accesses team/services within cultural boundaries	Willingness to learn and to be polite and respectful;
Seen undertaking appropriate and timely competent care (within scope of practice and competency)	Are positive behaviours (from client/patient/family) attributed i.e. are strengths acknowledge and commented on?
Identifies and shares new information with all Multidisciplinary/Interdisciplinary Health Care Team (M/IDHCT) as appropriate care provided is documented in an appropriate and timely manner; Prepared for M/IDHCT meetings;	Applies body of knowledge and experience/personality in delivery of health care
	Evidence of joining/engaging/communicating behaviours
	Checks for satisfaction (colleagues & clients/patients);
Clearly operates within professional boundaries	Exhibits trust and confidence;

QUESTIONS:	
Examples are cited that relate to areas of care e.g. Speech pathology for a person with having suffered a cerebro-vascular accident (CVA) and their ability to swallow safely;	Accurate documentation for referral/assessment and ongoing care & treatment leading to discharge using correct documentation and referral methods;
Ensuring that the student is aware of the need for consent and agreement;	Are the set goals and strategies reasonable regarding best available evidence and client's/patient's wishes;
How would identify if cultural practice is required?	
Honesty/upfront regarding well-being;	Maintains privacy and confidentiality (even if suicidal);
Does student demonstrate engagement strategies?;	
Being clear about the RNs role and the role of others in the multidisciplinary team;	Questions peers and clients/patients to learn more of the social context.
Responds appropriately to feedback from clients/patients;	Plan for anticipated and 'unanticipated' changes in the client's needs;
MEASUREMENTS:	
Evidence of comfort whilst working/talking with clients/patients of different ages/cultures etc:	Health outcomes are appropriately assessed through data and peer review;
Identification of the need for additional support/guidance (based on evaluation);	Ensure as a coordinator that multidisciplinary team fulfilling their brief (patient advocacy);
Risk assessment with appropriate reporting of risk issues immediately;	Appropriate level of consultation with community and individuals.
Clear evidence of appreciating and dealing with functional level of clients/patients;	Use appropriate language and documentation to communicate with the M/IDHCT;
Clinical practices commensurate with practitioner level (beginning);	Relates to discharge resources required in a timely way;
Self-evaluation;	Evidence of clients willingness to change;
Appropriate use of language;	Seeks to extend knowledge about multidisciplinary team.
Client returns for next session;	
Identify needs and match to services in a timely manner;	Uses and documents systematic & holistic assessment;
Scenarios offered/Other: Communicator / "transferor" / coordinator; Respect/confidently-competently-appropriately; role clarity/ perception/ 3rd Year confidence	

STANDARD 3:
MAINTAINS THE CAPABILITY FOR PRACTICE

RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe, and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals' capability for practice. RNs are responsible for their professional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health. The registered nurse:

3.1 considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice
3.2 provides the information and education required to enhance people's control over health
3.3 uses a lifelong learning approach for continuing professional development of self and others
3.4 accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role, and for the actions of others to whom they have delegated responsibilities
3.5 seeks and responds to practice review and feedback
3.6 actively engages with the profession, and
3.7 identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people.

OBSERVATIONS
Knows and verbalises critical appraisal of situations in a supportive manner
Questions practice of others
Engages in clinical discussion about client/patient progress with M/IDHCT
Accesses journals & databases / evidence through research and policies/procedures;
Utilises reflective practice; conducts education sessions
Uses an established communication model
Recognises own limitations/scope of practice
Role models
Assists team members, mentors students/peer supports and shares best practice/knowledge
Understands own learning needs
Open to guidance by others (including juniors)
Uses preceptor for support & debriefing as well as fulfils role for others;
Appears confident/comfortable in work
Objectively receives and gives feedback
Relates care to care plan
Shows initiative within their scope of practice
QUESTIONS
What resources do you have/use?
How could that be done better?
How will you share your knowledge with others?
Have you or how do you contribute to the learning of another?
Awareness of policy/procedure
Challenges existing frameworks
Seeks clarity of orders.
Tell me what prompted you to….?
What additional education might you need?
Do you engage in journal clubs?
Understands registration requirements; explores policy/procedure when faced with a new skill
Follows guidelines; uses critical thinking
Membership of a professional group/organisations

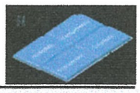
MEASUREMENTS
Self education
Evidence of reflection and appropriate use of models
Analyses orders to be given; completes all documentation appropriately care plans and assessment tools
Feedback on pt education/consumers/carers
Attends in-services/development seminars
Follows guidelines
Uses critical incidents and case studies to embody learning; shares a reflective journal
Other: Attends short courses and participates appropriately

STANDARD 4:
COMPREHENSIVELY CONDUCTS ASSESSMENTS

RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice.
The registered nurse:

4.1. conducts assessments that are holistic as well as culturally appropriate
4.2. uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice
4.3. works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/ or for referral, and
4.4. assesses the resources available to inform planning.

OBSERVATIONS
Systematic/accurate/holistic approach through use of a framework
Uses appropriate communication / language when undertaking assessment / hand-over: using "life skills profile"
CHIPPA (Communication/ History / Inspection / Percussion / Palpation / Auscultation):
Reviews charts/past data to see what info was gathered
Relies on theory and evidence to conduct assessment; utilises appropriate equipment
Appropriate response/nursing action to the data collected i.e. plans (and prioritises both in assessment and in planning)
Listens and questions appropriately in a culturally sensitive & aware manner
Seeks clarity of assessment data and responds positively to feedback as well as asks for assistance when required (scope issue)
Spends time with the clients
QUESTIONS
Why did you use that-tool/assessment/approach, etc?
What assessment frameworks/tools do you know?
Understands Care planning & delivery based on appropriate assessment and uses the multidisciplinary team.
MEASUREMENTS
Evidence gathered is appropriate and accurately documented
Includes clear risk assessments when necessary
Notes reflect clients/patients changes
'Sees' connectedness of presentation with assessment and presentation and diagnosis
Taking and recording accurate physiological and other measurements when necessary
Uses and documents range of assessment techniques
Can perform assessment skills
Can articulate decision process clearly
Scenarios offered/Other: Admission processes/ assessment processes. Patient assessment – focused / Tools / Techniques / Frameworks / Linking / communication; Education knowledge / tools: application: Use case scenario and then observe student articulate critical thinking & analysis. Wound assessment. May use nursing diagnosis



STANDARD 5:
DEVELOPS A PLAN FOR NURSING PRACTICE

RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the RNs appraisal of comprehensive, relevant information, and evidence that is documented and communicated.

The registered nurse:

5.1 uses assessment data and best available evidence to develop a plan

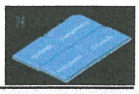
5.2 collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and timeframes are agreed with the relevant persons

5.3 documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes

5.4 plans and negotiates how practice will be evaluated and the time frame of engagement, and

5.5 coordinates resources effectively and efficiently for planned actions.

OBSERVATIONS
Follows agreed clinical pathway(s) and makes appropriate decisions promptly (incorporating Allied Health Professional recommendations)
Can form an appropriate care plan for new admission
Appropriate response/nursing action to the data collected i.e. plans (and prioritises both in assessment and in planning)
Documents/hands-over relevant information (for all clients/patients)
Effective organisational skills
Works within a safe practice framework
Thorough risk assessment of self and others and clients/patients; note taking strategies are contemporaneous and appropriate
Appropriate interaction/conversation with clients/patients and family and the multidisciplinary team leading to identification of agreed achievable documented goals (admission to discharge)
Uses appropriate bio-psycho-social assessment with 'correct' communication skills
Thinks about 'tomorrow' *(planning ahead?)*
Observed undertaking care and responding appropriately and promptly
Clear demonstration of knowledge re: health issues
QUESTIONS
Explore how a shift might be planed and prioritizing care appropriately
Have referrals been sent to M/IDHCT & *would you know how to?*
When should you seek clarification on particular criteria/rules? (E.g. restraint/medicine administration: documentation/consent/ evaluation)
Integrates knowledge and data analysis in terms of critical thinking
Are the clients/patients & family satisfied with the care? *How would you know?*
Explore how to plan a shift and prioritise: Are you able to prioritise the most acutely ill clients/patients in your care?
Referrals to others "DASSA" (sic Drug and Alcohol Services), counseling, psychiatry
Location of appropriate support/services and location
MEASUREMENTS
Documents are appropriately utilised to show a clear plan of care to order to manage pt load
Shows that there is appropriate bio-psycho-social assessment with 'correct' communication skills
Is performance as would be expected regarding (e.g. time management and health comes).
Compare data from that setting/area with the overall service (e.g. Hospital Acquired Infections, (HAI's) etc.)
Identifies needs of clients/patients and/or expected outcome
Is the nurse able to tell if the clients/patients are making appropriate progress *(how would you know?)*
Knows who to contact and who to pass on info to achieve health outcomes



STANDARD 6:
PROVIDES SAFE, APPROPRIATE AND RESPONSIVE QUALITY NURSING PRACTICE

RNs provide and may delegate, quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment, and the best available evidence to achieve planned and agreed outcomes.

The registered nurse:

6.1 provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people

6.2 practises within their scope of practice

6.3 appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse's scope of practice or others' clinical or non-clinical roles

6.4 provides effective timely direction and supervision to ensure that delegated practice is safe and correct

6.5 practises in accordance with relevant policies, guidelines, standards, regulations and legislation, and

6.6 uses the appropriate processes to identify and report potential and actual risk related system issues and where practice may be below the expected standards.

OBSERVATIONS	
Uses protocols/ procedure / documentation to support decision making	Promptly responds to unsafe practice; seen undertaking and responding appropriately
Behaves in a manner that makes peers & colleagues and patients/clients comfortable and is non-threatening	Communicates effectively with the team both nursing and multi-disciplinary (attitude & demeanor)
Interaction is engaging/ listens and responds appropriately	Seen undertaking appropriate and timely competent care
Reflection on outcomes	Uses appropriate language
High standards of client/patient care	Clearly operates within professional boundaries
Follows and evaluates care and/or treatment plan at start of period of duty and during span of care;	Produces a plan to assist/guide the management of care
Shows knowledge of clinical nursing practice	Identifies and uses resources (people and kit)
Accepts the client/patient as a partner rather than recipient of care	Uses language and appropriate cultural approaches to meet the needs of the client/patient in terms of care and information
Deals with unexpected events	
Terminology is appropriate and abbreviations are avoided	Constructively delegates/negotiates with others acknowledging scope of practice
How much direction does the student need and do they seek guidance?	Does the student manage the task in accordance with the scope of practice
Consults clinical notes appropriately	Timely and appropriate delivery of care
Team player including effective communication	Acts as the clients/patients advocate and ensure clients/patients safety
Liaises with the multidisciplinary team and Allied Health Professionals	See student undertaking client/patient teaching taking place effectively and appropriately
Applies body of knowledge and experience / personality in delivery of health care	Clinical practices commensurate with practitioner level (beginning)
QUESTIONS	
When would you use/apply particular criteria/rules? (e.g. restraint / medicine administration: documentation / consent / evaluation)	How might your responses reflect the local policy-procedure & best evidence?
How might you respond to pts request? (E.g. address as / advocacy):	Demonstrates effective skills that meet best practice guidelines and can articulate the rationale

Prioritises actions and acts in a timely manner if a client/patient is deteriorating and/or there are other clinical variations	Can explain rationale for the appropriate delegation of care – what will you do to demonstrate safe/timely care in those circumstances?
Can articulate processes clearly.	Appreciates the importance of understanding the client/patients condition / therapy / intervention.
Can you explain the rational for the care provided?	
MEASUREMENTS	
Documents are appropriately utilized	Presents clear evidence of progress (OR NOT) of clients/patients
Exception reporting is evident	Recalls info and when and how to use
Documentation e.g. such as handover notes are appropriately utilised & accurate report writing	Demonstrates that they can manage varying client/patient /RN ratios in a timely and appropriate manner
Does the student make clear challenges to scope of practice?	Care is sensitive to 'case' shows understanding of costings per case
Clients/patients safely discharged home	
Aware of wider evidence and this is clear in how they use evidence in practice;	Minimal wastage/healthy clients/patients / satisfied clients/patients
Scenarios offered/Other: Restraint and how it is used/needle stick injury and management & reporting/work colleague being ill/pain management; communication/professionalism/policy and guidelines/respect & dignity/problem solving/deals with deteriorating patients. Provides care and rationale for clients/patients care plan; creates and uses written care plan; ability to develop knowledge base to enable them to provide individuals with the right education – listening/communication rapport/recognises own lack of knowledge; Delegates appropriately; knows if care has been met or not; prioritises care of critical clients/patients; Knows when care to be delivered is outside scope of practice Leadership of clients/patients care/Team working & Education for all / recognises clients/patients issues/effective time management/attends education sessions	

STANDARD 7:
EVALUATES OUTCOMES TO INFORM NURSING PRACTICE

RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly.
The registered nurse:
7.1 evaluates and monitors progress towards the expected goals and outcomes
7.2 revises the plan based on the evaluation, and
7.3 determines, documents and communicates further priorities, goals and outcomes with the relevant persons.

OBSERVATIONS
Problem based learning
Contributes to the multidisciplinary team case presentations; handover verbal/written
Demonstrates understanding *of all stages of the process*
When clients/patients are unwell is the level of care/basic needs being met (within reason?)
Documentation and feedback
Interview with clients/patients and family
Clear outputs that relate to client/patient progress
Team meetings, case presentations, care plans and development in an ongoing way
Involves clients/patients in discussion
Check care plans
Inter-professional liaison and collaboration
Uses critical thinking to interpret clients/patients progress
QUESTIONS
Acknowledging ongoing interpretation
Rationale presented clearly for clients/patients progress towards outcomes
Do you ask how the client/patient feels about….X?
Are the clients/patients & family satisfied with the care? (*How would you know?)*
How do you consult?
Clear progress assessment in practice
Use benchmarks to evaluate and measure
Progress questioning.
MEASUREMENTS:
Documents are accurate
Case based information access and Observed Structured Clinical Assessments (OSCAs)
Complies with managed clinical pathways / protocols
Clear progress towards recovery (OR NOT) of clients/patients
Critically analyses/evaluates relevant data
Scenarios offered/Other: Enquiry; Tools; observe predetermined situations (wound care/medicines/client care etc.) including OSCAs.

Initial and Ongoing Nursing Assessment of a Client-Patient Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	The initial and ongoing nursing assessment of a client/patient (should include first contact)
Demonstration of:	The ability to effectively and safely assess the needs of a single client/patient.

	Performance Criteria (RN assessor please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	**Independent: (I)**	**Supervised: (S)**	**Assisted: (A)**	**Marginal: (M)**	**Dependent: (D)**
PREPARATION FOR INITIAL CONTACT WITH THE CLIENT/PATIENT	1. Identifies specific indications for contact / communication / action with the client/patient (i.e. what initial information is available, if any?).	1.2, 1.3, 1.5, 4.5, 6.1, 6.5.	✓				
	2. Verifies the validity of any written information concerning this client/patient.	1.6, 4.5, 5.1, 6.5	✓				
	3. Reviews the patient documentation / history / information / medication chart / communication(s) from members of the healthcare team and others (family/friends etc).	1.4, 4.1, 4.5, 5.1, 6.5	✓				
	4. Effectively and in a timely manner performs hand hygiene.	1.1, 1.2, 2.2, 3.1, 6.5	✓				
	5. Gathers the necessary equipment for assessment (if appropriate) includes assessment documentation.	1.6, 4.1	✓				
	6. Locates & greets the client/patient & "*takes in*"/assesses a range of cues (visual, auditory and olfactory) at the point of contact.	1.1-6, 2.1-3, 3.1, 4.1, 4.2, 4.3, 5.1, 6.5, 7.1	✓				
	7. Effectively carries out an initial client/patient assessment analyzing and critically evaluating those initial findings.	4.1, 4.4, 5.2, 6.5		✓			
	8. Responds promptly and appropriately should the outcome of the initial assessment require immediate escalation.	5.2, 7.1, 7.2	✓ N/A				
	9. Makes the client/patient 'feel at ease, and identifies the client/patient's ability to engage visually / verbally / cognitively and physically (i.e. their motor response).	2.1, 2.2	✓				
CARRYING OUT THE INITIAL NURSING ASSESSMENT OF THE CLIENT/PATIENT	10. Effectively carries out a comprehensive and systematic assessment with / of the client/patient; i. Notes/'senses' impression; ii. Gathers a range of evidence from patient and 'family'; iii. Utilises appropriate assessment equipment and iv. Appropriate assessment tools; v. Acts with appropriate urgency should the need be evident during the nursing assessment; vi. Other: Please specify:	4.1-4, 5.1, 6.5, 7.2 i. ✓ ii. ✓ iii. ✓ iv. ✓ v. N/A vi. *May not be necessary* N/A ✓					
	11. Clear evidence of a developing rapport and a therapeutic relationship in the interaction with the client/patient.	1.1-7, 2.1, 2.2	✓				
	12. Uses a range of questioning styles and demonstrates appropriate listening skills.	1.2, 2.1, 2.2, 2.3,5.1, 7.1	✓				
	13. Demonstrates a communication style that is purposeful & professional in demeanour illustrating a sense of caring.	1.2, 2.1, 2.3	✓				

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
CARRYING OUT THE INITIAL NURSING ASSESSMENT OF THE CLIENT/PATIENT	14. Explores, through the use of an appropriate framework, dimensions for gathering a health history; a. Social; b. Emotional; c. Physical and developmental; d. Intellectual e. Spiritual and f. Considers Health education and Health promotion opportunities.	1.1-7, 4.1-4, 5,1, 5.3, 7.1	a. b. c. d. e. f.	A A A A A A				
	15. Acknowledges and values data from a variety of sources bringing 'meaning' to the findings of the nursing assessment.	4.1, 4.2, .5.1, 5.3		A				
	16. Documents a plan of care in agreement with the client/patient and significant others that uses the framework utilised above (e.g. Activities of Living).	1.3, 1.4, 4.1, 6.5, 7.3		A				
	17. Evidence of a developing therapeutic relationship with the client/patient; e.g. gives client/patient a clear explanations regarding the nursing assessment.	2.1, 2.3, 3.1, 5.2,		A				
	18. Maintains dignity at all times, provides privacy and comfort measures – displays problem solving abilities particularly related to; i. the maintenance of appropriate personal space; ii. the management of boundary issues and iii. any other; Specifically:_____	1.3, 1.4, 2.1 4.3, 4.4 *May not be necessary*	i. ii. iii.	A A N/A A				
	19. Monitors the patient according to local policy / procedure / best evidence.	4.4, 5.1, 6.5, 7.1		A				
	20. Ensure patient is positioned appropriately and comfortably & prepared for any intervention in this period (paying particular attention to DRABCD). ***(e.g. airway, breathing, circulation, etc)***	1.2, 2.1, 2.2, 5.3, 6.1, 6.2, 7.1		A				
	21. Prepares any intervention/medication and completes them appropriately and in a timely, safe and effective manner.	6.1, 6.5, 7.1		N/A A				
	22. If necessary uses safe medicine administration and employs safe practices during any interventions with the client/patient during the assessment period.	1.1, 1.2, 1.3, 2.1, 2.5, 3.2, 4.2, 5.1, 5.2		N/A A				
	23. If necessary assists the patient to take the medication or deal with the intervention.	1.2, 7.1		N/A A				
	24. Implements appropriate beginning discharge planning, health education and promotion and teaching to client/patient and carer(s).	1.3, 1.4, 1.6, 3.3, 4.3, 4.4, 5.2, 6.5, 7.1, 7.2, 7.3			A			
CLOSING THE ACTIVITY	25. Concludes the nursing assessment period with the client/patient by considerately concluding the therapeutic relationship.	2.1-5		A				
	26. Facilitates client/patient repositioning to maintain privacy dignity, ensures comfort as far as possible at that point.	1.1, 1.4, 2.1, 3.1, 5.4, 7.2		A				
	27. Cleans/tidies area; disposes of any waste appropriately and as soon as is practicable; removes gloves & other PPE (as necessary); performs hand hygiene appropriately.	6.5		A				

	28. Replaces, cleans and/or disposes of equipment appropriately.	6.5					

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
DOCUMENTATION & COMMUNICATION	29. Reporting and Recording of relevant information: i. Findings from assessment and possible nursing diagnoses; ii. Nursing Care; iii. Medication chart; iv. Other if appropriate (e.g. particular assessment chart) Specify i.e. plan Waterlow, Falls (Frame)	3.4, 5.4, 6.5, 7.1, 7.2, 7.3 *May not be necessary*	i.		A			
			ii.		A			
			iii.	A				
			iv.	A				
EDUCATIONAL OPPORTUNITY	30. Demonstrates ability to reflect on the activity and to link theory to practice i. Relates to decisions made, ii. Evidence utilised and iii. Implications for assessing & planning of client/patient care.	1.1, 1.2, 1.6, 3.2, 5.1	i.	A				
			ii	A				
			iii.	A				

Berman, A et al 2014 ***Kozier & Erb's Fundamentals of Nursing***, 3rd Ed (Aust), Pearson, Australia
Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', ***Journal of Nursing Education***, vol. 22(9), pp. 376-381
Crisp, J & Taylor, C 2013 ***Potter and Perry's Fundamentals of Nursing***, 4th Ed, Elsevier, Australia
Tollefson, J 2015, Clinical psychomotor skills: assessment tools for nursing students, 4th Ed., South Melbourne, Vic. Cengage learning, Australia.

Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skilful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection).

over the 3 weeks of placement I have become more confident in ongoing nursing assessment of a client/patient. Being placed on a surgical ward I have cared for and observed patients with varying conditions and levels of health. I have gained more confidence in looking after a patient and am slowly becoming able to detect and respond to changes

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Comments by RN:

You have demonstrated an ability to conduct patient' assessments including, vital signs, falls risk, skin integrity, etc. In order to further develop, as discussed, apply an A-G format to your assessment, think of the relevance of each assessment, combine obs with your own assessment ie BP → capillary re-fill, hot, cold hands, short of breath, any odema in legs? Consider what the results mean and how they may link to ~~comorbiditi~~ comorbidities, diagnoses or meds.

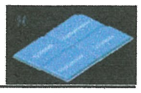
Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 6/5/19

Clinical Facilitator/Educator: *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 03/05/19



Caring for a client/patient requiring wound management
Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	The management of a client/patient requiring wound care
Demonstration of:	The ability to effectively and safely manage a simple wound for a single client/patient.

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
PREPARATION FOR THE ACTIVITY	1. Identifies specific indications for contact / communication / action with the client/patient (i.e. are there any specific orders?).	1.2, 1.3, 1.5, 4.5, 6.1, 6.5		A				
	2. Verifies the validity of any written orders to provide appropriate wound management.	1.6, 4.5, 5.1, 6.5		A				
	3. Reviews the client/patient documentation / history / information / medication chart / communication(s) from members of the multidisciplinary team and considers the evidence.	1.4, 4.1, 4.5, 5.1, 6.5, 7.3		A				
	4. Gathers the necessary equipment; i. Effectively and in a timely manner performs hand hygiene; ii. Clean and sterile gloves, apron, goggles (PPE); iii. Sterile scissors and/or clip/staple/stitch remover, sharps container; iv. Dressing pack, required dressing materials; v. Appropriate solutions if necessary and if necessary vi. Other: Specify	1.1, 1.5, 1.6, 4.1, 4.4, 4.5, 5.1. 5.2, 6.5, 7.1, 7.2 *May not be necessary*	i. ii. iii. iv. v. vi.	A A A A N/A N/A				
CARRYING OUT THE MANAGEMENT OF A CLIENT/PATIENT REQUIRING WOUND CARE	6. Evidence of therapeutic interactions; e.g. gives client/patient a clear explanation regarding the management of the wound.	2.1, 2.2, 2.3, 3.1, 4.3, 5.3, 6.2, 6.5		A				
	7. Undertakes assessment of the situation identifying that it is appropriate to manage the wound 'this way' in the circumstances e.g. that it is required/considers any medication (analgesia) or any vital sign or other assessments required.	1.1, 1.4, 3.1, 3.4, 4.1-6, 5.1-4, 6.1, 6.2, 7.1, 7.2			A			
	8. Maintains dignity, provides privacy, pain relief and other comfort measures – displays problem solving abilities.	1.3, 1.4, 2.1 4.3, 4.4		A				
	9. Assists the client/patient to an appropriate position as necessary.	3.1, 5.2, 7.1		A				
	10. Performs hand hygiene and uses PPE (if required).	1.1, 1.2, 2.2, 3.1, 6.5		A				
	11. Verbally reassure client/patient is comfortable & prepared.	1.4, 2.1,2.3, 3.1, 4.3, 4.4, 7.1		A				
	12. Put on clean disposable gloves and remove the tape/bandage or ties.	6.1-5, 7.1, 7.2		A				
	13. With gloved hand remove dressing one layer at a time, taking care not to disturb drains or tubes. Keep soiled surface out of client/patients eye line. If the dressing is	6.1-5, 7.1, 7.2		A				

	'stuck', explain to the client/patient that you will moisten the dressing so that it comes free without any discomfort.						
	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
	14. Observe any drainage e.g. amount / character / consistency / colour / odour.	5.1, 6.1, 6.2, 6.5, 7.1		A			
	15. Remove PPE and perform hand hygiene effectively.	1.1, 1.2, 2.2, 3.1, 6.5	A				
	16. If necessary cleans the wound utilising appropriate solution(s) and dresses the wound using appropriate choice of dressing and fixation.	1.2, 1.5 4.5, 5.1, 5.3, 6.2, 6.5, 7.1, 7.2	A				
CLOSING THE ACTIVITY	17. Repositions client/patient & maintains privacy dignity, ensures comfort as far as possible throughout & at that point.	1.4, 2.1, 4.2, 4.4, 4.5, 7.1, 7.2	A				
	18. Concludes the interaction with the client/patient by considerately concluding the therapeutic relationship.	2.1, 6.5, 7.1.	A				
	19. Cleans/tidies area; disposes of any waste appropriately and as soon as is practicable; removes gloves & other PPE (as necessary) and performs hand hygiene appropriately.	1.1, 1.2, 2.2, 3.1, 6.5	A				
DOCUMENTATION & COMMUNICATION	20. Reporting and Recording of relevant information: i. Nursing Care; ii. Medication chart; iii. other if appropriate (e.g. particular assessment chart (wound)) Specify i.e. plan Wound chart	3.4, 5.4, 6.5, 7.1, 7.2, 7.3 ***May not be necessary***	i. ii. iii.	A A A			
EDUCATIONAL OPPORTUNITY	21. Demonstrates ability to reflect on the activity and to link theory to practice; i. Relates to decisions made; ii. Evidence utilised and iii. Implications for planning of patient care.	1.1, 1.2, 1.5, 3.2, 3.3, 4.1, 4.2, 5.1, 6.5, 7.1	i. ii. iii.	A A A			

Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', ***Journal of Nursing Education***, vol. 22(9), pp. 376-381.
Crisp, J & Taylor, C 2013 ***Potter and Perry's Fundamentals of Nursing***, 4th Ed, Elsevier, Australia
Tollefson, J 2015, Clinical psychomotor skills: assessment tools for nursing students, 4th Ed., South Melbourne, Vic. Cengage Learning, Australia.

Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skilful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Compulsory Reflection by Student: : Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection)

Being on a surgical ward, I was exposed to many wounds that followed correct wound management. On my placement I became more confident in non-touch technique and Sterile technique. I was able to perform aseptic technique on a few simple wounds however still lack the confidence with slightly more complex wounds. I would benefit from further practice as all wounds and their management are different. From the wounds I did on prac I have gained more knowledge from.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Comments by RN:

Demonstrated understanding of the importance of reviewing notes and analgesia requirements prior to attending to dressings. Clear and therapeutic communication and respects patient' privacy. Showing an understanding of dressing types, wounds suitable for non-touch versus Sterile aseptic technique.

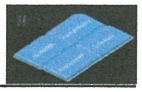
Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 10/5/19

Clinical Facilitator/Educator: *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 9/05/19



Managing Medication Administration Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	The management of Medication Administration for a (single client/patient) or (group of clients /patients) Route: _____ *Please delete as appropriate* *(e.g. a group of clients/patients)* *(please enter administration route)*
Demonstration of:	The ability to effectively and safely manage medication administration for a *single client/patient* or a *group of clients/patients*. *(Please delete as appropriate)*

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
PREPARATION FOR THE ACTIVITY	1. Identifies specific indications for action with the client/patient concerning medicine administration (i.e. what are the specific orders?).	1.2, 1.3, 1.5, 4.5, 6.1, 6.5	A				
	2. Verifies the validity of any written orders to provide a particular medicine at that time.	1.6, 4.5, 5.1, 6.5	A				
	3. Reviews the client/patient documentation / history / information/medication chart/communication(s) from members of the multidisciplinary team and considers the evidence.	1.4, 4.1, 4.5, 5.1, 6.5	A				
	4. Effectively and in a timely manner performs hand hygiene. ◦ Alco wipe between packets / touching split pill etc	1.1, 1.2, 2.2, 3.1, 6.5		A			
	5. Gathers the necessary documents/equipment: i. Medication Sheet; ii. Medication trolley (if appropriate); iii. Specific equipment related to the route of administration: ***(i.e. for oral suspension or IV routes, etc.)*** ***Please specify equipment:*** _____	1.1, 1.5, 1.6, 4.1, 4.4, 4.5, 5.1. 5.2, 6.5, 7.1, 7.2 ***May not be necessary***	i. A ii. A iii. N/A				
CARRYING OUT THE ACTIVITY	6. Evidence of therapeutic interactions; e.g. gives client/patient a clear explanation regarding the medicine to be administered; explores importance of medication compliance & health education and promotion advice.	1.3, 2.1, 2.2, 3.1, 4.3, 4.4, 5.1, 5.2, 6.1, 6.5, 7.1	A	A			
	7. Undertakes assessment of the situation identifying that it is appropriate to administer the medication in the circumstances e.g. that it is required/consider any medication allergies/any vital sign or other assessments and appropriate method of recording the medication.	1.4, 4.1-6, 5.1-4, 6.5	A				
	8. Maintains dignity, provides privacy and other comfort measures – displays problem solving abilities	1.3, 1.4, 2.1 4.3, 4.4	A				
	9. Assists as appropriate with the positioning of the client/patient.	1.1, 1.4, 2.1, 3.1, 5.4, 7.2	A				
	10. Performs hand hygiene and uses PPE (if required).	1.1, 1.2, 2.2, 3.1, 6.5	A				
	11. Ensure patient is comfortable & prepared.	1.2, 1.3, 4.3, 5.2, 6.5	A				
	12. Appropriately prepares the medication to be administered.	1.1, 1.2, 1.4, 1.5, 6.1, 6.5, 7.1	A				

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
	13. Uses the 'rights' to safely administer the medication. look @ band + chart @ same time - MRN	1.1, 2.2, 3.1, 4.3, 6.1, 6.2, 7.1		✓			
	14. Administers/assists the patient to take the medication.	1.1, 2.2, 3.1, 4.3, 6.1, 6.2, 6.5	✓				
CLOSING THE ACTIVITY	15. Repositions client/patient, maintains privacy/dignity, ensures comfort as far as possible at that point.	1.1, 1.4, 2.1, 3.1, 5.4, 7.2	✓				
	16. Concludes the interaction with the client/patient by considerately concluding the therapeutic relationship.	2.1, 2.2, 5.3, 6.5	✓				
	17. Cleans/tidies area; disposes of waste appropriately, as soon as is practicable; removes gloves/other PPE (as necessary), performs hand hygiene.	1.1, 1.2, 2.2, 3.1, 6.5	✓				
DOCUMENTATION & COMMUNICATION	18. Reporting and Recording of relevant information; i. Medication chart; ii. Nursing Care; iii. Other if appropriate (e.g. particular assessment chart (vital signs) or recording such as S8) *Please specify:*_____	3.4, 5.4, 6.5, 7.1, 7.2, 7.3 ***May not be necessary***	i ii iii	✓ ✓ N/A				
EDUCATIONAL OPPORTUNITY	19. Demonstrates ability to reflect on the activity and to link theory to practice i. Relates to decisions made; ii. Evidence utilised and iii. Implications for planning of client/patient care.	1.1, 1.2, 1.6, 3.2, 5.1	i ii iii	✓ ✓ ✓				

Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', ***Journal of Nursing Education***, vol. 22(9), pp. 376-381

Crisp, J & Taylor, C 2013 ***Potter and Perry's Fundamentals of Nursing***, 4th Ed, Elsevier, Australia

Tollefson, J 2015, Clinical psychomotor skills: assessment tools for nursing students, 4th Ed., South Melbourne, Vic. Cengage Learning, Australia.

Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skilful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection).

Whilst doing medication administration on prac I ensured that I referred to the MIMS and IV injectable handbook to ensure I was educated on the drug I was giving my patient. Advice and guidence from my RN allowed me to gain further confidence in my administration of medications. I still have more to learn and become efficient in but am confident in my 6 rights of medication

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Comments by RN: Good demonstration of PO med administration. Just be aware of checking BP for diuretics ie Furosemide, is it contraindicated? Also don't forget MRN check and don't leave pt until tablets are taken. Use opportunity ie - ventolin via spacer to watch pt self administer and use the opportunity to check/educate technique. Great use of rights re checking med slip, exp. dates and good pt communication and use of medichart.

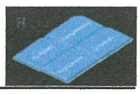
Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☐ **Excellent** ☒

Student Name: *(please print)* Milly Shennan **Sign:** MShenn **Date:** 10/5/19

Clinical Facilitator/Educator: *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 8/5/19



Managing the Care of a Client-Patient
Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	The management of a client/patient for a span of duty/period of care
Demonstration of:	The ability to effectively and safely coordinate the care of a single client/patient for a span of duty/period of care.

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
PREPARATION FOR THE SPAN OF DUTY	1. Identifies specific indications for contact / communication / action with the client/patient (i.e. are there any specific orders?).	1.2, 1.3, 1.5, 4.5, 6.1, 6.5					
	2. Verifies the validity of any written orders to provide any aspect of care.	1.6, 4.5, 5.1, 6.5					
	3. Reviews the client/patient documentation / history / information / medication chart / communication(s) from members of the multidisciplinary team.	1.4, 4.1, 4.5, 5.1, 6.5					
	4. Effectively and in a timely manner performs hand hygiene.	1.1, 1.2, 2.2, 3.1, 6.5					
	5. Gathers the necessary equipment for assessment (if appropriate).	1.1, 1.5, 1.6, 4.1, 4.4, 4.5, 5.1. 5.2, 6.5, 7.1, 7.2					
	6. Carries out a comprehensive assessment with / of the client/patient.	4.1-4, 5.1, 6.5, 7.2					
	7. Documents a plan of care in agreement with the client/patient and significant others for the period of care/span of duty.	1.1, 2.3, 3.4, 6.1, 6.5					
CARRYING OUT THE ORGANISATON & DELIVERY OF THE CARE REQUIRED FOR A PATIENT DURING A SPAN OF DUTY	8. Evidence of therapeutic interactions; e.g. gives client/patient a clear explanation regarding the period of care/span of duty.	2.1, 2.3, 3.4, 6.5					
	9. Undertakes assessment of each situation/interaction identifying that it is appropriate to carry out the agreed care in the circumstances e.g. that it is required and appropriate based on the assessments undertaken.	4.1-6, 5.1, 7.1					
	10. Maintains dignity at all times, provides privacy and comfort measures – displays problem solving abilities.	1.3, 1.4, 2.1, 4.3, 4.4					
	11. Considers the Activities of living in which the client/patient has any deficits and will therefore require assistance.	1.1, 1.3, 3.1, 5.1, 6.1					
	12. Ensure client/patient is comfortable & prepared for any intervention in the time span.	1.4, 2.1, 2.3, 4.3, 5.1, 6.5					
	13. Prepares any intervention/medication.	5.1-5, 6.5. 7.1					
	14. Uses the 'rights' to safely administer the intervention / medication(s) to the client/patient during the period of care/span of duty.	1.1, 2.2, 3.1, 4.3, 6.1, 6.2, 7.1					
	15. Assists the client/patient with the intervention/medication.	1.1, 2.2, 3.1, 4.3, 6.1, 6.2, 6.5					

	Performance Criteria (Please place your initials in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
CLOSING THE ACTIVITY	16. Concludes the period of duty with the client/patient by considerately concluding the therapeutic relationship.	2.1, 2.2, 3.3, 6.5	✓				
	17. Cleans/tidies area; disposes of any waste appropriately and as soon as is practicable; removes gloves & other PPE (as necessary).	1.1, 1.2, 2.2, 3.1, 6.5	✓				
	18. Repositions client/patient maintains privacy dignity, ensures comfort as far as possible at that point.	1.2, 2.3, 2.5, 7.1	✓				
	19. Replaces, cleans and/or disposes of equipment appropriately, performs hand hygiene.	1.1, 1.2, 2.2, 3.1, 6.5	✓				

DOCUMENTATION & COMMUNICATION	20. Reporting and Recording of relevant information; i. Nursing Care; ii. Intervention/Medication chart; iii. Other if appropriate (e.g. particular assessment chart) Specify: Falls, waterlow, care plan hourly rounding	3.4, 5.4, 6.5, 7.1, 7.2, 7.3 *May not be necessary*	i.	✓				
			ii.	✓				
			iii.	✓				

EDUCATIONAL OPPORTUNITY	21. Demonstrates ability to reflect on the activity and to link theory to practice i. Relates to decisions made, ii. Evidence utilised and iii. Implications for planning of client/patient care.	1.1, 1.2, 1.6, 3.2, 5.1	i.	✓				
			ii.	✓				
			iii.	✓				

Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', ***Journal of Nursing Education***, vol. 22(9), pp. 376-381

Crisp, J & Taylor, C 2013 ***Potter and Perry's Fundamentals of Nursing***, 4th Ed, Elsevier, Australia

Tollefson, J 2015, Clinical psychomotor skills: assessment tools for nursing students, 4th Ed., South Melbourne, Vic. Cengage Learning, Australia.

Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues.
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skilful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues.
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection.)

During my placement I was given a small patient load under the supervision of my RN. This allowed me

to attempt to give a full hollistic care towards my patients. In order to better my practice I want to aim to become more confident in advocating for planning care of my patient, completing all necessary paperwork, making descions within my scope and documenting/ handing over a patient. With further time management practice and an increased confidence in my scope of practice I hope to better improve my management of a patient load.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☑ **Excellent** ☐

Comments by RN:

You have consistantly shown an ability to care for a patient load, yet not always holistically. To have full care within your scope, as discussed try to advocate for planning care, providing care, completing all associated paperwork, making decisions within your scope and documenting / handing over your pt. You achieved this on some shifts, moving forward the more you can do this the more you will grow in confidence, time management, RN scope etc.

Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☑ **Excellent** ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 10.5.19

Clinical Facilitator/Educator: *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 8/5/19

Monitoring and Responding to Changes in a Client-Patient Condition
Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	Monitoring and responding to changes in a client/patient condition
Demonstration of:	The ability to effectively and safely monitor and respond to changes in a client/patient condition

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
PREPARATION FOR THE SPAN OF DUTY	1. Obtains comprehensive handover (tape recorder/bedside) to identify specific indications for contact/communication or action with the group of clients/patients (i.e. are there any specific orders).	1.2, 3.1, 3.3, 3.4, 4.3, 4.4, 5.1, 5.2, 6.1-5, 7.1	A				
	2. Reviews the group of clients/ patients progress notes/ previous medical files/medication chart/nursing care plans /any other documentations from members of the multidisciplinary team to verify the validity of any written orders.	1.1, 1.2, 1.3, 2.5, 9.5		A			
	3. Performs hand hygiene effectively and in a timely manner.	1.1, 1.2, 2.2, 3.1, 6.5	A				
	4. Gathers the necessary equipment for assessment (if appropriate).	1.1, 1.5, 1.6, 4.1, 4.4, 5.1. 5.2, 6.5, 7.1, 7.2	A				
	5. Carries out a comprehensive systematic assessment with / of the group of clients/patients.	1.2, 3.1, 3.3, 3.4, 4.1-4, 5.1, 5.2, 6.1-6, 7.1		A			
CARRYING OUT THE ACTIVITY	6. Monitors health status of the group of clients/patients (i.e. vital signs/ fluid balance/ mental status, etc.).	1.1-4, 2.1-3, 4.1-4, 5.1, 5.2, 6.1-6, 7.1		A			
	7. Undertakes assessment of each situation/interaction identifying any changes in a client/patient condition that requires prioritization and immediate or timely response including appropriate escalation.	1.1, 1.2, 2.1-3, 3.1, 3.3, 4.1-4	A				
	8. Maintains dignity at all times, provides privacy and comfort measures – displays problem solving abilities.	1.3, 1.4, 2.1 4.3, 4.4	A				
	9. Considers the Activities of living in which the client/ patient has any deficits and will therefore require assistance.	5.1-5	A				
	10. Ensure the group of clients/patients is comfortable and prepared for any intervention in the time span.	1.2, 1.3, 4.3, 5.2, 6.5	A				
	11. Gathers necessary equipment and checks clinical guidelines for any intervention/medication.	1.1, 1.5, 1.6 4.1, 4.4, 4.5, 5.1 5.2, 6.5, 7.1, 7.2	A				
	12. Informs the shift coordinator/on call medical officer (RN) regarding the changes in a client/patient condition in an appropriate and timely manner. Follows appropriate escalation protocols.	2.1-3, 5.1,4 6.5,7.1, 7.2	A				

	Performance Criteria (Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
	13. Liaises with the healthcare team to deal with the deterioration of the client/patient; must include; i. Accurate assessment recording; ii. Accurate communication during referral; iii. Use of reporting protocols (e.g. ISBAR); iv. Timely and appropriate response whilst awaiting further intervention. v. Other Please Specify:	1.1-2, 2.1-3, 5.1-4, 6.1-5, 7.1, 7.2 *May not be necessary*	i.		✓			
			ii.			✓		
			iii.			✓		
			iv.		✓			
			v.	NA				
CLOSING THE ACTIVITY	14. Monitors health status of the group of clients/patients (i.e. vital signs/ fluid balance/ mental status, etc.).	1.1-4, 2.1-3, 4.1-4, 5.1, 5.2, 6.1-6, 7.1		✓				
	15. Cleans/tidies area; disposes of any waste appropriately and as soon as is practicable; removes gloves and other PPE (as necessary).	1.1, 1.5, 1.6, 4.1, 4.4, 4.4, 5.1. 5.2, 6.5, 7.1, 7.2		✓				
	16. Ensures the group of clients/patients dignity, privacy and comfort at the end of a span of duty/ period of care.	1.2, 2.3, 2.5, 7.1		✓				
	17. Replaces, cleans and/or disposes of equipment according to organisational guidelines.	1.1, 1.5, 1.6, 4.1, 4.4, 4.5, 5.1. 5.2, 6.5, 7.1, 7.2		✓				
DOCUMENTATION & COMMUNICATION	18. Reporting and Recording of relevant information; i. Observation chart and fluid balance chart; ii. Nursing care plan; iii. Clients/ patients progress notes; iv. Medication chart; v. other documentation(s) if appropriate (i.e. particular assessment chart and/or transfer/handover) Specify:_____	3.4, 5.4, 6.5, 7.1, 7.2, 7.3 *May not be necessary*	i.	✓				
			ii.	✓				
			iii.	✓				
			iv.	✓				
			v.	NA				
EDUCATIONAL OPPORTUNITY	19. Demonstrates ability to reflect on the activity and to link theory to practice; i. Relates to decisions made; ii. Evidence utilised and iii. Implications for planning of care for the group of clients/patients.	1.1, 1.2, 1.5, 3.2, 3.3, 4.1, 4.2, 5.1, 6.5, 7.1	i.	✓				
			ii.	✓				
			iii.	✓				

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Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skilful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection)

During my placement I witnessed a patient deteriorate on the ward after returning from surgery. As I was conducting a set of observations I was able to depict a sudden drop in blood pressure. Both the patient and their family were concerned however after consulting my RN and developing a plan of care I felt confident in reassuring them and helping the patient to understand what is going on.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Comments by RN:

You have shown the ability to identify when a patient is out of range. Moving forward try to practice assessing and documenting in range base-lines also so as to notice early changes in pts condition. Similarly when assessing a deterioration in a pt ie- your hypotensive pt. Assess A-G to try to identify if anything else is changed. In addition to obs assess 'is the patient symptomatic or asymptomatic? ie dizzy, slow capillary refil, take BP bi-laterally- document findings in progress notes also- this = pain assessment as well as this is also a deterioration.

Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? ***(please initial)***

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 6/5/19

Clinical Facilitator/Educator: *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 3/5/19

Clinical skills Competency

COMPETENCY: Documentation	**CRITERIA:** C=Competent S=Requires Supervision D=Requires Development
DEMONSTRATES: The ability to accurately record information about a patient in a timely manner **RN please place your initials in the appropriate column**	

PERFORMANCE CRITERIA (numbers indicate *NMBA National Registered Nurse*, Standards **2016**)	C	S	D
1. Identifies indications for documentation in the patient's chart/record (1.1, 3.3, 3.4)	✓		
2. Uses appropriate medical terminology and approved abbreviation and acronyms (1.1, 1.4 2.7, 3.4, 3.6, 3.7, 6.1)	✓		
3. Provides relevant and accurate content (1.1, 1.4, 1.6, 2.7, 3.3, 3.4, 3.6, 3.7, 6.1		✓	
4. Adheres to legal requirements (1.4, 1.5)	✓		
5. Demonstrates ability to effectively use the facilities' standard forms (1.4,1.5, 6.5)	✓		
6. Demonstrates the ability to link theory to practice (1.1, 3.3, 3.4, 3.5)		✓	

*Source - Tollefson, J, & Hillman, E. 2016 "Clinical Psychomotor Skills: Assessment Tools for Nurses" Revised 6th Edition - CENGAGE Learning (pp88-91).

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement*– model for reflection)

I become more confident in my documention The more I do it. I have aimed to write patient progress notes throughout my shift as I perform tasks to maintain the accuracy of the now I am doing. I still need a bit more practice in getting the correct order of tasks however feel my confidence is growing

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? (Please **initial**)

Unsatisfactory ☐ Satisfactory ☐ Good ☑ Excellent ☐

Comments by RN:

Competence in the use of local forms ~~and~~ and charts. Progress notes adhere to legal requirements, as discussed try to apply a template or order to your notes as this increases accuracy and relevance. Also document what you do and understand, not what the nurse tells you to document. Take a pt and practice notes on 1 pt during the shift.

Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? (Please **initial**) :

Unsatisfactory ☐ Satisfactory ☐ Good ☑ Excellent ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 6/5/19

Clinical facilitator (RN): *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 03/05/19

NB Completion of this competency is required to satisfactorily complete this placement.

Clinical skills Competency

COMPETENCY: Clinical handover	**CRITERIA:** C=Competent S=Requires Supervision D=Requires Development
DEMONSTRATES: The ability to clearly and concisely report the condition of a patient or group of patients to another health care professional **RN please place your initials in the appropriate column**	

PERFORMANCE CRITERIA (numbers indicate *NMBA Registered Nurse Standards for Practice*, **2016**)	C	S	D
1. Identifies indication (1.1, 3.3, 3.4)	A		
2. Conducts the handover in private surroundings (1.2, 2.1, 2.7, 6.1	A		
3. Uses a template (1.1, 1.2 1.6, 3.4, 6.1))		A	
4. Provides information that is accurate, concise and complete (1.1, 1.5, 1.6, 2.7, 3.4 6.1)		A	
5. Uses Medical terminology appropriately. (1.1, 1.4, 2.7, 3.4, 6.1)	A		
6. Delivers information in a timely manner (1.4, 1.6, 2.7, 3.4, 3.6, 3.7, 4.3, 6.1	A		
7. Demonstrates ability to link theory to practice. (1.1, 3.3, 3.4, 3.5)	A		

*Source - Tollefson, J, & Hillman, E. 2016 "Clinical Psychomotor Skills: Assessment Tools for Nurses" Revised 6th Edition - CENGAGE (pp84-87).

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* – model for reflection)

With more and more practice on my handovers I can feel myself slowly becoming more confident. In order to improve my handovers I need to learn to only state important and relevant information. I still have alot to learn however with more practice hope to became more confident.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? (Please initial)

Unsatisfactory ☐ Satisfactory ☐ Good MS Excellent ☐

Comments by RN:

You can identify the important information to handover and have shown an ability to follow ISBAR, just take care (as discussed) not to give to much background to a current condition / directive etc and try not to rely on the order of information in the 'cheat sheet' A good base handover, cont to take any opportunity to practice and advance as your scope increases.

Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? (Please initial) :

Unsatisfactory ☐ Satisfactory ☐ Good ☑ Excellent ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 10·5·19

Clinical facilitator (RN): *(please print)* Shannon Weiley **Sign:** [signature] **Date:** 9/5/19

NB Completion of this competency is required to satisfactorily complete this placement.

CLINICAL LEARNING GOALS

Clinical goals can be viewed as a well thought out itinerary for your learning. They can give you guidance through clinical experience, keep you focused on the most important areas and can be used to communicate to others, such as your preceptor or Clinical Facilitator RN. They can offer information such as what you hope to achieve during your clinical experience and where your interests lie.

Clinical goals may be prescribed (such as the competencies you need to achieve in your clinical placement book and you may also develop your own. In any sense the goals should be SMART (Fowler, 1998, cited in Levett-Jones & Bourgeois, 2011 2nd Edition).

S Specific

M Measurable

A Achievable

R Realistic

T Timely

Learning goals help you become a safe, effective, competent and confident registered nurse. Your goals will become progressively more sophisticated as you proceed through the program and each semester they will build upon and consolidate what you have already learnt (Levett-Jones & Bourgeois, 2011, p77-78, 2nd Edition).

When developing clinical goals you should consider the following

What do I want to learn? (goal)

Why do I want to learn it? (rational)

How are you going to learn it? (strategy)

How are you going to prove that you have achieved your goal? (evidence)

Refer to the Text - Levett-Jones & Bourgeois, 2011, 2nd Edition, The Clinical Placement; an essential guide for students, p77-78 it has a good example of how to set out your clinical goals.

Goal What do I want to learn?	**Rational** Why do I want to learn it?	**Strategy** How am I going to learn it?	**Evidence** How am I going to prove that I have achieved my objective?
Have the ability to confidently perform an ECG on placement	Having a better understanding of how an ECG works and how to correctly perform it is vital in nursing practice.	Watch an RN perform an ECG and then try myself whilst asking for feedback and advice.	Have my facilitator or RN watch me do an ECG and have them sign me off if they believe I am competent.
Become familiar with the names of medications and their use.	As a nurse, it is beneficial if you have an extensive knowledge of the drug you are administering and its action.	Through observation and practice. Also researching and looking up drugs I am unfamiliar with in the MIMS	explain a drug and its use to an RN or my facilitator.
Practice injections and become confident in administrating injectable medications.	Injections can be intimidating but with more practice I hope to become more confident.	Observe an RN administering injectable medications and ask for advice and feedback when I practice myself.	Have an RN or my facilitator watch me inject a needle into a patient and sign me off if I perform it correctly.
Become confident in medication calculations	It is an important component of drug administration and I want to perform it correctly.	Practice calculations for different medication dosages until I become confident.	Have an RN or my facilitator guide me and offer advice on my medication calculations.
Become more confident in basic patient care.	A patients comfort is highly important and building a good therapeutic relationship with them.	Observe how my RN interacts with patients and mimic behaviour.	Have my facilitator observe my interactions with patients and offer feedback and advice to better improve my care.

14.	How does the patient call system and TV unit work?	By the controller next to the bed → connected
	Guedels airway	Storage room
	Resuscitation masks	Storage room
	Thermometers	Observation / Storage room
	Suction equipment - How does it work?	Storage room
	Oxygen masks & tubing	Storage room
15.	Locate patients/staff toilets	along the ward
16.	Linen Trolley	along the ward
17.	Pan/Utility Room	SW 3.51 (along the ward)
18.	Sphygmomanometer/Glucometers	medication room
19.	Stethoscopes	medication room
20.	Visitors Lounge	next to emergency department
Questions to ask your Preceptor/Facilitator		
21	Where does staff have handover?	Nurses Station / bedside
22.	What is the ward's phone number if you are sick?	29799 (CNE for ward) level 3 surgical
23.	Where do you leave your bag/belongings?	Tea room in lockers and Storage cupboards
	Where can you obtain meals?	cafeteria on level 1.
24.	What is the ward routine for am shift, pm shift, and night shift?	am shift 0700 - 1530 pm shift 1300 - 2130 night shift 2030 - 0700
25.	How do the phones work?	Type in 29888 then proceed with the number you need to call.

Have a great placement!

Search and Find

Students PLEASE locate the following equipment and supplies in the ward you have been placed in and write where they are found in the column provided.

	EQUIPMENT	LOCATION
1.	Fire Exits	infront of lifts on level 3
	Fire Extinguishers and what fires they are used for?	3.69. Paint, Oil, electrical + liquid fires.
	Fire Blanket	SW 3.33 (tea room)
	Fire Hose	in between 3.32 + 3.33
2.	Emergency Arrest Buzzer	In patients room on wall
	Emergency Trolley - Adult	nurses station
	Emergency Trolley - Paediatric	—
3.	Defibrillator	Resusitation trolley
4.	ECG Machine	SW3.40 (Storage room)
5.	Procedure & Policy Manual	nurses station
6.	Infection Control Manual	nurses station + medication room
	Drug Cupboards	Medication room
	D.Ds	medication room
	Antibiotics	medication room
	Trolley	medication room
	Creams, lotions	medication room/ Storage
	Ventolin etc.	medication room
	Water for irrigation	storage room (SW 3.66)
	Oral medications	medication room
7.	Syringes/needles etc.	medication room
8.	Patient charts X-Rays	nurses station
	Old notes	nurses station
	Notes for filing	nurses station
	Stationery	nurses station
9.	Sterile supplies	Storage room (SW3.66)
10.	Infusion devices	Storage room (SW3.66) treatment room
11.	Computer - for patient data	Nurses station
12.	Scrub sinks & gloves	on the ward / Storage room
13.	Bed unit - how do you elevate/work the bed?	bed controller connected to bed.

The Clinical Office
Faculty of Medicine and Health
University of New England
Armidale NSW 2351

Professional Experience Facilitator Evaluation Form

CNA HSNS263 → Nursing practice: Focus on integrated care.
(insert unit code and title)

Trimester: 1 Year: 2

This evaluation form is confidential and the information collected will help formulate feedback to the professional experience facilitators regarding their interaction with students in practice.

Professional Experience Facilitator's Name: Shannon Weiley

Strongly Agree ①	Agree ②	Neither Agree nor Disagree ③	Disagree ④	Strongly Disagree ⑤	Not Applicable ⑥

1. They demonstrated enthusiasm in the professional experience teaching role.
●②③④●⑥

Comments: Shannon demonstrated enthusiasm towards my placement ensuring that I was gaining as much knowledge out of my experience as possible. She was very professional in her teaching role.

2. They communicated in a manner that displayed respect for you as the student.
●②③④●⑥

Please describe: Shannon was very easy to communicate with. She assisted with any concerns or issues I may of had and made herself easily contactable.

3. Feedback regarding practice was timely and specific.
●②③④⑤⑥

If not, please provide suggestions for improvement: _____

4. They encouraged development of your knowledge, skills, attitudes and behaviors, and assisted you to link theory to practice.

●②③④⑤⑥

Comments: Shannon was very encouraging towards our learning and was able to answer any questions in regards to our theory that we had. She made print outs with education on them that I fand very beneficial.

5. Information regarding progress was treated with confidentiality and respect.

●②③④⑤⑥

Comments: Shannon displayed respect to us students whilst on prac and ensured confidentiality was displayed at all times.

6. They provided helpful guidance in overcoming problems associated with your placement/learning.

●②③④⑤⑥

Comments: Shannon was very supportive whilst on placement and was able to help with any problems I had.

7. The time spent with your Professional Experience Facilitator was educational and beneficial to your development.

●②③④⑤⑥

Comments: Shannon always offered educational advice that was extremely beneficial to our practice and placement.

Please provide additional feedback: Excellent facilitator!!