Charles Darwin University

Clinical Assessment Portfolio 2014

NUR125 Fundamental Nursing Practice

BNUR - Bachelor Nursing
School of Health / Faculty of Engineering, Health, Science and the Environment

Student Name:__________________________________________________________

Student Number:________________________________________________________

Dates of Placement: From:__________________________ to:________________________

Health Facility:__________________________________________________________

Unit Name:_______________________________________________________________

Nurse Unit Manager:_______________________________________________________

Contact Details:__________________________________________________________

*Student is reminded to keep a certified copy for own records
**A completed CDU cover sheet must be attached prior to submission
INTRODUCTION TO PORTFOLIO AND EXPLANATION OF ASSESSMENT:
The Charles Darwin University (CDU) Clinical Assessment Portfolio for Bachelor of Nursing students is designed to guide the student and Clinical Facilitator / Preceptor through the clinical placement experience. Please do not hesitate to contact the Unit Coordinator for assistance, explanation or to provide feedback. To achieve a pass grade for this assessment, students must satisfactorily complete all assessment items. A Learning Agreement will only be utilised for students failing to meet the Nursing and Midwifery Board Australia Competency Standards. All assessments must be witnessed by a Registered Nurse working in the health facility or the Clinical Facilitator / Preceptor responsible for the placement.

Assessments
1. **Attendance record:** This must be accurate and complete. Any absences must be reported to the health facility and the CDU Clinical Placement Office (CPO) prior to the shift commencing. A 100% attendance is required to complete the practicum. All make up time must be negotiated with the CDU CPO and the health facility.  
   See page: 7-8

2. **Clinical Objectives:** The student is responsible for setting their own clinical objectives for placement and should begin to identify these prior to the commencement of placement. The student must set two objectives per week. These objectives, the strategies and the demonstrated evidence that objectives have been met, are graded. Students who do not meet their objectives may not achieve a pass for the unit. The objectives and their associated strategies must fit within the appropriate year Scope of Practice and be relevant to the unit or team in which the placement occurs. The objectives should increase in complexity over the course of the placement.

   **The objectives must be realistic, achievable, measurable and assessable.**

   For example: “I will demonstrate the ability to provide holistic nursing care to my patient load of 4 patient. This may include medication administration, health assessments, attending to activities of daily living and full documentation. I will be able to discuss rational of care with my preceptor”

   Remember to make the learning objectives something that you can show evidence of successful achievement. They should relate to the clinical /community area of your placement and /or your scope of practice. Align your objectives with the most relevant NMBA Domains and standards. The objectives should increase in complexity each week of placement.

   **NMBA Standards:** Select 3-5 NMBA competency standards relevant to the objective (including the number and title). Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

   **Resources:** The resources utilised should extend beyond those easily sourced such as policies, procedures and your preceptor. These are important but should be in addition to resources that show you have critically reflected on the achievement of your objective and improved performance.

   **Student Self-evaluation:** How did you achieve your objective? How did this make you feel? What were your thoughts, anything surprising?

   **Strategies to improve performance:** Re-evaluate your performance and determine what strategies you need to improve performance.

3. **Nursing and Midwifery Board Australia (NMBA) Competency Feedback & Assessment:** Based on the NMBA Competency Standards: Interim Feedback (midway) and Final Assessment (completion).

   This feedback and assessment instrument is based on the Australian Nursing and Midwifery Council Competency Standards (2006). Student’s competency is assessed according to each NMBA Domain. CDU expects that students perform their nursing care within the specified Scope of Practice.  
   See pages: 8-9

   It is within this scope that CDU expects the student to be assessed in relation to the NMBA Competency Standards. The instrument is based on Bondy’s work (1983). The grading scale is outlined on the following page.
Grading scale for NMBA Competency Standards:

Students must attain a minimum rating of:

First year (NUR125): Assisted

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Independent: (I)</td>
<td>Refers to being safe &amp; knowledgeable; proficient &amp; coordinated and appropriately confident and timely. Does not require supporting cues</td>
</tr>
<tr>
<td>Supervised: (S)</td>
<td>Refers to being safe &amp; knowledgeable; efficient &amp; coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.</td>
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<tr>
<td>Assisted: (A)</td>
<td>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.</td>
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<tr>
<td>Marginal: (M)</td>
<td>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.</td>
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<tr>
<td>Dependent: (D)</td>
<td>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.</td>
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</table>

Is the student currently progressing satisfactorily?

Students must achieve minimum level of ‘Supervised’ in all NMBA Competencies Standards by the end of placement. ‘Unsatisfactory’ should be marked if student is graded below ‘Supervised’ in the Interim NMBA Feedback Assessment (p11) and with available evidence student appears unlikely to reach ‘Supervised’ by end of placement without intensive support or intervention. If ‘Unsatisfactory’ is marked the health facility is to contact Unit Coordinator for advice and refer to page 33 for Learning Agreement information. This feedback will allow extra supports to be put in place to assist the student.

Note: If ‘Satisfactory’ is marked, this does not mean the student has passed; it is an indication of the student’s progression.

See page: 12 (Interim)
And page: 19 (Final)

4. **CDU CLINICAL PLACEMENT LEARNING AGREEMENT:** This assessment is only required for students failing to meet the NMBA Competency Standards. If student is not meeting minimum standards a Learning Agreement should be entered into in consultation with Unit Coordinator. If the student is deemed grossly unsafe, the health facility retains the right to ask the student to leave the placement.

See page: 33
Medication Scope

NB: Where the policies of the facility do not allow the student to administer certain types or mode of medication the student must adhere to the lesser scope.

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-prescription topical</th>
<th>PO</th>
<th>PR or PV</th>
<th>SC or IMI</th>
<th>SL</th>
<th>Topical or Transdermal</th>
<th>Intrathoracic</th>
<th>Intravenous</th>
<th>Telephone orders</th>
<th>Intraosseous</th>
<th>Intranasal</th>
<th>Infusion with no additives</th>
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<tr>
<td>1</td>
<td>YES</td>
<td>X</td>
<td>X</td>
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Double checking of medications prior to administration

This process is an essential stage of medication administration to decrease the risk of potential harm to the patient. The process of double checking medication should be performed by 2 authorised health care professionals (Registered Nurse or Endorsed Enrolled Nurse). The CDU nursing student should be a third party when checking medications.

Medications that require checking by 2 authorised health care professionals (within the scope of medication administration for CDU nursing students) are as below:

- Medication administered as an additive to an IV infusion bag, burette or syringe driver
- Medication administered by direct IV injection
- Medications administered by intramuscular or subcutaneous
- Medications given to babies and children
- Controlled drugs
- Warfarin

Any questions regarding medication administration should be referred to the Unit Coordinator.
CDU CONTACTS:

UNIT COORDINATOR:
Name: ____________  Email: ________________  Phone: ____________

CLINICAL PLACEMENT OFFICE: varies by State. (Student to enter prior to placement starting)
Name: ____________  Email: ________________  Phone: ____________

CLINICAL COORDINATOR: To contact if unable to contact Unit Coordinator.
Name: Kobi Schutz  Email: kobi.schutz@cdu.edu.au  Phone: 08 8946 6397

SUBMISSION OF CLINICAL ASSESSMENT PORTFOLIO:

Due date: Within 10 working days of completion of the clinical placement. If the Clinical Assessment Portfolio is not received by the due date CDU School of Nursing policy for late submissions will apply. If unable to meet due date, request for an extension must be made to the Unit Coordinator prior to due date.

Clinical Assessment Portfolio must have a completed CDU cover sheet attached: Download from Learnline site.

Original copies must be submitted: Photocopies will not be accepted.

Student must make certified copies for their own records: Graduate positions often require copies of clinical placement assessment documentation. CDU recommends the Clinical Portfolio is sent via registered post or priority post. In the event that the Clinical Assessment Portfolio is lost, the student will be asked to re-submit. Students who cannot do this will receive a fail grade for placement.

Via mail:  In person:
External Student Support  Darwin: Faculty drop box in Blue Building 5
Charles Darwin University  Alice Springs: Faculty drop box at the Info Shop
Darwin NT 0909

Note: Do not post directly to the Unit Coordinator. The Clinical Assessment Portfolio will not be marked and the student will receive a fail grade for the placement.

ASSESSMENT:

The Clinical Assessment Portfolio forms part of the overall assessment for clinical units. Students are to refer to the Learnline site for the marking rubric which outlines how the objectives will be marked. Students should also refer to the Learnline site for information on how to complete the reflective section of your portfolio and requirements for the online discussion board.
STUDENT PREPARATION:

Prior to clinical placement students must complete the following checklist as preparation. Student should contact the Unit Coordinator if unsure of any aspect of the placement or assessment.

☐ I have read and understood the Unit Guide for this unit.

☐ I have found the geographical location of placement and know how to get there

☐ I understand that this Clinical Assessment Portfolio is a graded assessment and forms part of the overall grade.

☐ I have successfully completed the pre requisite CTB for the unit and the medication calculations test.

☐ I have considered my clinical objectives prior to commencing placement and formulated a learning plan.

☐ I understand the assessments and know the due dates for the unit.

☐ I have read and understood the information in the Clinical Placement Resource Manual 2014.

☐ I have met all pre-clinical requirements and understand that I am to carry copies with me while on placements so I can produce evidence of compliance if requested by the health facility.

(If directed by the Clinical Placement Office): I have made contact with the health facility where CDU has confirmed my placement to introduce myself, get my roster and confirm shift start and finish times.

☐ I know who to contact at CDU if I have any questions or problems while on placement.

☐ I understand I must complete 100% of the placement hours for the unit and must make up any sick days and missed days to pass the unit.

☐ I am aware of my responsibility to maintain appropriate behavior while undertaking my clinical placement in particular adhere to privacy and confidentiality of patient information and all matters related to the health facility.

If patient confidentiality is breached, the penalty may include termination of placement and a fail grade.

Name (print):

Student number:

Signature: ___________________________ Date: ___________________________
1. ATTENDANCE RECORD:
A 100% attendance is required to complete practicum; 120 hours for **NUR125**. Placement hours worked does not include breaks.

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SCOPE OF PRACTICE

First year students **must** work within the first year scope of practice. Second year students **must work within** the second year scope of practice and their practice can also include skills of the first year scope. Third year students **must work within** the third year scope of practice and can also include the skills of 1st and 2nd year scope of practice. NB The third year students will have skills that are within the scope of other years as third year students learn new skills but also consolidate and build on existing skills learnt in previous years.

<table>
<thead>
<tr>
<th>Year 1: Unit NUR 125 – Novice: Frequent or continuous cues; no patient load; continuous supervision</th>
<th>Year 2: Unit NUR 244 - Novice: Advanced beginner; frequent or occasional cues; medium level supervision (50% patient load)</th>
<th>Year 3: Unit NUR 343/344/349 Advanced-beginner: Minimal cues; minimal supervision (100% patient load)</th>
</tr>
</thead>
</table>
| Communicate and collaborate appropriately with colleagues, patients & carers/ families.  
  - Assist colleagues with patient care as appropriate | Demonstrate timely & accurate communication, documentation and evidence informed decision-making which addresses cultural safety & awareness.  
  - With supervision, implement nursing actions (procedures) for the low and medium acuity medical/surgical patient (50% patient load) including:  
    - Perform & document a health assessment  
    - Formulate nursing problem statements based on the above data and informed by evidence  
    - Conduct pain assessment and associated nursing interventions  
    - Monitoring patients and performing ECGs  
    - Provide evidence-informed rationales for the above interventions | Demonstrate professional communication, conduct and evidence-informed decision-making in all aspects of nursing across a range of cultural settings & acuity levels. Confidently provide accurate, logical, concise and appropriate recording and reporting of patient data (oral & written) to the health care team. Application of the nursing process (assessment, planning, evidence-informed intervention, rationales and evaluation) in a variety of medical / surgical patient care environments for low, moderate and high acuity patients across the lifespan. Provide all phases of the nursing process for 100% patient load considering time management, health assessments, planning and prioritising of clinical interventions and care. Apply the nursing process (assessment, planning, evidence-informed intervention, rationales and evaluation) for patients requiring medication:  
  - Further develop skills in the safe administration of medicines via the oral, topical and parental routes  
  - Manage medication regimes for 100% patient load & across varying modalities  
  - Intravenous therapy regimes including 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 | |

Establish and maintain a therapeutic relationship with patients & families appropriate to the clinical setting & inclusive of psychogeriatric and cognitively impaired clients.

Perform accurate, concise and appropriate recording and reporting of objective & subjective patient data using appropriate nursing and medical terminology. With continuous support:

- Handover of 1 patient
- Discuss evidence-informed rationales for implementing designated nursing care
- Assess patients’ input/output (direct & indirect observation, fluid balance & food/diet charts)
- Recognise & report significant fluid balance fluctuations

With continuous support implement nursing interventions for low acuity patients requiring assistance with ADLs:

- Positioning & mobility
- Personal hygiene
- Oral and eye care
- Oral dietary intake-assistance and assessment of patient’s eating/swallowing abilities
- Apply the nursing process (assessment, planning, intervention, rationales and evaluation) in the nursing care of patients with self-care deficits
- Discuss evidence-based rationales for the above interventions

Use safe manual handling techniques and equipment. With support, promote patient

Assess respiratory system & function:

- Describe the determinants of adequate oxygenation and the nurse’s role in assessment and provision of oxygen supplementation
- Discuss different evidence-informed rationales for providing supplementary oxygen

Perform a physical and psychosocial assessment of the well child & family

Apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) in the nursing care of patients with neurological deficits.

Apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) in the nursing care of patients with musculoskeletal deficits, i.e. spinal precautions, neurovascular observations.

With support, perform evidence-based nursing techniques in complex wound management, e.g. drain tubes & removal of sutures, staples & complex dressings.

Implementation, evaluation and benchmarking of the pre-registration nursing competencies assessment schedule (NCAS) for use across Australian universities. **Version 3 [CDU] Guidance Package Oct 2013**
<table>
<thead>
<tr>
<th>With supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) in the administration of S2 &amp; S4 medications (excluding restricted S4 &amp; S8).</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Articulate knowledge of legislation, charting and e-scribe medication administration contexts</td>
</tr>
<tr>
<td>- Discuss the pharmacokinetics &amp; pharmacology of all medications to be administered by the student and RN</td>
</tr>
<tr>
<td>- Discuss evidence-based rationales for safe administration and management of varying regimes including; oral, IM, nebulised, SC, ocular, aural, nasal, PR &amp; PV PEG/gastrostomy, nasogastric tube</td>
</tr>
<tr>
<td>- Intravenous therapy regimes including IV antibiotics</td>
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<table>
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<tr>
<th>With supervision, assess patients’ responses to hydration treatments including:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Intravenous infusions</td>
</tr>
<tr>
<td>- Blood or blood products</td>
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<tr>
<td>- Total parenteral nutrition</td>
</tr>
</tbody>
</table>

**Assist with admission and primary health assessment of low acuity patients including:**

| - Nursing history and primary assessment Appearance/presentation |
| - Weight and height |
| - Ward urinalysis |
| - Vital signs; TPR, BP, RR & pulse oximetry |

**With support conduct an assessment of patient pain.**

**With support assist with wound healing by primary intention:**

| - Dry wound dressing |
| - Assessment of pressure ulcer risk |
| - Assessment of falls risk |

**With supervision, assess and support respiratory function through body positioning and primary care planning and implementation.**

**Discuss student’s role in relation to Emergency Codes (Blue, Green, and Red etc.).**

**Assist with care of a low acuity patient requiring isolation or barrier nursing.**

**Assist with patient requiring isolation or barriers nursing.**

**Provide evidence-based collaborative management of patients who require the above interventions.**

Recognise and assist with collaborative management of clients exhibiting difficult / challenging behaviours:

| - Patients with mental health problems |
| - Aggressive patients |
| - Withdrawal syndrome and / or dependency behaviours (including working with AOD team) |
| - Cognitively impaired patients |

**Articulate knowledge of pharmacokinetics and pharmacology of all medications to be administered by the student and RN.**

**Discuss the pharmacokinetics & pharmacology of all medications to be administered by the student and RN.**

**With supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) for patients with complex hydration and nutritional requirements which may include:**

| - Management and care of nasogastric tubes |
| - Measures to maintain fluid balance, i.e. intravenous fluid replacement / supplementation therapy |
| - Discuss the rationales for the above interventions |

**With supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) for patients with complex needs related to the renal system including care and insertion of urinary catheters.**

**Work collaboratively with allied health workers & other team members.**

**With constant supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) for patients:**

| - Exhibiting difficult / challenging behaviours such as aggression |
| - Experiencing mental illness and related problems |
| - Experiencing withdrawal syndrome and/or dependency behaviours (including working with AOD team) |
| - Who are cognitively impaired |

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| - Management and care of nasogastric tubes |
| - Measures to maintain fluid balance, i.e. intravenous fluid replacement / supplementation therapy |
| - Discuss the rationales for the above interventions |
OBJECTIVES: WEEK 1

Two objectives per week of placement must be completed by student. When objective is achieved, each is to be signed by the RN working with student. NUR125 requires a total of 6 objectives (two per week for the three week placement). Please select 3-5 NMBA competency standards relevant to the objective (including the number and title).

Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

Objective # 1.

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

NMBA Standard(s) objective links to:

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Resources student will use to work towards achieving objective:

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Student self-evaluation:

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Strategies to improve performance:

__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Has the student successfully achieved their objective? Yes ☐ No ☐

RN signature: _____________________________ Date: _____________________________

RN name printed: _____________________________

Designation: _____________________________
OBJECTIVES: WEEK 1

Two objectives per week of placement must be completed by student. When objective is achieved, each is to be signed by the RN working with student. NUR125 requires a total of 6 objectives (two per week for the three week placement). Please select 3-5 NMBA competency standards relevant to the objective (including the number and title).

Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

Objective # 2.

NMBA Standard(s) objective links to:

Resources student will use to work towards achieving objective:

Student self-evaluation:

Strategies to improve performance:

Has the student successfully achieved their objective? Yes □ No □

RN signature: ___________________________ Date: ___________________________

RN name printed: ___________________________

Designation: ___________________________
Please complete an interim assessment at the midpoint (end week one) of your placement.

**NUR125** students must attain a minimum rating of ‘Assisted’ in all competencies by end of placement for NUR125.

(Please insert a ✓ and initial in the appropriate column)

<table>
<thead>
<tr>
<th>Professional Practice</th>
<th>Independent: (I)</th>
<th>Supervised: (S)</th>
<th>Assisted: (A)</th>
<th>Marginal: (M)</th>
<th>Dependent: (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Practices in accordance with legislation affecting nursing practice and health care</td>
<td></td>
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<tr>
<td>2. Practices within a professional and ethical framework</td>
<td></td>
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**Critical thinking and analysis**

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<tr>
<td>3. Practices within an evidence-based framework</td>
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<td>4. Participates in ongoing professional development of self and others</td>
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**Provision and Coordination of Care**

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<tbody>
<tr>
<td>5. Conducts a comprehensive and systematic nursing assessment</td>
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<tr>
<td>6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team</td>
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<tr>
<td>7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health</td>
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<tr>
<td>8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and the interdisciplinary health care team</td>
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**Collaborative and Therapeutic Practice**

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<td>9. Establishes, maintains &amp; appropriately concludes therapeutic relationships.</td>
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<td>10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care.</td>
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**Grading scale**

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**Scoring guide:**

- You should only ✓ one column for each of the one to ten descriptors.
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Reflection by Student: (Use Gibbs Reflective cycle or another model of reflection and discuss how you would approach your practice differently or more effectively. Please indicate the model you have used).

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Feedback (Facilitator/ Educator)

Comments by RN: (use ✔ & initial)

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How would you rate the student’s overall performance whilst undertaking this clinical placement? (use a ✔ & initial)

Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent ☐

Student Name: (please print) ______________________ Sign: __________________ Date:_________

Clinical Facilitator/Educator: (please print) _______________ Sign: __________________ Date:_________

Preceptor/Registered Nurse: (please print) _______________ Sign: __________________ Date:_________

Continue on a separate sheet if necessary
OBJECTIVES: WEEK 2

Two objectives per week of placement must be completed by student. When objective is achieved, each is to be signed by the RN working with student. NUR125 requires a total of 6 objectives (two per week for the three week placement). Please select 3-5 NMBA competency standards relevant to the objective (including the number and title). Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

<table>
<thead>
<tr>
<th>Objective # 1.</th>
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<tbody>
<tr>
<td>NMBA Standard(s) objective links to:</td>
</tr>
<tr>
<td>Resources student will use to work towards achieving objective:</td>
</tr>
<tr>
<td>Student self-evaluation:</td>
</tr>
<tr>
<td>Strategies to improve performance:</td>
</tr>
<tr>
<td>Has the student successfully achieved their objective? Yes No</td>
</tr>
</tbody>
</table>

RN signature: __________________________ Date: __________________________

RN name printed: __________________________

Designation: __________________________
OBJECTIVES: WEEK 2

Two objectives per week of placement must be completed by student. When objective is achieved, each is to be signed by the RN working with student. NUR125 requires a total of 6 objectives (two per week for the three week placement). Please select 3-5 NMBA competency standards relevant to the objective (including the number and title). Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

Objective # 2.

 NMBA Standard(s) objective links to:

Resources student will use to work towards achieving objective:

Student self-evaluation:

Strategies to improve performance:

Has the student successfully achieved their objective? Yes No

RN signature: ______________________ Date: ______________________

RN name printed: ______________________

Designation: ______________________
OBJECTIVES: WEEK 3

Two objectives per week of placement must be completed by student. When objective is achieved, each is to be signed by the RN working with student. NUR125 requires a total of 6 objectives (two per week for the three week placement). Please select 3-5 NMBA competency standards relevant to the objective (including the number and title).

Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

Objective # 1.

NMBA Standard(s) objective links to: _____________________________________________

Resources student will use to work towards achieving objective: _____________________________________________

Student self-evaluation: _____________________________________________

Strategies to improve performance: _____________________________________________

Has the student successfully achieved their objective? Yes No

RN signature: ______________________ Date: ______________________

RN name printed: _____________________________________________

Designation: _____________________________________________
OBJECTIVES: WEEK 3

Two objectives per week of placement must be completed by student. When objective is achieved, each is to be signed by the RN working with student. NUR125 requires a total of 6 objectives (two per week for the three week placement). Please select 3-5 NMBA competency standards relevant to the objective (including the number and title). Example: 2.1. Practises in accordance with the nursing professions codes of ethics and conduct.

Objective # 2.

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NMBA Standard(s) objective links to: __________________________________________
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Student self-evaluation: ________________________________________________________
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Strategies to improve performance: _____________________________________________
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Has the student successfully achieved their objective? Yes                                              No

RN signature: ________________________ Date: ________________________

RN name printed: ____________________________________________________________

Designation: ________________________
Nursing Competency Assessment Schedule-NCAS

BNUR/ BNURSE – NUR125  SEM____ / 2014

Please complete a final assessment at the end (end week three) of your placement.

<table>
<thead>
<tr>
<th>NUR125 students must attain a minimum rating of ‘Assisted’ in all competencies by end of placement for NUR125.</th>
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(Please insert a ✓ and initial in the appropriate column)

### Professional Practice
1. Practices in accordance with legislation affecting nursing practice and health care
2. Practices within a professional and ethical framework

### Critical thinking and analysis
3. Practices within an evidence-based framework
4. Participates in ongoing professional development of self and others

### Provision and Coordination of Care
5. Conducts a comprehensive and systematic nursing assessment
6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team.
7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health
8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and the interdisciplinary health care team.

### Collaborative and Therapeutic Practice
9. Establishes, maintains & appropriately concludes therapeutic relationships.
10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care.


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How would you rate your overall performance whilst undertaking this clinical placement? (use a ✔ & initial)

Unsatisfactory ☐  Satisfactory ☐  Good ☐  Excellent ☐
Feedback (Facilitator/ Educator)

Comments by RN:  
(use✓ & initial)  

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Continue on a separate sheet if necessary

How would you rate the student’s overall performance whilst undertaking this clinical placement? (use a ✓ & initial)  
Unsatisfactory □ Satisfactory □ Good □ Excellent □

Student Name: (please print) ___________________________ Sign: __________________ Date: __________

Clinical Facilitator/Educator: (please print) _______________ Sign: _______________ Date: __________

Preceptor/Registered Nurse: (please print) _______________ Sign: _______________ Date: __________
Guide for Assessors

The following is a guide to assist facilitators/educators to complete / assess competencies.

Professional Practice

1. Practises in accordance with legislation affecting nursing practice and health care

1.1 Complies with relevant legislation and common law.
1.2 Fulfils the duty of care.
1.3 Recognises and responds appropriately to unsafe or unprofessional practice.

**OBSERVATIONS:**
Uses protocols/procedure/documentation to support decision making; promptly responds to unsafe practice; seen undertaking and responding appropriately

**QUESTIONS:**
When would you use/apply particular criteria/rules? (e.g. restraint / medicine administration: documentation / consent / evaluation)

**MEASUREMENTS:**
Documents are appropriately utilised; exception reporting is evident;

**Scenarios offered/Other:**
Restraint and it’s use/needle stick injury and management & reporting/work colleague being ill/pain management

2. Practises within a professional and ethical nursing framework

2.1 Practices in accordance with the nursing profession’s codes of ethics and conduct.
2.2 Integrates organisational policies and guidelines with professional standards.
2.3 Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups.
2.4 Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures.
2.5 Understands and practises within own scope of practice.
2.6 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective nursing care.
2.7 Recognises the differences in accountability and responsibility between Registered Nurses, Enrolled Nurses and unlicensed care workers

**OBSERVATIONS:**
Uses appropriate language / communicates effectively with the team both nursing and multi-disciplinary (attitude & demeanor) / interaction is engaging/ listens and responds appropriately / behaves in a manner that makes peers & colleagues and patients/clients comfortable and is non-threatening; clearly operates within professional boundaries; see undertaking appropriate and timely competent care;

**QUESTIONS:** How might you respond to patients’ request? (E.g. address as / advocacy): How might your responses reflect the local policy-procedure & best evidence? Appreciates the importance of understanding the patients’ condition / therapy / intervention.

**MEASUREMENTS:**
Documentation e.g. such as handover notes are appropriately utilised and accurate report writing; does student make clear challenges to scope of practice?

**Scenarios offered/Other:** communication/professionalism/policy and guidelines/respect & dignity/problem solving/deals with deteriorating patients.
Critical Thinking and Analysis

3. Practises within an evidence-based framework
3.1 Identifies the relevance of research to improving individual/group health outcomes.
3.2 Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of nursing care.
3.3 Demonstrates analytical skills in accessing and evaluating health information and research evidence.
3.4 Supports and contributes to nursing and health care research.
3.5 Participates in quality improvement activities.

OBSERVATIONS: Knows when to utilise policy-procedure & best evidence / has capability to engage with systems to locate evidence in practice / demonstrates competence in practice but acknowledges own scope / problem solving evident on actions; questions nursing actions but is not 'hamstrung' by over analysis; considers scope and delegation

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 patient (prior to surgery); Use of resources to support Evidenced Based Practice (EBP); Can give examples of best practice: Consultation with Allied Health Professionals (AHP).

MEASUREMENTS: Reviews client/patient notes and uses appropriate model; Uses assessment tools; (i.e. falls/pressure) 'wound trace' and 'Braden score'; Identifies hospital/agency benchmarking; displays sound clinical knowledge base through data interpretation; Carries out the task successfully and appropriately.

4. Participates in ongoing professional development of self and others
4.1 Uses best available evidence, standards and guidelines to evaluate nursing performance.
4.2 Participates in professional development to enhance nursing practice.
4.3 Contributes to the professional development of others.
4.4 Uses appropriate strategies to manage own responses to the professional work environment

OBSERVATIONS: Knows and verbalises critical appraisal of situations in a supportive manner: Questions practice of others; Engages in clinical discussion about patient progress with Multidisciplinary Team (MDT); Assists team, mentors students/peer supports and shares best practice/knowledge; understands own learning needs; utilises reflective practice; conducts education sessions; role models; accesses journals & databases / evidence through research and policies/procedures; Appears confident/comfortable in work; uses preceptor for support & debriefing as well as fulfills role for others; uses an established communication model; objectively receives and gives feedback; recognises own limitations/scope of practice; open to guidance by others (including juniors; Relates care to care plan: shows initiative;

QUESTIONS: How could that be done better: What additional education might you need: How will you share your knowledge with others: What resources do you have/use? Have you or how do you contribute to the learning of another?; Tell me what prompted you … like to?: Journal clubs: Membership of a professional group/organisations; Awareness of policy/procedure; Follows guidelines; uses critical thinking; Understands registration requirements; explores policy/procedure when faced with new skill; Challenges existing frameworks; Seeks clarity of orders;

MEASUREMENTS: Self education; attends in-services/development seminars; evidence of reflection and appropriate use of models; analyses orders to be given; completes all documentation appropriately care plans and assessment tools; feedback on patient education/consumers/carers; follows guidelines; Uses critical incidents and case studies to embody learning; shares a reflective journal

Other: attends in-services/ short course participation
Provision and Coordination of Care

5. Conducts a comprehensive and systematic nursing assessment

5.1 Uses a relevant evidence-based assessment framework to collect data about the physical socio-cultural and mental health of the individual/group.
5.2 Uses a range of assessment techniques to collect relevant and accurate data.
5.3 Analyses and interprets assessment data accurately

**OBSERVATIONS:** Systematic/accurate/holistic approach through use of a framework; relies on theory and evidence to conduct assessment; utilises appropriate equipment; CHIPPA (Communication/ History / Inspection / Percussion / Palpation / Auscultation): Appropriate response/nursing action to the data collected i.e. plans (& prioritises both in assessment and in planning); Reviews charts/past data to see what info was gathered: Uses appropriate communication / language when undertaking assessment / hand-over: using "life skills profile": 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: Listens and questions appropriately in a culturally sensitive & aware manner:

**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 Multidisciplinary Team (MDT);

**MEASUREMENTS:** Evidence gathered is appropriate and accurately documented: Includes clear risk assessments when necessary: taking and recording accurate physiological and other measurements when necessary; notes reflect patients changes; Uses and documents range of assessment techniques; can perform assessment skills: can articulate decision process clearly: ‘sees’ connectedness of presentation with assessment and presentation and diagnosis


6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team

6.1 Determines agreed priorities for resolving health needs of individuals/groups.
6.2 Identifies expected and agreed individual/group health outcomes including a time frame for achievement.
6.3 Recognises and documents a plan of care to achieve expected outcomes.
6.4 Plans for continuity of care to achieve expected outcomes.

**OBSERVATIONS:** Uses appropriate bio-psycho-social assessment with ‘correct’ communication skills: Appropriate interaction/conversation with patients and family and the Multidisciplinary Team (MDT) leading to identification of agreed achievable documented goals (admission to discharge): documents/hands-over relevant information (for all patients); Follows agreed clinical pathway(s) and makes appropriate decisions promptly (incorporating Allied Health Professionals (AHP) recommendations): works within a safe practice framework; seen undertaking and responding appropriately to recommendations of others; can form an appropriate care plan for new admission; Clear demonstration of knowledge re: health issues; Thorough risk assessment self, others and patient; note taking strategies are contemporaneous and appropriate; effective organisational skills; thinks about ‘tomorrow’ {planning ahead?};

**QUESTIONS:** Explore how to plan a shift and prioritise: Are you able to prioritise the most acutely ill patient(s) in your care? When should you seek clarification on particular criteria/rules? (E.g. restraint/medicine administration: documentation/consent/evaluation): Are the patient and family satisfied with the care? How would you know? Have referrals sent to Allied Heath and would you know how to? Integrates knowledge and data analysis in terms of critical thinking: Location of appropriate support/services and location; Referrals to others services, e.g. counseling, psychiatry:

**MEASUREMENTS:** Documents are appropriately utilised to show a clear plan of care to manage patient load; in an appropriate time frame is evident; identifies needs of patient and/or expected outcome; Knows who to contact and who to pass on information to achieve health outcomes); Is the nurse able to tell if the patient is making appropriate progress {how would you know?}; Shows that there is appropriate bio-psycho-social assessment with ‘correct’ communication skills; Compare data from that setting/area with the overall service); is performance as would be expected re time management and health outcomes.
7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes

7.1 Effectively manages the nursing care of individuals/groups.
7.2 Provides nursing care according to the documented care or treatment plan.
7.3 Prioritises workload based on the individual's/group's needs, acuity and optimal time for intervention.
7.4 Responds effectively to unexpected or rapidly changing situations.
7.5 Delegates aspects of care to others according to their competence and scope of practice.
7.6 Provides effective and timely direction and supervision to ensure that delegated care is provided safely and accurately.
7.7 Educates individuals/groups to promote independence and control over their health.
7.8 Uses health care resources effectively and efficiently to promote optimal nursing and health care.

OBSERVATIONS: 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; accepts the patient as partner rather than recipient of care; uses language and appropriate cultural approaches to meet the needs of the patient in terms of care and information; terminology is appropriate and abbreviations are avoided; constructively delegates/negotiates with others acknowledging scope of practice; deals with unexpected events; how much direction does the student need and do they seek guidance; reflection on outcomes; does the student manage the task in accordance with the scope of practice; identifies and uses resources (people and kit); Timely and appropriate delivery of care; Team player including effective communication; liaises with Multidisciplinary Team (MDT) & Allied Health Professionals (AHP); consults clinical notes regularly; high standards of patient care; patient advocate and patient safety; see student patient teaching taking place effectively and appropriately.

QUESTIONS: Demonstrates effective skills that meet best practice guidelines and can articulate the rationale; Prioritises actions and acts in a timely manner if a patient is deteriorating and/or other 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;

MEASUREMENTS: Demonstrates that they can manage varying patient/RN ratios in a timely and appropriate manner; care is sensitive to ‘case’; shows understanding of costings per case; presents clear evidence of progress (OR NOT) of patient; recalls info and when and how to use; minimal wastage/healthy patients/ satisfied patients / patients discharged home; aware of wider evidence and this is clear in how they use evidence in practice;

Scenarios offered/Other: Provides care and rationale for patient 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 patient(s); Knows when care to be delivered is outside scope of practice. Leadership of patient care/Team working & Education for all / recognises patient issues/effective time management/attends education sessions

8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals / groups, significant others and the interdisciplinary health care team.

8.1 Determines progress of individuals/groups toward planned outcomes.
8.2 Revises the plan of care and determines further outcomes in accordance with evaluation data.
8.3 Recognises and responds appropriately to unsafe or unprofessional practice.

OBSERVATIONS: Problem based learning; contributes to the Multidisciplinary Team; case presentations; handover verbal/written; Team meetings, case presentations, care plans and development in an ongoing way; clear outputs that relate to patient progress; documentation and feedback; involves client in discussion; demonstrates understanding of all stages of the process; inter-professional liaison and collaboration; interview with patient and family; uses critical thinking to interpret client progress; check care plans;

QUESTIONS: Acknowledging ongoing interpretation; clear progress assessment in practice; rationale presented clearly for patient progress towards outcomes; how do you consult?; progress questioning; use benchmarks to evaluate and measure; do you ask how the patient feels about….X?

MEASUREMENTS: Documentation is accurate; clear progress towards recovery; comply with managed clinical pathways / protocols; analyses/evaluates relevant data and critically analyses data; case based access and OSCAs

Scenarios offered/Other: Enquiry; Tools; observe predetermined situations (wound care/medicines/client care etc.) including OSCAs.
Collaborative & Therapeutic Practice

9. Establishes, maintains and appropriately concludes therapeutic relationships
9.1 Establishes therapeutic relationships that are goal directed and recognises professional boundaries.
9.2 Communicates effectively with individuals/groups to facilitate provision of care.
9.3 Uses appropriate strategies to promote an individual’s/group’s self-esteem, dignity, integrity and comfort.
9.4 Assists and supports individuals/groups to make informed health care decisions.
9.5 Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security.

**OBSERVATIONS:** Evidence of joining/engaging/communicating behaviours; Professional role articulated clearly; Confidentiality is addressed; Student initiates conversation/interactions appropriately (privacy / safety / quiet) and adjusts strategies as required in different situations based on evaluation; are positive behaviours attributed strengths acknowledge and commented on?; when patient is unwell is the level of care/basic needs being met (within reason?); Clear advocacy evident; Recovery model used, with the clients journey; evidence of cultural and racial respect; accesses team/services within cultural boundaries; Appropriate communication and dress for the context; continuity of care/communication; demonstrates appropriate level of knowledge of clinical nursing practice; enhancing and growing communication skills repertoire; empathetic & knowledgeable practice within social context; willingness to learn and to be polite and respectful; applies body of knowledge and experience/personality in delivery of health care; exhibits trust and confidence; Ability to problem solve and direct patients appropriately; checks for satisfaction (colleagues and patients);

**QUESTIONS:** Does student demonstrate engagement strategies?; Honesty/upfront regarding wellbeing; How would identify if cultural practice is required?; Ensuring that the student is aware of the need for consent and agreements; Maintain privacy and confidentiality (even if suicidal); Responds appropriately to feedback from patients and clients; Questions peers and clients to learn more of the social context;

**MEASUREMENTS:** Evidence of comfort whilst working/talking with clients of different ages/cultures etc.: appropriate use of language; client returns for next session; evidence of client’s willingness to change; identification of the need for additional support/guidance; risk assessment; reporting risk issues immediately; Clear evidence of appreciating and dealing with functional level of client; Clinical practices commensurate with practitioner level (beginning); Health outcomes are appropriately assessed through data and peer review; self-evaluation; level of consultation with community and individuals;

10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care
10.1 Recognises that the membership and roles of health care teams and service providers will vary depending on an individual’s/group’s needs and health care setting.
10.2 Communicates nursing assessments and decisions to the interdisciplinary health care team and other relevant service providers.
10.3 Facilitates coordination of care to achieve agreed health outcomes.
10.4 Collaborates with the health care team to inform policy and guideline development.

**OBSERVATIONS:** Appropriate level of quality of working, communication (written & verbal) and relationships with other professionals; able to identify policy/procedure and the appropriate evidence base (EBP) illustrating safe and pertinent ways of working; identifies and shares new information with all Interdisciplinary Health Care Team (IDHCT) as appropriate care provided is documented in an appropriate and timely manner; handover info is accurate and timely; agrees/adheres with treatment plans for care from all IDHCT; Prepared for IDHCT meetings;

**QUESTIONS:** Accurate documentation for referral/assessment and ongoing care & treatment leading to discharge using correct documentation and referral methods; Are the set goals and strategies reasonable regarding best available evidence and patient’s wishes; Examples are cited that relate to areas of care, e.g. Speech pathology for a person with a CVA and their ability to swallow safely; Being clear about the RNs role and the role of others in the IDHCT; Plan for anticipated and ‘unanticipated’ changes in the client’s needs;

**MEASUREMENTS:** Uses and documents systematic & holistic assessment; identify needs and match to services in a timely manner; use appropriate language and documentation to communicate with the Interdisciplinary Health Care Team (IDHCT); relates to discharge resources required in a timely way; seeks to extend knowledge about IDHCT;

**Scenarios offered/Other:** Communicator / coordinator; Respect/confidently-competently-appropriately; role clarity/ perception/ 3rd Year confidence
**Employer Skills**

The eight core skills competencies listed are to be implemented across the three year nursing program. The matrix below shows where the skills fall in each year level. These are compulsory competencies that will be completed by all students whilst on placement.

<table>
<thead>
<tr>
<th>Year ONE</th>
<th>Year TWO</th>
<th>Year THREE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Semester 1</td>
<td>Semester 2</td>
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<tr>
<td>The initial and ongoing nursing assessment of a client/patient</td>
<td></td>
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<tr>
<td>Caring for a client/patient requiring wound management</td>
<td>NUR125</td>
<td>NUR125</td>
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<tr>
<td>Managing medication administration</td>
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<tr>
<td>Managing the Care of a Client/Patient</td>
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<tr>
<td>Managing the Care of a group of Clients/Patients</td>
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<tr>
<td>Monitoring and Responding to Changes in a Client-Patient’s Condition.</td>
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<tr>
<td>Teaching a Client/Patient</td>
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<tr>
<td>Teaching a Colleague</td>
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</table>

Key overarching structure of each of the competency assessments……
- Preparation for the activity
- Carrying out the activity
- Closing the activity
- Documenting and communicating the activity, and finally
- Educational Opportunity or Learning from the activity
Caring for a client/patient requiring wound management

**Employer Competencies (Skills Areas)**

<table>
<thead>
<tr>
<th>Clinical Competency Area (NUR125)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competency exemplar:</strong> The management of a client/patient requiring wound care</td>
</tr>
<tr>
<td><strong>Demonstration of:</strong> The ability to effectively and safely manage a simple wound for a single client/patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Criteria</th>
<th>The coding below indicates the NMBA National Competency Standards for the Registered Nurse (2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carrying Out The management of a client/patient requiring wound care</strong></td>
<td>Independent: (I)  Supervised: (S)  Assisted: (A)  Marginal: (M)  Dependent: (D)</td>
</tr>
<tr>
<td>1. Identifies specific indications for contact / communication / action with the client/patient (i.e. are there any specific orders?).</td>
<td>1.2, 2.5, 4.2, 9.5</td>
</tr>
<tr>
<td>2. Verifies the validity of any written orders to provide appropriate wound management.</td>
<td>1.1, 1.2, 1.3, 2.5, 9.5</td>
</tr>
<tr>
<td>3. Reviews the client/patient documentation / history / information / medication chart / communication(s) from members of the multidisciplinary team and considers the evidence.</td>
<td>1.1, 1.2, 1.3, 2.5, 3.1, 3.2, 3.3, 9.5</td>
</tr>
<tr>
<td>4. Effectively and in a timely manner washes hands.</td>
<td>1.2, 7.1, 9.5</td>
</tr>
<tr>
<td>5. Gathers the necessary equipment</td>
<td>3.1, 3.3, 5.2, 5.3, 7.1, 7.3, 8.1, 9.5</td>
</tr>
<tr>
<td>i. Clean and sterile gloves, apron, goggles (PPE)</td>
<td>i.</td>
</tr>
<tr>
<td>ii. Sterile scissors and/or clip/staple/stitch remover, sharps container</td>
<td>ii.</td>
</tr>
<tr>
<td>iii. Dressing pack, required dressing materials</td>
<td>iii.</td>
</tr>
<tr>
<td>iv. Appropriate solutions if necessary</td>
<td>iv.</td>
</tr>
<tr>
<td>v. Other: Specify___________________________</td>
<td>v.</td>
</tr>
<tr>
<td>May not be necessary</td>
<td></td>
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<tr>
<td>6. Evidence of therapeutic interactions; e.g. gives client/patient a clear explanation regarding the management of the wound;</td>
<td>2.1, 2.3, 9.1 9.2</td>
</tr>
<tr>
<td>7. Undertakes assessment of the situation identifying that it is appropriate to manage the wound ‘this way’ in the circumstances e.g. that it is required/considers any medication (analgesia) or any vital sign or other assessments required.</td>
<td>3.1, 3.3, 5.2, 5.3, 8.1</td>
</tr>
<tr>
<td>8. Maintains dignity, provides privacy, pain relief and other comfort measures – displays problem solving abilities</td>
<td>5.1, 5.2, 5.3, 6.1, 7.1, 9.3, 9.6</td>
</tr>
<tr>
<td>9. Assists the client/patient to an appropriate position as necessary;</td>
<td>1.2,2.3,2.5,7.1, 9.5</td>
</tr>
<tr>
<td>10. Put on PPE (if required) and Washes hands</td>
<td>1.2, 2.2, 7.1, 9.5</td>
</tr>
<tr>
<td>11. Ensure client/patient is comfortable &amp; prepared</td>
<td>1.2, 2.3 2.5, 9.1, 9.2, 9.3</td>
</tr>
<tr>
<td>12. Put on clean disposable gloves and remove the tape/bandage or ties</td>
<td>5.2, 5.3, 7.1, 9.3, 9.5</td>
</tr>
<tr>
<td>13. With gloved hand remove dressing one layer at a time, taking care not to disturb drains or tubes. Keep soiled surface out of client/patients eye line. If the dressing is ‘stuck’, explain to the client/patient that you will moisten the dressing so that it comes free without any discomfort.</td>
<td>5.2, 5.3, 7.1, 9.3, 9.5</td>
</tr>
</tbody>
</table>

**PREPARATION FOR THE ACTIVITY**

1. Identifies specific indications for contact / communication / action with the client/patient (i.e. are there any specific orders?).
2. Verifies the validity of any written orders to provide appropriate wound management.
3. Reviews the client/patient documentation / history / information / medication chart / communication(s) from members of the multidisciplinary team and considers the evidence.
4. Effectively and in a timely manner washes hands.
5. Gathers the necessary equipment
   i. Clean and sterile gloves, apron, goggles (PPE)
   ii. Sterile scissors and/or clip/staple/stitch remover, sharps container
   iii. Dressing pack, required dressing materials
   iv. Appropriate solutions if necessary
   v. Other: Specify___________________________
   May not be necessary
   □
5.1, 5.2, 5.3, 6.1, 7.1, 9.3, 9.6
6. Evidence of therapeutic interactions; e.g. gives client/patient a clear explanation regarding the management of the wound;
7. Undertakes assessment of the situation identifying that it is appropriate to manage the wound ‘this way’ in the circumstances e.g. that it is required/considers any medication (analgesia) or any vital sign or other assessments required.
8. Maintains dignity, provides privacy, pain relief and other comfort measures – displays problem solving abilities
9. Assists the client/patient to an appropriate position as necessary;
10. Put on PPE (if required) and Washes hands
11. Ensure client/patient is comfortable & prepared
12. Put on clean disposable gloves and remove the tape/bandage or ties
13. With gloved hand remove dressing one layer at a time, taking care not to disturb drains or tubes. Keep soiled surface out of client/patients eye line. If the dressing is ‘stuck’, explain to the client/patient that you will moisten the dressing so that it comes free without any discomfort.
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<tbody>
<tr>
<td>14. Observe any drainage e.g. amount / character / consistency / colour / odour</td>
<td>5.2, 8.1</td>
</tr>
<tr>
<td>15. Remove PPE and Washes hands</td>
<td>1.2, 2.2, 7.1, 9.5</td>
</tr>
<tr>
<td>16. If necessary cleans the wound utilising appropriate solution(s) and dresses the wound using appropriate choice of dressing and fixation</td>
<td>1.2, 3.1, 3.2, 3.3, 5.3, 7.1, 9.3, 9.5</td>
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<table>
<thead>
<tr>
<th>Closing the activity</th>
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<tbody>
<tr>
<td>17. Repositions client/patient &amp; maintains privacy dignity, ensures comfort as far as possible throughout &amp; at that point;</td>
<td>1.2, 2.3, 2.5, 7.1, 1.2, 9.1, 9.3, 9.5</td>
</tr>
<tr>
<td>18. Concludes the interaction with the client/patient by considerably concluding the therapeutic relationship</td>
<td>1.2, 9.1, 9.3 9.5</td>
</tr>
<tr>
<td>19. Cleans/tidies area; disposes of any waste appropriately and as soon as is practicable; removes gloves &amp; PPE (as necessary).</td>
<td>1.1, 1.2, 1.3, 9.5, 10.1</td>
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<thead>
<tr>
<th>Documentation &amp; Communication</th>
<th></th>
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<tbody>
<tr>
<td>20. Reporting and Recording of relevant information:</td>
<td></td>
</tr>
<tr>
<td>i. Nursing Care</td>
<td>1.1, 1.2, 1.3, 2.6, 9.2, 10.2</td>
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<tr>
<td>ii. Medication chart;</td>
<td></td>
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<tr>
<td>iii. other if appropriate (e.g. particular assessment chart (wound) and/or anticoagulant therapy chart)</td>
<td></td>
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<tr>
<td>Specify i.e. plan</td>
<td>May not be necessary</td>
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<tr>
<th>Educational opportunity</th>
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<tr>
<td>21. Demonstrates ability to reflect on the activity and to link theory to practice</td>
<td></td>
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<tr>
<td>i. Relates to decisions made,</td>
<td>1.2, 2.1, 2.3, 3.1, 3.2, 4.1, 4.2, 5.2, 5.3, 7.1, 8.1</td>
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<tr>
<td>ii. Evidence utilised and</td>
<td></td>
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<tr>
<td>iii. Implications for planning of patient care.</td>
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**Grading scale**

| 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. |
Reflection by Student: (Use Gibbs Reflective cycle or another model of reflection and discuss how you would approach your practice differently or more effectively. Please indicate the model you have used).

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

How would you rate your overall performance whilst undertaking this clinical activity? (use a ✔ & initial)

Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent ☐
### Feedback (Facilitator/ Educator)

**Comments by RN:**

<table>
<thead>
<tr>
<th>Comments</th>
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</table>

*How would you rate the overall performance of this student during this clinical activity (use a √ & initial):*

- Unsatisfactory
- Satisfactory
- Good
- Excellent

---

**Student Name:** (please print) __________________________ Sign: ________________ Date: ____________

**Clinical Facilitator/Educator:** (please print) ______________ Sign: ______________ Date: ____________

**Preceptor/Registered Nurse:** (please print) ______________ Sign: ______________ Date: ____________

*Continue on a separate sheet if necessary*
**CLINICAL COMMUNICATION SKILLS FEEDBACK**

**Student name:**

**Assessor:**

**Clinical Placement venue:**

**Date:**

This set of criteria is designed to provide feedback on clinical communication skills of students you have preceptored /facilitated / mentored and observed during a clinical placement. Please respond by ticking and initialing the appropriate level obtained.

<table>
<thead>
<tr>
<th>Please initial a box for each item</th>
<th>Limited 1</th>
<th>Developing 2</th>
<th>Satisfactory 3</th>
<th>Good 4</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verbal communication</strong></td>
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</tr>
<tr>
<td>Ability to communicate with patients and staff at a social level</td>
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<td>Ability to communicate with patients and staff about nursing procedures</td>
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<tr>
<td>Ability to communicate with patient and staff about medical procedures</td>
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<td>Ability to participate in discussions with patient and staff</td>
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<td>Knowing the right words or terms to express thinking to patients and staff</td>
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<td><strong>Written Communication</strong></td>
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<td>Ability to write notes about patients in clear English from a verbal shift change</td>
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<tr>
<td>Ability to summarize essential elements of patients’ conditions from a verbal shift change</td>
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<td>Ability to correctly use nursing terminology</td>
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<td><strong>Responding to verbal communication</strong></td>
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<td>Responds to verbal communication appropriately</td>
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<td>Responds to verbal request accurately</td>
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<td>Asking another person to repeat what he or she said as required</td>
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</table>

Please provide additional comments in the space below.

CDU CLINICAL PLACEMENT LEARNING AGREEMENT:

A Learning Agreement is only used if the student has been identified as having learning needs which without intervention will lead to a FAIL grade for the Clinical Assessment Portfolio. This decision is based on the student’s inability to meet the NMBA Competency Standards within their Scope of Practice for the relevant year level of study. This Agreement must be developed in consultation with the CDU Unit Coordinator (or other CDU representative), student and with the host health facility.

Has the student successfully achieved the requirements of this Learning Agreement?

YES [ ]

NO [ ]

Unit Coordinator must be notified of outcome either by phone or email towards completion of practicum.

Student name: ____________________________ Student number: ____________________________

Clinical venue: ____________________________

Clinical venue contact name: ____________________________ Contact number: ____________________________

Areas of concern are (please link to NMBA Competency Standards):

<table>
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<tr>
<th>Professional Practice</th>
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<tr>
<td>1. Practices in accordance with legislation affecting nursing practice and health care</td>
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<th>Critical thinking and analysis</th>
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<td>3. Practices within an evidence-based framework</td>
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</table>
4. Participates in ongoing professional development of self and others

**Provision and Coordination of Care**

5. Conducts a comprehensive and systematic nursing assessment

6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team.

7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health

8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and the interdisciplinary health care team.

**Collaborative and Therapeutic Practice**

9. Establishes, maintains & appropriately concludes therapeutic relationships.

10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care.
CDU CLINICAL PLACEMENT LEARNING AGREEMENT:

A Learning Agreement is only used if the student has been identified as having learning needs which without intervention will lead to a FAIL grade for the Clinical Assessment Portfolio. This decision is based on the student’s inability to meet the NMBA Competency Standards within their Scope of Practice for the relevant year level of study.

Aims of Learning Agreement:

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IMPLEMENTATION, EVALUATION AND BENCHMARKING OF THE PRE-REGISTRATION NURSING COMPETENCIES ASSESSMENT SCHEDULE (NCAS) FOR USE ACROSS AUSTRALIAN UNIVERSITIES.