University of New England

University of New England
School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

SECOND YEAR
HSNS310/510 Mental Health Nursing

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	Maitland → Mental health unit hospital
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	Janelle Nixon
PRECEPTOR CONTACT TELEPHONE:	02 49392456
LOCATION (eg: town name):	Maitland
WARD/UNIT:	Mental health
PLACEMENT DATES:	FROM 27/5/19 TO 7/6/19

For more information, additional copies of documents or questions related to your Clinical Record Book please contact the Clinical School 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 77-78 of your Clinical Placement textbook for guidance (Levett-Jones, T and Burgeois, S 2018 'The Clinical Placement: An essential guide for Nursing Students" 6TH 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 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 in Moodle or in this book.

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 at the beginning of and end of each shift.
- ☑ 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 through Moodle Assessment; Task; Submit your CRB in the HSNS310/510 unit site.**
- ☑ **You must keep your original clinical record book as it may be called on for auditing purposes.**

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 (p9-11) "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; Teaching a client/patient (NCAS) pp23-26
- Participation in basic documentation/charting (Tollefson) p27
- Clinical handover (Tollefson) p28
- Mental status assessment (Tollefson) p29

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

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
- Neurological assessment
- Cranial nerve assessment
- Reproductive assessment
- Mental Health assessment

Documentation

- Document and interpret a basic 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)
- Monitor IV infusions (calculate rates of flow)
- Changing of IV/SC infusions- maintenance fluid only
- 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	27/5/19	0800	JBonfield	J Bonfield	1630	JBonfield	J Bonfield	8	JBonfield	J Bonfield (RN)
Tuesday	28/5/19	0800	JBonfield	J Bonfield	1630	JBonfield	J Bonfield	8	JBonfield	J Bonfield (RN)
Wednesday	29/5/19	0800	JBonfield	J Bonfield	1630	JBonfield	J Bonfield	8	JBonfield	J Bonfield (RN)
Thursday	30/5/19	0800	JBonfield	J Bonfield	1630	JBonfield	J Bonfield	8	JBonfield	J Bonfield (RN)
Friday	31/5/19	0800	Wayne Cotton	COTTON	1630	[illegible]	COTTON	8	[illegible]	COTTON RN
Saturday										
Sunday										
Monday	3/6/19	0700	Bsmith	B. Smith	1530	Bsmith	B. Smith	8	BSmith	B. Smith RN
Tuesday	4/6/19	0700	SEMAAN		1530		K. SEMAAN	8		K. SEMAAN RN
Wednesday	5/6/19	0700	JNixon	J. Nixon	1530	JNixon	J Nixon	8	JNixon	J Nixon
Thursday	6/6/19	0700	JNixon	J. Nixon	1530	JNixon	J. Nixon	8	JNixon	J Nixon
Friday	7/6/19	0700	JNixon	J Nixon	1530	JNixon	J. Nixon	8	JNixon	J Nixon
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) pp12-13	[signature]	6/6/19		
Teaching a client/patient (NCAS) pp23-26	[signature]	6/6/19		
Participation in basic documentation/charting (Tollefson) p27	[signature]	6/6/19		
Clinical handover (Tollefson) p28	[signature]	6/6/19		
Mental status assessment (Tollefson) p29	[signature]	6/6/19		
Communicates effectively in English	[signature]	6/6/19		
Communication with others	[signature]	6/6/19		
FUNDAMENTAL ASSESSMENTS *(if required copy competency from Tollefson text and upload completed assessment with your Clinical Record Book)*				
Infection Control				
Standard precautions	[signature]	5/6/19		
Hand hygiene (Tollefson text p5)	[signature]	3/6/19		
Aseptic technique/Wound care				
- Dry Dressing technique (Tollefson text p377)				
- 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				
Patient Care				
Effective patient communication	[signature]	31/5/19		
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)	[signature]	4/6/19		
Assisting with hygiene across the lifespan,(mouth care, shaving, hair care and nail care, eye care)(Tollefson text p274)				
Assisting with hygiene across the lifespan (mouth care, shaving hair care and nail care eye) (Tollefson p282)				
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower) (Tollefson p276)				
Assisting with elimination needs (toileting, bed pans, urinals, commodes) (Tollefson text p127)				
Assisting with mobility and use of mobility aids (Tollefson text p292)				
Pressure area care (Tollefson text p297)				
Range of motion, deep breathing and coughing exercises				
Assisting with lifting and positioning of patients using safe manual handling techniques				
Basic CPR				

	Safe Practice Demonstrated		Needs more Supervised Practice	
	RN Signature	Date	RN Signature	Date
Bed making	[signature]	3/6/19		
Care of body after death				
Respiratory interventions				
- - Oxygen therapy via nasal cannula or various masks (Tollefson text p308)				
- - Suctioning (Tollefson text p319)				
Management of a person with a tracheostomy (Tollefson text p339)				
Assessment				
Recording and interpreting of blood pressure; temperature, pulse and respiration (TPR) measurements (Tollefson pp204, 209)	[signature]	3/6/19		
Recording and interpreting of height, weight and waist circumference measurement (Tollefson p197)	[signature]	3/6/19		
Recording and interpreting of blood glucose measurement (Tollefson text p223)	[signature]	4/6/19		
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 (Tollefson text pp78-82)				
Respiratory Assessment Spirometry				
Cardiac Assessment Conduct and interpret a 12 lead electrocardiogram (Tollefson text pp54-59)				
Renal assessment				
Neurological assessment and Observation (Tollefson pp42-48) -				
Cranial nerve assessment				
Reproductive assessment				
Mental Status assessment (Tollefson text p53)	[signature]	29/5/19		
Documentation				
Document and interpret a basic care plan and integrated patient notes	[signature]	29/5/19		
Recording and monitoring fluid balance charts				
Medication Administration (adults and children)				
Calculate and administer doses of oral, topical and PR medications (Tollefson text pp140-148)	[signature]	3/6/19		
Administration of medication via a nebuliser				
Administration and management of oxygen therapy				
Administration of parenteral (injectable) medications (IMI, S/C) (Tollefson text p149)				
Monitor IV infusions (calculate rates of low)				
Changing of IC/SC infusions – maintenance fluid only				
Management of blood transfusions (after completion of blood safe elearning package)				

ADDITIONAL ACTIVITIES

e.g. Attended In-service on new medication, Wound care clinic, Simulation

→ Spent the day working at the clozapine treatment clinic

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Nursing Competency Assessment Schedule-NCAS

INTERIM | FINAL ✓

Please initial

Registered Nurse Standards for Practice (NMBA 2016)

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.

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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 the course of my mental health placement I believe I displayed my ability to critically analyse and link theory to practice within my scope. I ensured I engaged in Therapeutic and professional practices whilst maintaining capability for my nursing practice. During my placement I completed necessary assessments on my clients in an effective, correct and cohesive manner to ensure my clients overall mental health + wellbeing.

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
	JV

Milly always works within HNE policies, procedures and guidelines. She provides safe and effective nursing care, always involving pts in their care.

Continue on a separate sheet if necessary

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 7/6/19

Clinical facilitator: *(please print)* J Nixon **Sign:** JNixon **Date:** 6/6/19

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 TWO: 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 THREE: 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 FOUR: 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 FIVE: 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 SIX: 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 SEVEN: 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.

Teaching a Client-Patient
Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	Teaching a client/patient
Demonstration of:	The ability to effectively teach a 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 TEACHING THE CLIENT/PATIENT	1. Identifies with the client/patient specific indications for teaching the client/patient (i.e. what initial information is available, if any? Examples may be relaxation techniques, self-medication administration, etc.).	1.1-6, 2.1-5, 4.2, 4.3, 5.1-5, 6.1, 6.5, 7.1-3					
	2. Verifies the validity of any written information concerning this client/patient; (e.g. communication and/or learning and/or skill specific in terms of abilities).	2.1, 2.2, 3.2, 6.5, 7.1					
	3. Reviews the patient documentation/history/information / medication chart/communication(s) from members of the healthcare team and others (includes family/friends /carers).	1.4, 2.1-5, 4.1, 4.5, 5.1, 6.5					
	4. Considers a range of factors that affect/influence learning and develop strategies to minimise/optimise these factors.	1.1-7, 2.1-5, 4.3, 5.2, 5.3, 6.5, 7.1, 7.2					
	5. Effectively plans the activities to work through with the client/patient (and carer) to optimise their learning.	1.1-7, 2.1-5, 4.3, 5.2, 5.3, 6.5, 7.1, 7.2					
	6. Gathers the necessary equipment for the teaching activity (if appropriate).	1.6, 4.1					
	7. Locates & greets the client/patient & "*takes in*"/assesses a range of cues (visual, auditory and olfactory) at the point of contact.	2.1-5, 4.1, 4.4, 5.2, 6.5					
	8. Ensures that the setting/environment is conducive to the activity in order to minimise distractions and maximise concentration.	4.1, 4.4, 5.2, 6.5, 7.1, 7.2					
	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) whilst explaining the activity.	1.1, 1.2, 2.1, 2.2, 7.1					

CARRYING OUT THE TEACHING OF A CLIENT/PATIENT	10. Carries out a comprehensive and systematic assessment with/of the client/patient concerning their understanding of the intended teaching event; i. Notes impressions of their understanding; ii. Gathers a range of evidence from patient and 'family'; iii. Utilises appropriate strategies; iv. Appropriate teaching tools and v. Acts appropriately & supportively should this be evident during the activity. vi. Other: Please specify: _____	1.1, 1.2, 1.3, 1.4, 2.1-5, 3.1, 3.2, 3.4, 5.1, 5.3, 6.1, 6.2, 6.5, 7.1 *May not be necessary*	i. ii. iii. iv. v. vi.					

	11. Clear evidence of a developing rapport and a therapeutic relationship in the teaching interaction with the client/patient.	1.1, 1.2, 1.3, 1.4, 2.1-5, 7.1					
	12. Uses a range of questioning styles and demonstrates listening skills during exploration/explanation of the activity.	2.1, 2.3, 4.3, 6.5, 7.1, 7.2					
	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. Demonstrates the skill at an appropriate pace, exhibits a professional demeanour which illustrates a sense of caring.	2.1-5, 3.2, 4.2, 4.3, 7.1-3						
	14. Explores & verifies, through the use of an appropriate educative framework, that the client/patient is understanding what is happening; a. Knowledge; b. Skill and c. Attitude/behavior.	1.2, 1.3, 2.1-5, 4.2, 4.3	i. ii. iii.					
	15. Acknowledges and values data from observing the teaching event.	1.1-4, 2.1-5, 3.1-4, 5.1, 7.1						
	16. Demonstrates the ability to give helpful and constructive feedback about all aspects of the teaching activity/skill.	1.3, 2.1-5, 3.4, 6.5, 7.2						
CARRYING OUT THE TEACHING OF A CLIENT/PATIENT	17. Documents the outcome of the teaching event in the nursing plan of care in agreement with the client/patient and significant others.	5.3, 6.5, 7.1, 7.3						
	18. Maintains a therapeutic relationship with the client/patient whilst encouraging and supporting practice of the skill.	2.1-4, 3.4, 6.5						
	19. 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, 6.5 *May not be necessary*	i. ii. iii.					
	20. If necessary uses the 'rights' to assist in the safe administration of any medication (i.e. self-administration) to the client/patient during the teaching activity.	1.1, 2.2, 3.1, 4.3, 6.1, 6.2, 7.1						
	21. Implements appropriate beginning discharge planning & teaching to client/patient and carer.	1.3, 1.4, 1.6, 3.3, 4.3, 4.4, 5.2, 6.5, 7.1, 7.2						

CLOSING THE ACTIVITY	22. Concludes the teaching activity with the client/patient by considerately concluding the therapeutic relationship;	1.2, 1.3, 2.1-5, 4.3				
	23. Facilitates client/patient repositioning to maintain privacy dignity, ensures comfort as far as possible at that point;	1.3, 1.4, 2.1 4.3, 4.4				
	24. Cleans/tidies area; explains the disposal of any waste appropriately and as soon as is practicable; removes gloves & other PPE (as necessary);	1.1, 1.2, 1.3, 6.5				
	25. Explores with the client/patient if appropriate how to replace, clean and/or dispose of equipment;	1.1, 1.5, 1.6, 4.1, 4.4, 4.5, 5.1 5.2, 6.5, 7.1, 7.2				

DOCUMENTATION & COMMUNICATION	26. Reporting and Recording of relevant information: i. Outcome of the client/patients attempt to undertake the skill; ii. Share the observations about their client/patients'; a. knowledge; b. skill and c. attitude/behaviour iii. Other if appropriate (e.g. particular assessment chart) Specify i.e. plan	3.4, 5.4, 6.5, 7.1, 7.2 *May not be necessary*	i.	✓				
			ii.a	✓				
			ii.b	✓				
			ii.c	✓				
			iii.					

	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)
EDUCATIONAL OPPORTUNITY	27. Demonstrates ability to reflect on the activity and to link theory to practice; i. Relates to teaching strategies used & decisions made, ii. Evidence utilised and iii. Implications for assessing & planning of client/patient education in the future.	1.2, 2.1-5, 3.1, 3.2, 4.1, 4.2, 5.2, 5.3, 7.1, 7.3	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
Rorden, J, W, 1987 ***Nurses as Health Teachers: A Practical Guide***, Saunders, San Jose, California, USA
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)

Patients can be educated on many different things. During my time on the ward I chose to educate a patient on the dangers of illicit drug use and its harmful affects both mentally and physically. I aimed to educate this patient in an appropriate and timely manner whilst including all neressary information.

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:

Milly is competent and provides care that is safe, effective and assists in improving pt outcomes.

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:** 7/6/19

Clinical Facilitator/Educator: *(please print)* J Nixon **Sign:** Nixa **Date:** 6/6/19.

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 Registered Nurse Standards for Practice 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. Content is relevant and accurate (1.1.,1.4., 2.7., 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 an ability to link theory to practice (1.1., 3.3., 3.4., 3.5)			

*Source - Tollefson, J, & Hillman, E. 2016 "Clinical Pyschomotor 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* pp95-102 – model for reflection)

Documentation is a vital skill that needs to be correctly completed after every contact with the patient or when any new information regarding the client is obtained. During my placement I felt assured that I documented information regarding a patient in an effective and timely manner.

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:

Milly records her documentation and progress notes accurately and in a timely manner.

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:** 7/6/19

Clinical facilitator (RN): *(please print)* J Nixon **Sign:** JNixon **Date:** 6/6/19.

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

Clinical Skills Compentency

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.)			
2. Conducts the handover in private surroundings (1.2, 2.1, 1.6., 3.4, 6.1)			
3. Uses a template (1.1., 1.2., 1.6., 3.4., 6.1.)			
4. Provides information that is accurate, concise and complete (1.1.,1.5., 1.6., 2.7., 3.4.,6.1)			
5. Medical terminology is appropriately used (1.1, 1.4, 2.7, 34., 6.1)			
6. Delivery of information is timely (1.4,1.6, 2.7, 3.4, 3.6, 3.7, 4.3, 6.1)			
7. Demonstrates 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 (pp84-87).

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp95-102 – model for reflection)

When conducting my handover's to other health professionals I ensured I utilised ISBAR correctly. This enabled me to perform a correct and informative handover in an efficient and timely manner. I hope to get more practice of this skill to allow me to advance in nursing.

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:

Milly is competent in providing an accurate handover to other staff. Terminology is concise and accurate always delivered in a timely manner

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:** 7/6/19

Clinical facilitator (RN): *(please print)* J Nixon **Sign:** JNixon **Date:** 6/6/19

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

Clinical Skills Competency

COMPETENCY: Mental status assessment	**CRITERIA:** C=Competent S=Requires Supervision D=Requires Development
DEMONSTRATES: The ability to assess a patient's mental status **RN please place your initials in the appropriate column**	

PERFORMANCE CRITERIA (numbers indicate *NMBA Registered Nurses Standards for Practice, 2016)*	C	S	D
1. Identifies indication (1.1, 3.3, 3.4)	✓		
2. Displays problem-solving abilities, eg patient's age, culture and language require consideration when assessing the mental status (1.1, 1.2, 1.3, 2.3, 4.2, 6.1)	✓		
3. Evidence of therapeutic interaction with the patient, eg gives patient a clear explanation of procedure (1.4, 1.5, 2.1, 2.2, 3.2)	✓		
4. Assesses general appearance and each of the following (4.1, 4.2, 4.3, 6.1): - level of consciousness - orientation - mood - knowledge and vocabulary - judgement and abstraction - memory - language and speech - sensory and motor assessment	✓		
5. Documents relevant information (1.4, 1.6, 2.7, 2.7, 3.5, 6.2, 6.5, 7.3)	✓		
6. Demonstrates ability to link theory to practice. (1.1, 3.3, 3.5)	✓		

*Source - Tollefson, J, & Hillman, E. 2016 "Clinical Pyschomotor Skills: Assessment Tools for Nurses" Revised 6th Edition - CENGAGE (pp49-53).

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp95-102 – model for reflection)

i felt that i demonstrated the ability to asses a patient and perform a mental status assesment. i ensured i did this task in an appropriate and timely manner and gathered all necessary information. with practice i believe i will better this skill.

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:

Milly is competent in completing a mental state examination on the pts in her care and documents relevant information and links theory to practice.

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:** 7/6/19

Clinical facilitator (RN): *(please print)* J Nixon **Sign:** Nixa **Date:** 6/6/19.

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

CLINICAL OBJECTIVES

UNIT HSNS310/510 Mental Health Nursing

Students will successfully complete an attached 80hr clinical placement in a mental health setting as part of this unit. During the placement, students will be expected to achieve the following objectives under the direct supervision of a registered nurse:

- Demonstrate knowledge of common mental health problems and illnesses;
- Apply critical reasoning skills and evidence-based clinical decision making to assessment, planning and documentation of person-centred and recovery focused mental health care;
- Demonstrate a beginning capacity to undertake a comprehensive mental health assessment, and include common standardised assessment tools, ie mental status examination, suicide risk, Mental Health Outcomes and Assessment Tools (MO-OAT);
- Demonstrate a beginning capacity to undertake a comprehensive mental health assessment including the use of commonly used standardised tools;
- Demonstrate a beginning capacity to work collaboratively to negotiate a shared understanding of mental health problems with consumers and their carers that leads to shared decision making and an agreed treatment plan;
- Participate in planning, providing and evaluating a range of effective and evidence-based pharmacological, non-pharmacological and psychotherapeutic treatments/ interventions for common mental health problems;
- Demonstrate an understanding of Specific Legal and ethical concerns in the mental health care setting;
- demonstrate capacity to assist clients to identify, strengthen and utilise existing strengths;
- Demonstrate cultural competence in meeting the mental health care needs of Aboriginal people and people from cultural and linguistically diverse backgrounds.

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, 2015, p71-73, 3rd 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, 2015, 3rd Edition, The Clinical Placement; an essential guide for students,p71-73 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?
To conduct a full mental status assessment confidently.	It is a crucial assessment used in a mental health facility to asses a patient and deliver the best care.	Observe the health professionals I am working with conduct an assessment and gain some tips.	Conduct an assesment in a professional manner whilst my RN observes me and provides constructive feedback.
Correctly document information regarding a patient	important skill to learn. It is used for legal purposes and a means of communication between nurses.	Read previous notes and prepare my own to practice. I will then ask for feedback from my RN.	To be signed off by my RN when I confidently and professional document for a patient.
Confidently educate a patient regarding legal rights or a health issue.	educating a patient on their legal rights is very important. The patient will be more compliant if they know what is goingon	Inform myself on legal patient education that needs to be given so I am providing accurate information.	perform patient education and have my RN observe me do so and sign me off if they believe I'm competent.
Confidently perform a handover to staff regarding a patient in an effective manner.	It is important to communicate the patients condition to health professionals in a correct and efficient way.	observe healthcare professionals handover. Use ISBAR and conduct a handover whilst being accompanied by my supervisor.	Signed off as competant in my clinical book to show that I am able to complete a handover in a professional manner.
Provide therapeutic, hollistic and comprehensive patient care.	Having a therapeutic relationship with my patients is very important as it creates a mutal trust and respect.	observe how other health professionals engage in a therapeutic relationship and try to mimic their behaviour.	Create therapeutic relationships with my patients and have my facilitator sign my book when they believe I am establishing a good relationship with my patients.
gain further knowledge of the action and side effects of the medications used in mental health.	having an understanding of what the drug is you are administering and why you are doing so is very important.	Use the MIMS to look up any drugs I am unfamiliar with and gain an understanding of why the patient is receiving it.	Have my facilitator question my knowledge of a certain drug and its uses and assist me to learn it properly. → confidently explain a drug and its uses to my facilitator.

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	At the end of the hallway near door
	Fire Extinguishers and what fires they are used for?	near nurses station
	Fire Blanket	near nurses station
	Fire Hose	near nurses station
2.	Emergency Arrest Buzzer	near nurses station
	Emergency Trolley - Adult	Storage cupboard near nurses station
	Emergency Trolley - Paediatric	N/A
3.	Defibrillator	Storage cupboard on the ward
4.	ECG Machine	Storage cupboard on the ward
5.	Procedure & Policy Manual	nurses station
6.	Infection Control Manual	nurses station
	Drug Cupboards	treatment room
	D.Ds	treatment room
	Antibiotics	treatment room
	Trolley	treatment room
	Creams, lotions	treatment room
	Ventolin etc.	treatment room
	Water for irrigation	Storage room
	Oral medications	treatment room
7.	Syringes/needles etc.	treatment room
8.	Patient charts X-Rays	nurses station
	Old notes	nurses station
	Notes for filing	nurses station
	Stationery	draws at nurses station
9.	Sterile supplies	Store room
10.	Infusion devices	Store room
11.	Computer - for patient data	Nurses station
12.	Scrub sinks & gloves	along the wall on the ward
13.	Bed unit - how do you elevate/work the bed?	bed control next to bed

14. How does the patient call system and TV unit work?	TV in communal lounge room phone is communal.
Guedels airway	Storage room
Resuscitation masks	Storage room
Thermometers	Storage room
Suction equipment - How does it work?	Storage room
Oxygen masks & tubing	Storage room
15. Locate patients/staff toilets	hallway towards The Ward
16. Linen Trolley	along the ward
17. Pan/Utility Room	along the ward
18. Sphygmomanometer/Glucometers	treatment room
19. Stethoscopes	draw in nurses station
20. Visitors Lounge	next to the ward
Questions to ask your Preceptor/Facilitator	
21 Where does staff have handover?	Nurses station
22. What is the ward's phone number if you are sick?	4939 2456
23. Where do you leave your bag/belongings?	In lockers in the staff room
Where can you obtain meals?	Staff room
24. What is the ward routine for am shift, pm shift, and night shift?	am shift 7am → 3.30pm (ward) 8am → 4.30pm (community) pm shift 1.30pm → 10pm (ward) night shift
25. How do the phones work?	Straightfoward, simple and easy to use

Have a great placement!

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Professional Experience Facilitator Evaluation Form

CNA HSNS310 - Mental health Nursing
(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: Janelle Nixon

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.
●②③④⑤⑥

Comments: Janelle was very enthusiastic and encouraging in her facilitator role. She was very helpful in her teaching skills.

2. They communicated in a manner that displayed respect for you as the student.
●②③④⑤⑥

Please describe: Janelle was very respectful towards us as students in the way she communicated to us.

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

If not, please provide suggestions for improvement: Janelle provided us with constructive feedback that was very specific to our mental health practice.

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

●②③④⑤⑥

Comments: Janelle was very encouraging in developing my knowledge, skills, attitudes and behaviours towards linking the theory I knew on mental health to practice.

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

●②③④⑤⑥

Comments: Janelle was very respectful and confidential in regards to our clinical progress.

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

●②③④⑤⑥

Comments: Janelle provided plenty of helpful guidance towards any problems or issues I faced whilst on placement.

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

●②③④⑤⑥

Comments: The time I spent with my facilitator Janelle was very beneficial to my placement, learning and mental health nursing development.

Please provide additional feedback: