PRECEPTOR MANUAL

Bachelor of Midwifery

School of Health
Charles Darwin University
February 2014
Dear Preceptors,

Congratulations on your decision to actively participate in the teaching and guidance of CDU midwifery students.

As the Theme Leader for Midwifery in the School of Health at Charles Darwin University, I wish to thank you for taking on the role and responsibilities of preceptoring our midwifery students. This booklet is designed to provide you with information about the preceptor role and the links between the role, CDU and their relationship to the ANMC National Competency Standards.

Once again, thank you for supporting our CDU midwifery students.

Midwifery Theme Leader
School of Health
Charles Darwin University.
Glossary of Terms

**Mentor:** Someone who provides an enabling relationship that facilitates another’s personal growth and development. The relationship is dynamic, reciprocal and may become tense. The mentor’s role is to assist with career development and guide the mentee through the organisational, social and political networks. (Morton-Cooper & Palmer 1993), *Mentoring and Preceptorship: a guide to support roles in clinical practice*, published Blackwell Science.

**Preceptee:** A student learning midwifery within a clinical area which may be attached to a primary, secondary or tertiary agency.

**Preceptor:** Registered Midwife or Nurse, prepared for the role of supervision, clinical teaching, assessment and the provision of feedback to students (Heffernan, Heffernan, Brosnan, & Brown, 2009).

Contents

SECTION 1. .......................................................................................................................... 7

PRECEPTORING CHARLES DARWIN UNIVERSITY (CDU) STUDENTS ................................. 7

What are the necessary characteristics for being a CDU preceptor? ........................................ 8
  Characteristics of a preceptor: ................................................................................................. 8
  What are the roles and responsibilities of a CDU preceptor? ............................................... 9

SECTION 2:.......................................................................................................................... 12

TEACHING AND LEARNING ............................................................................................... 12

Characteristics of Adult Learners ........................................................................................... 12

Teaching and Learning Strategies ......................................................................................... 13
  General teaching strategies.................................................................................................... 13
  For the beginner student: ..................................................................................................... 14
  Indicators of Learning Progress. ......................................................................................... 14
  Red Flag behaviours ........................................................................................................... 15

SECTION 3 .......................................................................................................................... 16

ASSESSMENT ....................................................................................................................... 16
  Giving Feedback ................................................................................................................... 16
  How to give feedback .......................................................................................................... 17
  Timing.................................................................................................................................. 17
  Format................................................................................................................................. 17
  Involving the student in self-assessment ............................................................................. 17
  Always allow the student to respond to your feedback ....................................................... 17
  Being constructive (some ‘rules of thumb’) ....................................................................... 17

GUIDELINE FOR ASSESSING CLINICAL COMPETENCY ............................................... 19

SECTION 4:.......................................................................................................................... 21

SITUATIONS WHERE PRACTICE IS NOT IMPROVING OR IS UNSAFE ............................... 21

What happens if you identify problems? ................................................................................. 21

FLOWCHART FOR CLINICAL PLACEMENT UNITS .......................................................... 22
REFERENCES .................................................................................................................................................. 23

Other useful resources .................................................................................................................................... 23

Web sites of interest. .......................................................................................................................................... 24

APPENDIX A .................................................................................................................................................. 25

COMPETENCIES ASSESSMENT EXAMPLE ......................................................................................... 25
  Assessment and care for a woman in her antenatal period .............................................................................. 25

APPENDIX B .................................................................................................................................................. 29

BRIEF REFLECTION WORKSHEET .......................................................................................................... 29

APPENDIX C .................................................................................................................................................. 31

Scope of Practice for CDU Direct Entry Bachelor of Midwifery Students 2012 .................................................. 31
SECTION 1.

PRECEPTORING CHARLES DARWIN UNIVERSITY (CDU) STUDENTS

This booklet provides information related to preceptoring midwifery students from Charles Darwin University.

Thank you for choosing to be a CDU preceptor. This is a very important role and one that carries an added responsibility because it embraces the concept of facilitating learning among enthusiastic students as they commence their professional journey in health service delivery and women-centred care. Whilst this process is dynamic and some times very unpredictable, the role and responsibility of a preceptor is extremely rewarding.

The preceptor model for teaching students aims to provide a supportive network that enables the preceptor to facilitate the student’s professional, social and physical transition to the graduate midwife role in the real world of health care. It is a means to build a supportive teaching and learning environment for students (preceptees).

CDU along with many other universities and regulatory authorities have adopted the preceptor model of clinical supervision because it:

- Empowers students and improves the quality of students’ problem solving, learning and reflection in and on clinical practice;
- Assists preceptors to assess students within their Scope of Practice and helps them compare skill development with previous attempts and specified ANMC Competency Standards within the real world of clinical practice;
- Assists with role-socialisation processes;
- Provides the opportunity for students to learn time management, organisational skills, and delegation;
- Fosters students’ skill acquisition and helps them apply theory to practice;
- Builds students’ self-confidence as they are socialised into the role of the Registered Midwife;
- Enables students to assume increased levels of responsibility under direct supervision and at their own pace and Scope of Practice;
- Reduces the reality shock of the transition of student to Registered Midwife;
- Acknowledges expertise of skilled Registered Midwives who are expert role models for professional practice;
- Promotes a teaching and learning culture within organisations through commitment to quality improvement and life long learning;
- Helps preceptors to develop a professional portfolio, including preceptor activities in readiness for annual registration.
What are the necessary characteristics for being a CDU preceptor?

To be a successful preceptor you need to be clinically competent but you do not need to be an expert in all areas of your practice area, or have years of experience. You do need some teaching skills and completing a preceptor program is recommended. The Clinical Learning team in the NT offers preceptor programs at least twice per year. It is more important to be confident in your practice, enjoy what you are doing and have a genuine interest in teaching and supporting learners.

Characteristics of a preceptor:

- Shows respect for the learner and by doing so create a safe environment for professional growth;
- Demonstrates expert knowledge and skill and the ability to share these attributes in a way that is useful and interesting to the learner;
- Be able to make judgements about competence/proficiency of CDU students on the same part of the register, and in the same field of practice and be accountable for such decisions;
- Discusses current developments, reveals broad reading, discusses divergent points of view, relates topics to other disciplines, directs students to useful literature in the field, explains the basis for their actions and decisions and answers questions enthusiastically, clearly and precisely;
- Demonstrates enjoyment of midwifery and/or patient care and enthusiasm for teaching;
- Demonstrates knowledge and a willingness to share time, knowledge and skills;
- Is committed to a high level of evidence-based, quality midwifery care;
- Has a good understanding of the Australian Nursing and Midwifery Council National Competency Standards for the Registered Midwife;
- Communicates clear goals and expectation while remaining open and respectful to others;
- Recognises that, when appropriate, he or she must relinquish some of the control in the clinical area to the learner;
- Able to assess and give constructive feedback on the students’ level of clinical competence, knowledge and professionalism relative to the students’ level of experience and knowledge;
- Promotes active involvement of the learner in all aspects of practice.
What are the roles and responsibilities of a CDU preceptor?

Your role as a preceptor is to support students in practice, orient the student to the practice area and assist in the socialization of the student to the practice area. Supporting the student incorporates teaching, supervision, feedback and assessment, both formal and informal. Strength of preceptorship lies in enabling learners to develop their own knowledge and skills in an atmosphere conducive to learning, with colleagues who have experienced for themselves, and who have been prepared for, and understand the challenges confronting the learner.

The role of the Preceptor is to:

- Provide quality women centred/patient / client care and support and educate the student in the process;
- Orientate students to the clinical area;
- Enhance and reinforce students' level of clinical knowledge and skill;
- Assist students with meeting their learning objectives and needs; Identify learning needs with each preceptee and topics for further learning
- Contribute to the students' organisational skills and prioritising of care;
- Encourage students' critical thinking and problem solving skills;
- Assess students' performance and clinical competence;
- Assist in the socialisation of students' to the professional setting;
- Consult and liaise with the CDU Clinical Supervisor, Clinical Liaison Midwife and/or Unit Co-ordinator regarding students' formative and summative progress.

How can I prepare myself to become a preceptor?

Step 1. Make sure you feel comfortable with taking on this role, discuss this with the MUM, CLM and / or CDU Supervisor;

Step 2. Contact the Clinical Liaison Midwife and find out the students level of clinical skills practice and prior clinical experience

Step 3: First contact with the student

It is important to have a positive start. This occurs best in a supportive, open, and trusting relationship. Start by getting acquainted. This is best done one-on-one; take half an hour or so after handover to meet, share backgrounds and clarify expectations of each other. Other items to address as soon as possible are:

- Goals and objectives
- Skills already acquired
- Skills needed
- Plans for how feedback will occur
- Ways of contacting each other outside the work place (negotiable)
Points to remember

- Beginners can have a difficult time in rapidly changing situations. It is important not to overload them, and take this into account if there are a few tasks not completed at the end of their shift.

- Gradually add a few things, to make learning easier.

- Look for evidence that the student can manage the current "lesson" before adding on more.

- Try to add responsibilities only as fast as the student is able to manage them.

- Pushing students too fast can stifle learning and possibly stall their progress.

- Agree together on readiness to move on or to add on.

Some characteristic behaviours of a new beginner (novice)

- Tend to focus exclusively on the task at hand;
- Neglecting other events occurring at the same time;
- Following rules exactly as directed or learned;
- Refusing to take shortcuts in procedures;
- Faced with practicing a new skill, they focus totally on the skill itself. You will sometimes need to call attention to things that are happening around them.

These are behaviours are in direct contrast to the behaviours of an expert who:

- Anticipates the unexpected
- Doesn’t have to think in step-wise inferential manner
- Responds immediately, automatically, and intuitively
- Focuses on the goal and the actions to achieve it

It is important to remember the student is in a new area and depending on her/his background, may take some time to ‘acclimatise’ and become efficient. Given that CDU BMID students may already be a Registered Nurse, they will have differing levels of experience and problem solving ability. Patricia Benner (1984) adapted the Dreyfuss (1980) model of skills acquisition and these levels give some idea of where people are at in their level of expertise.

- **Novice**
Beginners have had no experience of the situations in which they are expected to perform. "Just tell me what I need to do and I'll do it."

• **Advanced beginner**

Advanced beginners are those who can demonstrate marginally acceptable performance, those who have coped with enough real situations to note, or to have pointed out to them by a mentor, the recurring meaningful situational components.

N.B. This is the level at which the BMID student should be on course completion.

• **Competent practitioner**

Competence, typified by the nurse who has been on the job in the same or similar situations two or three years, develops when the nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware. The competent person does not yet have enough experience to recognize a situation in terms of an overall picture or in terms of which aspects are most salient, most important.

• **Proficient practitioner**

The proficient performer perceives situations as wholes rather than in terms of chopped up parts or aspects, and performance is guided by maxims.

• **Expert**

The expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse (midwife), with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The expert operates from a deep understanding of the total situation.

SECTION 2:

TEACHING AND LEARNING

Characteristics of Adult Learners

Adult learning is often described as self-directed or experiential (Knowles, 1973 & 1984; Burns, 2006). Knowles describes five assumptions about adult learning:

1. Adults are independent and self-directing;
2. Adults have a deep life experience which is a rich resource for learning;
3. Learning is valued and integrated into daily life;
4. The orientation to learning changes from subject centered to problem centered;
5. Motivation to learn is driven by internal drivers rather than external ones.

The literature describes several different learning styles and teaching styles. What is most important is that the student and the preceptor are able to work together harmoniously.

Matching the learning stage to the preceptor teaching style

<table>
<thead>
<tr>
<th>Teaching style</th>
<th>Authoritarian</th>
<th>Motivator/Facilitator</th>
<th>Delegator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learner stage or type</td>
<td>Dependant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interested</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-directed</td>
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</tbody>
</table>

(Adapted from Grow, 1991)
As a general guide, a beginner or a dependant student will learn better in the structured environment provided by the authoritarian practitioner. This is not always the case and matching the preceptor with the student can sometimes be tricky. If there is a personality conflict between the student and the preceptor, it may be that there is a mismatch between the learning style of the student and the teaching/supervisory style of the preceptor. This is not unresolvable and it is important to identify this situation early and arrange a change that satisfies both parties.

**Teaching and Learning Strategies**

*General teaching strategies*

- Proceed from the simple to the complex;
- Build on the known to reach the unknown;
- Teach skills in small chunks that are easy to process cognitively;
- Utilise natural breaks or pauses in job sequence to help identify ‘chunks’ or stages for teaching. **Make the most of any supernumerary time the student has.**
- Role model and demonstrate – perform a skill and talk your way through it, and invite the student to ask questions;
- Answer questions – make students feel free to ask questions and to seek help without fear of loss of confidence or self-esteem. You are an expert, share your knowledge;
- Allow students to challenge you. Keep your knowledge base up to date and be willing to engage in open debate about practice issues. Role modelling is a powerful tool and if you are comfortable being challenged, students will be comfortable in an advocacy role when they need to be for a woman in their care;
- Encourage students to provide a rationale for their actions and provide them with a rationale for your decisions. This is also important when giving feedback on performance;
- Utilise all opportunities for student learning. View all clinical scenarios through a framework of “what can be learnt from this setting?”
- Offer debriefing to students involved in a critical incident;
- Allow time wherever possible for discussion and reflection on practice. Reflection is an important part of learning and provides an opportunity for the student to explore practice and develop critical thinking skills. Questions from a student like “what made you decide to offer Mary an ARM (artificial rupture of the fetal membranes)?” should not be perceived as a
threatening challenge but rather a part of the process of inquiry and clarification that leads to safe and competent clinical decision making;

- Give negative feedback in private. Importantly not in front of women clients or their families and away from other staff.

**For the beginner student:**

- Try to be patient with the beginner behaviours;
- Encourage the student to ask questions;
  
  - What would you do in this situation?
- Your student doesn't ask questions; Try using leading questions, such as:
  
  - What questions do you have about …?
  
  - Where are some places you have considered looking for the answers?
  
  - What do you need to find out about …?
- Help with organization and time management;
  
  - Have your student prepare a workload plan for the day
  
  - Assist the student to identify their learning needs for the day
  
  - Assist the student to identify any unplanned activities
  
  - Assist the student to prioritise their workload and ask the student to justify their priorities
- Expect the student to miss things, they are learning;
- Ask questions such as:
  
  - ‘What will you want to look for?’
  
  - ‘When you … what should you notice?’
- Keep the environment as stable as possible. This can be a challenge in a busy birth suite but too much external stimulation and change of environment can block the student’s thought processes and delay learning.

**Indicators of Learning Progress.**

Burns and colleagues (2006) describe the following behaviours that indicate the student is ‘getting it’

- Completes client assessments, history taking thoroughly;
- Develops and implements reasonable care plans;
- Can explain rationale behind actions/ care choices;
- Articulates sound decision making;
- Is organised, independent and time efficient;
- Is self-confident but knows limits and asks for help;
- Documentation and charting is on time and concise;
- 'Connects' with clients in a caring manner.

**Red Flag behaviours**

- Incomplete client assessments, missing data
- Hesitant, anxious, defensive, not collegial
- Uneasy rapport with clients and misses cues
- Is unable to explain reasoning for actions/diagnosis etc
- Is unable to prioritise workloads
- Unable to create a care plan independently
- Documentation is poor and inconsistent

(Burns et al, 2006, pp 181).

In an undergraduate course students should be showing some signs of ‘getting it’ at the end of their first year; where the student is already an RN this will occur more quickly. When the student returns for a second year/rotation to an area she/he may be a little hesitant at first, but after a few shifts ‘getting it’ behaviours should accelerate as the student's confidence returns. At the completion of the course, students should be at the advanced beginner level in Bennett's levels of expertise. See progression diagram below:

Will Taylor, Chair, Department of Homeopathic Medicine, National College of Natural Medicine, Portland, Oregon, USA, March 2007. [http://www.businessballs.com/consciouscompetencelearningmodel.htm](http://www.businessballs.com/consciouscompetencelearningmodel.htm)
SECTION 3

ASSESSMENT

The standards used to measure nursing and midwifery competence are those developed by the Australian Nursing and Midwifery Council (2006) and thus utilised by the nursing and midwifery regulatory authorities in all Australian States and Territories. In the case of midwifery, the ANMC standards are also endorsed by the Australian College of Midwives. All Australian nurses and midwives are expected to use the relevant national competency standards when performing self assessment of competence.

The standards are broad and principles based and are designed to be used at the macro level as a benchmark when developing curricula and evaluation tools. Consequently there is a range of assessment tools in the student’s clinical portfolio with which to assess competence in practice. The tools have been developed by distilling the micro activities that define essential midwifery practice from the broad competency standards. They are grounded in the language of the contemporary midwife clinician and are applicable across the various clinical settings.

All midwives currently registered in Australia should be familiar with the ANMC National Competency Standards for the Midwife. Copies in pdf are available for download from the ANMC web site. Hard copies are no longer available.

www.anmc.org.au

All competencies have associated performance criteria (indicators) and, for example, midwifery students are assessed according to the level of a beginning midwife. To deem a student as competent means the student is capable of performing the activity efficiently and without any cues from the assessor/instructor. i.e. If you, as a midwife/clinician, would feel confident that the student is able to perform the activity/skill safely without direct supervision*

*Supervision is the oversight, direction, guidance and/or support provided in the clinical area to a student by a registered midwife. As per the ANMC (2006) supervision may be:

Direct – when the supervisor is actually present and personally supervises, works with, guides and directs the person being supervised.

Indirect – when the supervisor works in the same facility or organisation as the student, but does not constantly observe their activities. The supervisor must be available for ready access.

If a student is deemed to require further practice at a particular activity it is important that this is not seen as failure in a terminal sense. The aim is to be able to practice without supervision in a safe manner to the level of a beginning practitioner by the end of the course. Assessment itself is a learning process.

Giving Feedback

*Catch the student doing something right and reinforce it*

Feedback should be regular ongoing and not all given at the end of placement interview. In order to provide the student with feedback you must have knowledge about the student’s performance. You can obtain this knowledge in different ways:
- Observing the student at work
- Asking questions
- Observing the students interactions with others, women/patients and staff.
- Reviewing the students documentation
- Talking to other midwives/staff
- Observing the student's time management skills

**How to give feedback.**

Assessment and feedback is relatively easy where progress towards competencies is smooth. Encouragement is much easier to give than criticism, most of us respond better to praise. It is essential however that feedback be given *often*, and *honestly*. Assessment should be a continuous process, with constructive feedback including aspects on which to focus and refine. If it is necessary to adjust students' techniques, then this is better done *early*.

Some points outlined in Stuart (2003) that may assist you in this are:

**Timing**

Feedback that is *recent*, fair and includes points for improvement or refinement is constructive; students generally respond well to this style of feedback. For feedback to have maximum impact it should take place while it is still relevant and points raised are therefore more meaningful and alive.

**Format**

May be oral or written. Informal feedback ‘on the run’ is inevitably oral. Written feedback can form part of the more formal assessments of the competencies the students are required to achieve.

**Involving the student in self-assessment**

Students should be encouraged to self-assess. In conjunction with their preceptor students should be guided to identify strengths and areas for improvement. Both parties can be guided by the ANMC competency standards (2006) as applied to practice.

The brief reflection worksheet at the end of this document may be useful for the student to assist in clarifying thoughts and identifying areas of strength and areas for further development.

**Always allow the student to respond to your feedback.**

To ensure that the student has understood what you are saying, would like further comments from you or if they wish to explain themselves allow them the time to do so. This helps them to clarify what you are saying and to choose whether to take your advice.

**Being constructive (some ‘rules of thumb’)**

- Maintain privacy - not given in front of patients, staff or other students
- Specific – e.g. directed to actual behaviour that has been observed
• Immediate – this makes the feedback more meaningful and practical since the student can relate it to what has actually happened
• Break the feedback information up into small pieces that the student can ‘digest’
• Use evidence from practice to support positive and negative aspects of performance. Avoid generalizations like ‘you did that really well’. The student needs to know what it was that defined the action as ‘really well’. E.g.; “you were very gentle with the baby and protected his head”

• Reinforce the good points; balance the negative and positive ‘the praise sandwich’.

  Positive feedback

  

  Negative feedback

  

  Positive feedback

• **Top:** Say what was done well (encourage student)
• **Middle:** Say what was not so good or wrong (correct mistakes)
• **Bottom:** Give specific suggestions for the next time (improve performance)

N.B. Students tend to remember only the negative, although it is important that the negative criticism does need become ‘lost’ in between the praise.

• Ensure the student makes a commitment to improve the aspect/s of practice that requires improvement. This should be a brief written plan. There is room for this on the assessment forms.

• Set a date for the next assessment
GUIDELINE FOR ASSESSING CLINICAL COMPETENCY.

The following scales may help you to make a decision about where a student is at in their clinical progress.

<table>
<thead>
<tr>
<th>Level</th>
<th>Meaning</th>
</tr>
</thead>
</table>
| 1-2  | Independent & excellent performance | Safe: requires & seeks minimal prompts for thinking & action.  
Demonstrates an excellent understanding of knowledge underpinning practice. Very coordinated, proficient and confident in technical clinical skills. Professional & caring at all times. Excellent effective interpersonal communication skills with patients & staff. Very good ability to synthesise theory & practice with minimal prompts. Very well developed clinical reasoning skills.  
Must always be supervised by a Registered Midwife. |
| 3-4  | Infrequently assisted & good performance | Safe: requires & seeks infrequent prompts for thinking or action.  
Demonstrates a sound understanding of knowledge underpinning practice. Coordinated, proficient and confident in technical clinical skills. Professional & caring at all times. Good effective interpersonal communication skills with patients & staff. Good ability to synthesise theory & practice with minimal prompts. Good clinical reasoning skills.  
Minimum standard for Year 3. |
| 5-6  | Assisted & satisfactory performance | Safe: requires and seeks prompts for thinking or action.  
Demonstrates a satisfactory understanding of knowledge underpinning practice. Coordinated, proficient and confident in most technical clinical skills. Professional & caring at all times. Appropriate interpersonal communication skills with patients & staff. Satisfactory ability to synthesise theory & practice with minimal prompts. Satisfactory clinical reasoning skills.  
This is the minimum standard first and second year students must achieve. |
| 7-8  | Frequently assisted & Borderline performance | Unsafe: requires frequent verbal and/or physical prompts and direction.  
Deficit in knowledge underpinning practice. Requires frequent prompting to elicit knowledge. Hesitant, unconfident and/or lacks proficiency in technical skills. Professional conduct and caring not consistently demonstrated. Occasionally demonstrates ineffective interpersonal communication skills. Requires frequent prompting to synthesise theory and practice. |
| 9-10 | Dependent & Unsatisfactory performance | Unsafe: requires ongoing verbal & physical prompts and direction.  
Requires ongoing prompting to elicit knowledge underpinning practice. Uncoordinated, unconfident and lacks proficiency in basic technical skills. Professional conduct and caring not consistently demonstrated. Frequently demonstrates ineffective interpersonal communication skills. Inability to synthesise theory and practice even with frequent prompting and support. |
SECTION 4:

SITUATIONS WHERE PRACTICE IS NOT IMPROVING OR IS UNSAFE.

There are various facets to be considered when dealing with unsatisfactory and/or unsafe clinical performance.

Firstly, unsatisfactory clinical performance must be differentiated from unsafe performance. Although unsafe performance is by its nature unsatisfactory, the reverse is not always the case.

A student is deemed unsatisfactory due to failure to meet the objectives and assessment of a given midwifery practice experience. This may be flagged midway through the first placement if the student appears to be ‘not getting it’. Identifying slow or poor progress early may ensure the student does pass the final assessments.

N.B. This would be after 3 attempts (assessments) at achieving the activity at the level of a beginning practitioner.

What happens if you identify problems?

Step 1. Clearly and objectively identify the problem and readily observable reasons why the student is finding that meeting their clinical objectives is challenging. Doubts over a student’s performance during their placement must be qualified in terms of outcomes and explanation. In general this will be based on the competencies as set out in the student’s Clinical Portfolio. By linking your assessment closely to the ANMC Competency Standards you will be able to keep your assessment objective, unambiguous, realistic and measurable.

Step 2. Ask yourself “can I talk to the student about this” (see alternative below).

Step 3. If you can, meet with the student to discuss your concerns. Extensive, constructive feedback is necessary here to help students understand any concerns you may have. It is crucial that problem areas are clearly documented, along with plans for development. It is important to find out if the student is aware of the problem and negotiate strategies for dealing with it.

Step 4. Let the CLM and/or CDU Supervisor or CDU Unit co-ordinator know what the identified problem is and what strategies have been put in place. The CDU Unit Coordinator must be advised about what has happened. It is crucial to keep anecdotal records and minutes of the meeting. These should be available to the student and CDU.

Step 5. Evaluate the strategies and provide ongoing feedback to the student. The CLM and/or CDU Supervisor/unit co-ordinator must be kept informed regarding progress. You must record your plan of action and the support provided, as well as input from the student.

OR

Step 2. If you cannot talk to the student then discuss the problem with the CLM and/or CDU Supervisor for advice and strategies on how to deal with the problem.
FLOW CHART FOR CLINICAL PLACEMENT UNITS

MID101, MID102, MID202, MID204, MID301, MID303, MID306, MID307

COMMENCE PLACEMENT

CLINICAL APPRAISAL

Progress determined as satisfactory by Agency/Facility clinical supervisors, educators, preceptors and Unit Coordinators

Placement Finished
Clinical Portfolio completed and submitted to appropriate CDU unit co-ordinator within two weeks of completion of clinical placement

All elements graded as satisfactory and a grade is recorded

Student proceeds to the next level of study or if course complete grade transcript signed and forwarded to Nursing & Midwifery Board of Australia.

Assessment elements graded as unsatisfactory

Learning Agreement achieved

One Learning Agreement opportunity for the remainder of placement, or additional placement arranged as per Learning Agreement

FAIL recorded for unit

UNSAFE PRACTICE reported – student working outside identified scope of practice

Student to meet with the BM Program Manager/Theme Leader to discuss course progression

Student removed from clinical placement

Progress determined as unsatisfactory by Agency/Facility clinical supervisors, educators, preceptors and Unit Coordinators i.e.
- Not achieved year level standard
- Not achieving scope of practice
- Not demonstrating professional conduct

Feedback provided to student

Placement Finished

Clinical Portfolio completed and submitted to appropriate CDU unit co-ordinator within two weeks of completion of clinical placement
REFERENCES

ANMC, 2006, National Competency Standards for Nurse/Midwives/Nurse Practitioner.


Other useful resources


Medical Journal of Australia has published a series of 14 Teaching tips on the run which are available online through the journal and are also available as a published booklet. The series
commenced in April 2004 through to August 2006.


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**Web sites of interest.**

University of British Columbia. Preceptor resources

[http://www.health-disciplines.ubc.ca/pm/index.htm](http://www.health-disciplines.ubc.ca/pm/index.htm)

University of Bournemouth. Practice based learning resources


Canadian Nurses Association Preceptor Handbook.


Royal Childrens Hospital Melbourne Preceptor site.


University of Kansas Medical School. Preceptor microskills.

[http://wichita.kumc.edu/strategies/microskills/index.html](http://wichita.kumc.edu/strategies/microskills/index.html)

Microskills article

[http://www.oucom.ohiou.edu/fd/monographs/microskills.htm](http://www.oucom.ohiou.edu/fd/monographs/microskills.htm)

One minute preceptor clinical teaching microskills examples.
APPENDIX A

COMPETENCIES ASSESSMENT EXAMPLE

Assessment and care for a woman in her antenatal period

<table>
<thead>
<tr>
<th>Student Name: _________________________</th>
<th>Date: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>Indicator</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>4.3</td>
<td>Organises workload to accommodate the assessment and collects records</td>
</tr>
</tbody>
</table>

Cues: Organises workload to facilitate midwifery care for women & their babies
<table>
<thead>
<tr>
<th>women &amp; their babies</th>
<th>Demonstrates appropriate time management and priority setting skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Adheres to universal precautions</td>
</tr>
<tr>
<td>Complies with policies and guidelines that have legal and professional implications for practice</td>
<td>Cue: Complies with legal policies and guidelines, for example occupational health, infection control.</td>
</tr>
<tr>
<td>8.1 10.1</td>
<td>Provides assistance and interpreter as required</td>
</tr>
<tr>
<td>4.1 7.2</td>
<td>Maintains woman’s privacy and confidentiality</td>
</tr>
<tr>
<td>3.1</td>
<td>Frames questions to achieve optimum communication</td>
</tr>
<tr>
<td>3.1 3.3 4.1</td>
<td>Addresses woman appropriately and seeks consent</td>
</tr>
<tr>
<td>3.1</td>
<td>Listens to woman and responds appropriately</td>
</tr>
<tr>
<td>5.1</td>
<td>Calculates expected date of birth correctly (using Naegles rule)</td>
</tr>
<tr>
<td>5.1 5.2</td>
<td>Ensure accuracy of demographic details</td>
</tr>
<tr>
<td>3.1 5.2 5.3 7.1 9.1</td>
<td>Discusses woman’s health during her pregnancy</td>
</tr>
<tr>
<td>5.2 5.3</td>
<td>Identifies woman’s health history and discusses the significance of this if appropriate</td>
</tr>
<tr>
<td>5.1 5.2</td>
<td>Discusses woman’s state of health since last visit</td>
</tr>
<tr>
<td>5.2 5.3 5.5 6.1 7.1 2</td>
<td>Gives appropriate advice for the relief of minor disorders</td>
</tr>
</tbody>
</table>
### Discuss the significance of the following aspects of the antenatal history that you have collected, or that has been collected:

<table>
<thead>
<tr>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic details</td>
<td>□</td>
</tr>
<tr>
<td>Obstetric history</td>
<td>□</td>
</tr>
<tr>
<td>Medical and surgical history</td>
<td>□</td>
</tr>
<tr>
<td>Family medical history</td>
<td>□</td>
</tr>
</tbody>
</table>
Discuss the rationale (includes providing the evidence) for, and the significance (importance) of, the following aspects of the antenatal assessment:

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>Weight (if done)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundal height and palpation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investigations/specimens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal examination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For example.

**Urinalysis.**

**Rationale.** It is recommended according to current best evidence to collect a mid stream urine for M&C at the first visit to exclude asymptomatic bacteruria. A dipstick should also be performed at the same time to screen for renal disease. Routine urinalysis for proteinuria is not necessary for low risk women as it is a poor predictor of pre eclampsia. The blood pressure will rise before protein appears in the urine.

**Significance:** Treating asymptomatic bacteruria improves the outcomes of pregnancy in respect of pyelonephritis, preterm birth and low birth weight.

Detecting protein in the urine may indicate chronic renal disease. In respect of pre eclampsia the blood pressure will rise before protein is detected in the urine, therefore routine testing is not cost effective.

Reference: 3 Centers’ Consensus Guidelines on Antenatal Care.

[www.3centres.com.au](http://www.3centres.com.au)

**Discuss findings on abdominal examination that could indicate:**

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory</th>
<th>Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oligo/polyhydramnios</td>
<td></td>
<td></td>
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<tr>
<td>Transverse lie</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Breech presentation □ □
Growth restriction □ □
Posterior position □ □

Assessor comments:
______________________________________________________________
______________________________________________________________

Remedial strategies (if necessary): Date for reassessment:______________
__________________________________________________________________
__________________________________________________________________

Student comments:
______________________________________________________________
______________________________________________________________

Assessor name: ___________________________________________
Assessor signature: ___________________________________________

Student signature: ___________________________________________
Name:
Date:
Clinical area:

*Take a moment to think about your clinical experience today, and then write your responses to the following;*

Fill the cloud with words that describe your clinical experience today?

What was the most important thing you learned today/this week?

Are there any unanswered questions in your mind?

How will you seek answers to these questions?
### APPENDIX C

**Scope of Practice for CDU Direct Entry Bachelor of Midwifery Students 2012**

The following table summarises the scope of practice for each year level for the CDU direct entry BM students. It indicates the level of midwifery skills and knowledge students should be able to demonstrate at the beginning and those they must achieve on completion. All students uphold the philosophy of midwifery practice as stated by the Australian College of Midwives and provide evidence-informed rationales for all midwifery actions. They must demonstrate professional accountability and responsibility for their actions & behaviour, according to their scope of practice & the ANMC Competency Standards, Code of Ethics and Practice. CDU’s BM students are ‘learners’ and are not part of the workforce (as distinct from the RN in an Employed Midwifery Student Program). Irrespective of past experience they work with close supervision from a RM.

<table>
<thead>
<tr>
<th>Year 1: Unit MID101</th>
<th>Year 2: Unit MID202</th>
<th>Year 3: Unit MID301;MID303:MID306:MID307</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice: frequent or continuous cues. No client load; continuous supervision.</td>
<td>Novice-advanced beginner; frequent or occasional cues.</td>
<td>Advanced-beginner. Minimal cues; minimal supervision</td>
</tr>
<tr>
<td>May initiate 2 continuity of care journeys.</td>
<td>Under the direct supervision of a midwife, and in collaboration with women clients, implement clinical decision making that is formed in consultation with other health care providers</td>
<td>Under the direct supervision of a midwife or equivalent, and in collaboration with the woman and where appropriate, other health care providers, form and implement own clinical decisions. Manage a small caseload of women (6-8)</td>
</tr>
<tr>
<td>Observe the role and scope of practice of the midwife; Communicate and collaborate appropriately with colleagues, women/ families</td>
<td>Demonstrate timely &amp; accurate communication, documentation and evidence informed decision-making which addresses cultural safety &amp; awareness. Discuss evidence-informed rationales for implementing designated midwifery care; With supervision conduct a first antenatal visit:</td>
<td>Demonstrate professional communication, conduct and evidence-informed decision-making in all aspects of midwifery practice across a range of cultural settings &amp; acuity levels.</td>
</tr>
<tr>
<td>• Actively listen</td>
<td>• History taking</td>
<td>Confidently provide accurate, logical, concise and appropriate recording and reporting of client/patient data (oral &amp; written) to the health care team.</td>
</tr>
<tr>
<td>• Observe a first antenatal visit</td>
<td>• DV screening</td>
<td>Manage a small caseload of women (6-8) under the direct supervision of a midwife or equivalent.</td>
</tr>
<tr>
<td>• Observe a subsequent visit</td>
<td>• Explain screening tests</td>
<td>Assessment, planning, evidence-informed intervention, rationales and evaluation) for women/patients requiring medication:</td>
</tr>
<tr>
<td>Establish and maintain an ongoing partnership with 2 women who are beginning their childbearing journey. Meet the 2 women through the supervising midwife.</td>
<td>• Explain care options</td>
<td>• Further develop skills in the safe administration of medicines via the oral, topical and parental routes</td>
</tr>
<tr>
<td></td>
<td>• Nutrition advice</td>
<td>• Manage medication regimes across varying modalities</td>
</tr>
<tr>
<td></td>
<td>• Breastfeeding advice</td>
<td>• Intra-venous therapy regimes including IV</td>
</tr>
<tr>
<td></td>
<td>• Discuss childbirth education needs</td>
<td></td>
</tr>
<tr>
<td>Assist CTG</td>
<td>Conduct scheduled antenatal assessments, including discussion of birth options; refer to the ACM guidelines for referral</td>
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<tr>
<td></td>
<td>Demonstrate knowledge of stages of labour and evidence for care;</td>
<td></td>
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<tr>
<td></td>
<td>Assist with assessment and care of labouring and birthing women;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Abdominal examination</td>
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<tr>
<td></td>
<td>- Assessment of progress</td>
<td></td>
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<tr>
<td></td>
<td>- Contraction pattern</td>
<td></td>
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<tr>
<td></td>
<td>- State of membranes</td>
<td></td>
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<tr>
<td></td>
<td>- Descent of PP</td>
<td></td>
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<tr>
<td></td>
<td>- FHR</td>
<td></td>
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<tr>
<td></td>
<td>- VE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assist with the birth of the baby</td>
<td></td>
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<tr>
<td></td>
<td>Assist with third stage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assist with the fourth or transition phase</td>
<td></td>
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<tr>
<td></td>
<td>Observe newborn examination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Administer IMI Vitamin K&lt;sub&gt;1&lt;/sub&gt; to newborn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assist with initiation of breastfeeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assist with medication administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Articulate knowledge of legislation, charting and e-scribe medication administration contexts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Safely administer S2 and S4 medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Explain the pharmacokinetics of the above medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work collaboratively with allied health workers &amp; other team members.</td>
<td></td>
</tr>
</tbody>
</table>

**Year 1: Unit MID102**

Novice: frequent or continuous cues. No client load/ work with a RM and share the care under continuous supervision; may provide midwifery care under the direct supervision of a midwife and based on the

**Year 2: MID204**

Novice-advanced beginner; frequent or occasional cues.

Under the direct supervision of a midwife, and in collaboration with women clients, implement clinical decision making that is formed in consultation with other health care providers.

**Year 3. MID307. Specialist neonatal care**

Advanced-beginner. Minimal cues; minimal supervision

Under the direct supervision of a midwife or a registered nurse, and in collaboration with women clients, implement clinical decision making that is formed in consultation with other health care providers.

**Antibiotics: narcotic infusions, epidurals & PCAs**

- Demonstrate knowledge about the storage and use of Schedule 2, 4 and 8 medications according to facility, statutory, State and Commonwealth law
- Discuss the pharmacology & pharmacokinetics of medications administered by the student

Discuss evidence-based collaborative management of women/patients who require the above interventions.

Recognise and assist with collaborative management of women experiencing challenges during their childbirth episode:

- Women with mental health problems
- Withdrawal syndrome and/or dependency behaviours (including working with AOD team)
- Cognitively impaired patients
- Medical/surgical complications
- Sexually transmitted infection/s
- Perinatal loss- early and late
- Birth of a baby with a congenital disorder

Perform and interpret CTG

Assist with family planning options

Provide evidence-based midwifery care for women experiencing the following complications:

- Antepartum haemorrhage
- Hypertension/preeclampsia/eclampsia
- Shoulder Dystocia
- Breech Birth
- Multiple pregnancy and birth
- Cord presentation and prolapse
- Cardiac disease
- Renal disease
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss evidence-informed rationales for implementing designated midwifery care;</td>
<td>Discuss evidence-informed rationales for implementing designated midwifery care;</td>
<td>Discuss evidence-informed rationales for implementing designated midwifery care;</td>
</tr>
<tr>
<td>Provide midwifery care to post caesarean women and their infants;</td>
<td>Demonstrate timely &amp; accurate communication, documentation and evidence informed decision-making which addresses cultural safety &amp; awareness.</td>
<td>Assess and care for well preterm infants</td>
</tr>
<tr>
<td>Assess woman’s/patients’ input/output (direct &amp; indirect observation, fluid balance &amp; food/diet charts);</td>
<td>Assess women in pre/early labour</td>
<td>- incubator care</td>
</tr>
<tr>
<td>Recognise &amp; report significant fluid balance fluctuations;</td>
<td>Provide evidence-based information to women in early labour;</td>
<td>- vital signs</td>
</tr>
<tr>
<td>With continuous support implement midwifery interventions for well women post caesarean sections that require some assistance with their care;</td>
<td>Assess and care for labouring and birthing women:</td>
<td>- monitor for hypoglycaemia</td>
</tr>
<tr>
<td>• Vital signs;</td>
<td>• Recognise the different stages of labour</td>
<td>- hygiene</td>
</tr>
<tr>
<td>• Positioning &amp; mobility</td>
<td>• Prepare the birthing room for birth</td>
<td>- oro/naso gastric feeding</td>
</tr>
<tr>
<td>• Personal hygiene</td>
<td>• Assist the birth of the baby</td>
<td>- supplemental oxygen</td>
</tr>
<tr>
<td>Use safe manual handling techniques and equipment;</td>
<td>• Assess newborn using the Apgar score</td>
<td>- oral/IV medications</td>
</tr>
<tr>
<td>With support promote patient comfort &amp; body alignment including:</td>
<td>• Assist with newborn resuscitation</td>
<td>- phototherapy</td>
</tr>
<tr>
<td>• Bed making – occupied and unoccupied</td>
<td>• Assist third stage</td>
<td></td>
</tr>
<tr>
<td>• Assist women requiring mobility support</td>
<td>• Assess blood loss</td>
<td></td>
</tr>
<tr>
<td>• Apply TED stockings</td>
<td>• Assist in management of excessive blood loss</td>
<td></td>
</tr>
<tr>
<td>Help with elimination management (care of indwelling catheters; bedpans) in relation to women post caesarean section and perineal toilet.</td>
<td>Use different pain management techniques when caring for women in labour &amp; birth.</td>
<td></td>
</tr>
<tr>
<td>Assist woman with basic baby</td>
<td>Assist with intrapartum CTG</td>
<td>Assist with Prostaglandin gel insertion</td>
</tr>
<tr>
<td></td>
<td>- apply</td>
<td>- Apply the CTG monitor as appropriate</td>
</tr>
<tr>
<td>Care:</td>
<td>Assist in the preparation of the IVI Syntocinon:</td>
<td></td>
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<tr>
<td>---------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>- Bathing/skin care</td>
<td>- Select appropriate IV fluid</td>
<td></td>
</tr>
<tr>
<td>- Buttock hygiene</td>
<td>- Prime line</td>
<td></td>
</tr>
<tr>
<td>- Cord care /eye care</td>
<td>- Explain the pharmacokinetics of Syntocinon</td>
<td></td>
</tr>
<tr>
<td>- Daily observations</td>
<td>- explain the side effects of IV Syntocinon</td>
<td></td>
</tr>
<tr>
<td>- Weighing</td>
<td>when used for induction of labour</td>
<td></td>
</tr>
<tr>
<td>- add Syntocinon to IV bag</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use safe and effective infection control measures &amp; standard precautions including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hand hygiene</td>
<td>Assist with preparation for ARM</td>
<td></td>
</tr>
<tr>
<td>- Use of personal protective equipment</td>
<td>- explain the reasons for an ARM</td>
<td></td>
</tr>
<tr>
<td>- Appropriate disposal of waste materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With support assist with wound healing by primary intention:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dry wound dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Assess wound healing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With supervision assess and supporting respiratory function through body positioning and primary care planning and implementation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Post caesarean section breathing/coughing exercises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss student’s role in Emergency Codes (Blue, Green, Red etc)</td>
<td></td>
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</tr>
<tr>
<td>With support conduct an assessment of patient pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls assessment in relation to women post – epidural/spinal anaesthetic;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide basic care to antenatal women;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Blood Pressure</td>
<td>Provide education as required to postnatal women</td>
<td></td>
</tr>
<tr>
<td>- Weighing</td>
<td>- Breast care</td>
<td></td>
</tr>
<tr>
<td>- Urinalysis</td>
<td>- Perineal wound care</td>
<td></td>
</tr>
<tr>
<td>- Auscultate fetal heart</td>
<td>- Lochia patterns</td>
<td></td>
</tr>
<tr>
<td>Provide newborn care</td>
<td>- Baby feeding behaviours</td>
<td></td>
</tr>
<tr>
<td>- daily care of the newborn</td>
<td>- Immunisations</td>
<td></td>
</tr>
<tr>
<td>- examination of the newborn</td>
<td>- Child family health nurse role</td>
<td></td>
</tr>
<tr>
<td>- collect newborn screening blood test on day 3</td>
<td>- Support groups in community</td>
<td></td>
</tr>
</tbody>
</table>

Administer S2 and S4 medications

Assist with education and milk preparation for women who choose to use a breastmilk substitute

Provide newborn care
- daily care of the newborn
- examination of the newborn
- collect newborn screening blood test on day 3
| with Pinard or Doppler | Using a simulator, demonstrate the steps in resolving shoulder dystocia and explain the rationale for the manoeuvres |