Clinical Assessment Portfolio 2017

HLTEN515B Implement and monitor nursing care for older clients – Placement

HLTEN508B Apply reflective practice, critical thinking and analysis in health care
HLTIN301C Comply with infection control policies & procedures
HLTEN504C Implement and evaluate a plan of nursing care
HLTEN502B Apply effective communication skills in nursing
HLTEN401B Work in the nursing profession
HLTWHS300A Contribute to WHS processes

Diploma of 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
Course: Diploma of Nursing
Placement: Semester 1
Faculty: Engineering, Health, Science and the Environment
Prepared by: Ruth Halls
Revised by: Ann Bolton

Acknowledgements: Carol Thorogood, Angela Sheedy, Jane McMurtrie, Joy Adams-Jackson, Cheryl Hunt, Vivienne Ducie, Frank Pearson, Christopher Ballantyne

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INTRODUCTION TO PORTFOLIO AND EXPLANATION OF ASSESSMENT:

The Charles Darwin University (CDU) Clinical Assessment Portfolio for Diploma 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 Competency Achieved grade for this assessment, students must satisfactorily complete assessment items 1-3. Assessment item 4 is only utilised for students failing to meet the Nursing and Midwifery Board of Australia enrolled nurse standards for practice. 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 (120 hours). All make up time must be negotiated with the CDU CPO and the health facility.

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 Competency Achieved 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: “By the end of week one I will successfully perform hygiene for my patient including oral care. I will observe any abnormalities with skin integrity. I will be able to discuss these abnormalities with my preceptor and the importance of correct positioning of my patient to prevent pressure areas.”

   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 indicators. The objectives should increase in complexity each week of placement.

   **NMBA EN Standards for Practice:** Select 3-5 NMBA practice standards and indicators relevant to the objective (including the number and title). Example: 2.2 Practices in accordance with the NMBA standards, codes and guidelines.

   **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 Australian (NMBA) Practice Standards Feedback & Assessment:** Based on the NMBA Standards for Practice: Interim Feedback (midway) and Final Assessment (completion).

   This feedback and assessment instrument is based on the NMBA Enrolled Nurse Standards for Practice (2016). Student’s competency is assessed according to each NMBA Domain. CDU expects that students perform their nursing care within the specified Scope of Practice

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

Students must attain a minimum rating of:

First semester (HLTEN515B and HLTEN508B): Assisted

<table>
<thead>
<tr>
<th>Grading Level</th>
<th>Description</th>
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<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>
</tr>
<tr>
<td>Assisted: (A)</td>
<td>Refers to being safe and knowledgeable most of the time; skillful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues.</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>
</tr>
<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 ‘Assisted’ in all NMBA Enrolled Nurse Standards for Practice by the end of placement. ‘Unsatisfactory’ should be marked if student is graded below ‘Supervised’ in the Interim NMBA Feedback Assessment (p16) 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 34 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: 17 (Interim)
And page: 20 (Final)

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

See page: 34 & 36
MEDICATION SCOPE

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

### MEDICATIONS THAT CAN BE ADMINISTERED BY A CDU ENROLLED NURSING STUDENT UNDER DIRECT RN SUPERVISION:

<table>
<thead>
<tr>
<th>Semester</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>Inhalation</th>
<th>Intranasal</th>
<th>Telephone orders</th>
<th>Intraosseous</th>
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<tbody>
<tr>
<td>1</td>
<td>YES</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>YES, S2, S4 and S8</td>
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<tr>
<th>Semester</th>
<th>Prime lines or change bags (no additives)</th>
<th>Saline flush</th>
<th>Infusion with no additives</th>
<th>Additives, Including IV AB and S8</th>
<th>Parenteral or TPN</th>
<th>Blood products and blood</th>
<th>S8 bolus</th>
<th>PCA</th>
<th>CVC</th>
<th>PICC</th>
<th>Epidural</th>
<th>Telephone orders</th>
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<td>YES</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: Ann Bolton  
Email: ann.bolton@cdu.edu.au  
Phone: 03 9918 8616

CLINICAL PLACEMENT OFFICE: varies by state. (Student to enter prior to placement starting)
Name:..................  
Email: NurPlacCoord@cdu.edu.au  
Phone:..................

CLINICAL COORDINATOR: To contact if unable to contact Unit Coordinator.
Name: Mel Dudson  
Email: clinicalcoordination@cdu.edu.au  
Phone: 08 8946 7735

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 a ‘Not Yet Competent’ grade will apply. If unable to meet due date, request for an extension must be made to the Unit Coordinator prior to due date. CDU recommends the Clinical Assessment 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 ‘Not Yet Competent’ grade for placement.

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. It is advised to obtain a certified copy of your portfolio signed by a justice of the peace for your records and to assist in future employment applications.

<table>
<thead>
<tr>
<th>Via mail:</th>
<th>In person:</th>
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</thead>
<tbody>
<tr>
<td>External Student Support</td>
<td>Darwin: Faculty drop box in Blue Building 5</td>
</tr>
<tr>
<td>Orange 1.2.32</td>
<td>Alice Springs: Faculty drop box at the Info Shop</td>
</tr>
<tr>
<td>Charles Darwin University</td>
<td>Darwin NT 0909</td>
</tr>
</tbody>
</table>

Note: Do not post directly to the Unit Coordinator. The Clinical Assessment Portfolio will not be assessed and the student will receive a ‘Not Yet Competent’ grade for the placement.

ASSESSMENT:

The Clinical Assessment Portfolio forms part of the overall assessments for clinical units. Students are to refer to the Learnline site for the rubric which outlines how the objectives will be assessed. Students should also refer to the Learnline site for information on how to complete the reflective section of the portfolio and requirements for any online discussion board.

This Clinical Portfolio also includes an assessment item for HLTEN508B Apply reflective practice, critical thinking and analysis of health; students should refer to the Learnline site for this unit for requirements of the reflective section.
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 forms part of the overall assessment.

☐ I have successfully completed the pre requisite CTB for the unit.

☐ 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 2017.

☐ 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 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 client information and all matters related to the health facility.

If client confidentiality is breached, the penalty may include termination of placement and a Not Yet Competent grade given.

Name: 

Student number: 

Signature: ______________________ Date: ________________
1. **ATTENDANCE RECORD:**

A 100% attendance is required to complete practicum; 120 hours for **HLTEN515B**. Placement hours worked **does not** include breaks.

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### SCOPE OF PRACTICE

<table>
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<tr>
<td><strong>Novice:</strong></td>
<td><strong>Novice:</strong></td>
<td><strong>Novice:</strong></td>
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<tr>
<td>Frequent or continuous cues, no patient load; continuous supervision</td>
<td>Advanced beginner; frequent or occasional cues; medium level supervision (2-4 patients)</td>
<td>Advanced-beginner: Minimal cues; minimal supervision (4-6 patients)</td>
</tr>
</tbody>
</table>

- Communicate and collaborate appropriately with colleagues, patients & carers/ families.
- Establish and maintain a therapeutic relationship with patients & families appropriate to the clinical setting & 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 comfort & body alignment including:
  - Bed making

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 (2-4) including:

- Perform and document a health assessment
- Formulate nursing problem statements based on the above data and informed by evidence
- Conduct pain assessment and associated nursing interventions
- Provide evidence-informed rationales for the above interventions

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.

With supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) in the administration of S2 & S4 medications

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 processes for 4-6 patients 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 4-6 patients & across varying modalities
- Intra-venous therapy regimes including IV 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 & pharmokinetics of medications administered by the student

Apply knowledge of emergencies in the clinical setting and the maintenance & use of emergency & resuscitation equipment.

With close supervision:
<table>
<thead>
<tr>
<th>Tasks</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positioning of patient</td>
<td>Help with continence management (daily care of indwelling catheters; use of commodes; continence pads, bedpans or urinals).</td>
</tr>
</tbody>
</table>
| Use of infection control measures & standard precautions including | • Clean and clinical hand hygiene  
• Use of personal protective equipment  
• Appropriate disposal of waste materials |
| Assist with care of a low acuity patient requiring isolation or barrier nursing. | - Use safe and effective infection control measures & standard precautions including:  
  - Clean and clinical hand hygiene  
  - Use of personal protective equipment  
  - Appropriate disposal of waste materials  

**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 / supplement therapy  
- Discuss the rationales for the above interventions |
| Assist with admission and primary health assessment of low acuity patients including: | • Nursing history and primary assessment appearance  
• Weight and height  
• Ward urinalysis  
• Vital signs; T, PR, BP, RR & pulse oximetry |
| With support, conduct an assessment of patient pain. | - With support assess with wound healing by primary intention:  
  - Dry wound dressing  
  - Assessment of pressure ulcer risk  
  - Assessment of falls risk |
| Work collaboratively with allied health workers & other team members. | - With supervision, assess patients’ responses to hydration treatments including:  
  - Intravenous infusions  
  - Blood or blood products  
  - Total parenteral nutrition |
| Discuss student’s role in Emergency Codes (Blue, Green, and Red etc.) | - Discuss evidence-based collaborative management of patients who require the above interventions. |
| With supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) for patients requiring respiratory, neurological, cardiac, urinary & gastrointestinal system assessments required for high acuity patients & in emergency settings | - 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 |
| With supervision, assess and support respiratory function through body positioning and primary care planning and implementation. | - With supervision, apply the nursing process (assessment, planning, evidence-informed intervention, rationales and evaluation) for paediatric patients including assessment, pain management, medication management & family interventions. |
| With constant supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) for patients: | - Discuss the rationales for these decisions. |
| - Exhibiting difficult / challenging behaviours such as aggression  
- Experiencing mental illness and problems  
- Experiencing withdrawal syndrome and/or dependency behaviours (including working with AOD team)  
- Who are cognitively impaired | - With support, adapt nursing skills and clinical decision-making in a broad range of nursing contexts including remote area health clinics, mental health and community health facilities and specialised acute care areas. |
HLTEN508B UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Apply foundations of contemporary nursing practice
2. Participate in professional review and development
3. Work within a contemporary health care environment
4. Use critical thinking and analysis effectively
5. Promote reflective practice of self and others

HLTEN515B UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Respond to the special health requirements of the older client
2. Contribute to the care plan development for the older client
3. Assist to evaluate outcomes of planned nursing care of the older client
4. Practice within the aged care environment
5. Address contemporary issues in aged care practice
6. Use strategies which relate to the progressive and variable nature of dementia
7. Develop and implement strategies to minimize impact of challenging behaviours

HLTN301C UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Follow infection control guidelines
2. Identify and respond to infection risks
3. Maintain personal hygiene
4. Use personal protective equipment
5. Limit contamination
6. Handle, package, label, store, transport and dispose of clinical and other waste
7. Clean environmental surfaces

HLTWHS300A UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Plan and conduct work safely
2. Support others in working safely
3. Contribute to WHS participative processes
4. Contribute to hazard identification, WHS risk assessment and risk control activities
5. Participate in the control of emergency situations
HLTEN504C UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Establish and maintain therapeutic relationships with clients
2. Assist clients in activities of daily living
3. Assist clients with movement
4. Prepare clients for procedures
5. Provide nursing care to meet identified needs
6. Monitor and evaluate clients during care
7. Prepare clients for discharge in consultation/collaboration with the Registered Nurse
8. Evaluate nursing care provided

HLTEN401B UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Apply the principles of primary health care delivery
2. Apply the principle of wellness
3. Work in the context of professional nursing practice
4. Handle issues arising in health care
5. Contribute to professional team work
6. Participate in professional skills development
7. Apply the Scope of Nursing Practice Decision Making Framework

HLTEN502B UNIT OBJECTIVES:

Upon completion of this unit, students will be able to:

1. Use effective communication skills in complex situations
2. Deliver complex information effectively
3. Identify and address actual and potential constraints to communication
4. Evaluate effectiveness of communication in complicated situations
5. Use information technology
6. Lead small group discussions
7. Give and receive feedback for performance improvement
8. Use the principles and processes of open disclosure effectively
OBJECTIVE WEEK 1

Two objectives per week of placement must be completed by student. When objective achieved, each is to be signed by the RN working with student. HLTEN515B Implement and monitor nursing care for older clients requires a total of 6 objectives. Please select 3-5 NMBA standards and indicators relevant to the objective (including the number and title). Example: 2.2 Practices in accordance with the NMBA standards, codes and guidelines.

Objective # 1.

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OBJECTIVE WEEK 1

Two objectives per week of placement must be completed by student. When objective achieved, each is to be signed by the RN working with student. HLTEN515B Implement and monitor nursing care for older clients requires a total of 6 objectives. Please select 3-5 NMBA standards and indicators relevant to the objective (including the number and title). Example: 2.2 Practices in accordance with the NMBA standards, codes and guidelines.

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: __________________________
OBJECTIVE WEEK 2
Two objectives per week of placement must be completed by student. When objective achieved, each is to be signed by the RN working with student. HLTEN515B Implement and monitor nursing care for older clients requires a total of 6 objectives. Please select 3-5 NMBA standards and indicators relevant to the objective (including the number and title). Example: 2.2 Practices in accordance with the NMBA standards, codes and guidelines.

Objective # 3.

________________________________________________________________________________________________________________________________________________________

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: __________________________________________________________________________________________
OBJECTIVE WEEK 2

Two objectives per week of placement must be completed by student. When objective achieved, each is to be signed by the RN working with student. HLTEN515B Implement and monitor nursing care for older clients requires a total of 6 objectives. Please select 3-5 NMBA standards and indicators relevant to the objective (including the number and title). Example: 2.2 Practices in accordance with the NMBA standards, codes and guidelines.

Objective # 4.

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: ___________________________
### INTERIM ASSESSMENT  
(Conducted at the midpoint of the placement)

**HLTEN508**/HLTEN515BB students must attain a minimum rating of ‘Assisted’ in all competencies by the end of placement for HLTEN508/HLTEN515BB.

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

<table>
<thead>
<tr>
<th>Professional &amp; Collaborative Practice</th>
<th>Dependent</th>
<th>Marginal</th>
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### Grading scale

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<tr>
<th>Grade</th>
<th>Description</th>
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<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>
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<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; skillful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues.</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>
</tr>
<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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INTERIM FEEDBACK:
WEEK 2
To be completed by Preceptor / Facilitator midway through placement followed by discussion with student.

Date:__________

Student strengths:__________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

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Areas for improvement with strategies:_______________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Student comments:________________________________________________________

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Is student currently progressing satisfactorily?  Yes ☐  No ☐

Students must achieve minimum level of ‘Assisted’ in all NMBA Enrolled Nurse Standards for Practice by the end of placement. ‘No’ should be marked if student is graded below ‘Assisted’ in the Interim NMBA Feedback Assessment (p15) and with available evidence student appears unlikely to reach ‘Assisted’ by end of placement without intensive support or intervention. If ‘No’ is marked above, health facility is to contact Unit Coordinator for advice and refer to page 28 for Learning Agreement information. This feedback will allow extra supports to be put in place to assist the student.

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

Attendance record complete: ☐  4 clinical objectives complete: ☐

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

Clinical Facilitator/Educator: (please print) Date: ______________________

Preceptor/Registered Nurse: (please print) Date: ______________________
OBJECTIVES:

WEEK 3

Two objectives per week of placement must be completed by student. When objective achieved, each is to be signed by the RN working with student. All three NMBA Domains must be addressed by completion of placement. Students must identify the NMBA Domain and the specific NMBA Standards for Practice the objective links to.

Objective # 5.

NMBA Domain(s) objective links to: ____________________________________________________________

Resources student will use to work towards achieving objective: ________________________________________

Student self evaluation and strategies to improve: __________________________________________________

RN signature and name (printed): ___________________________ Date: __________________

Objective # 6.

NMBA Domain(s) objective links to: ____________________________________________________________

Resources student will use to work towards achieving objective: ________________________________________

Student self evaluation and strategies to improve: __________________________________________________

RN signature and name (printed): ___________________________ Date: __________________
### FINAL ASSESSMENT  
(Conducted at the end of the placement)

**HLTEN508/HLTEN515BB** students must attain a minimum rating of ‘Assisted’ in all competencies by end of placement for HLTEN508/HLTEN515BB.

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

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### Has the student met the minimum requirements of the Clinical Assessment Portfolio?

Yes ☐  No ☐

Students must achieve minimum level of ‘Assisted’ in all standards for practice in the Final NMBA Assessment. If the student has not achieved this, or failed to complete parts of the Clinical Assessment Portfolio, ‘No’ should be marked and facility should contact the CDU Unit Coordinator.
**FINAL FEEDBACK:**

**WEEK 3**

To be completed by Preceptor / Facilitator at completion of placement followed by discussion with student.

Date: ______________________

Feedback on student placement (strengths / areas for improvement):

________________________________________________________________________

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Student comments (strengths and / or goals for next placement):

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<th>6 clinical objectives complete:</th>
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Student Reflection

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

Unsatisfactory ☐  Satisfactory ☐  Good ☐  Excellent ☐

Continue on a separate sheet if necessary
Guide for Assessors
The following is a guide to assist facilitators and or educators to complete and assess competencies.

Professional and Collaborative Practice

Standard 1. Functions in accordance with the law, policies and procedures affecting enrolled nursing practice
Indicators:
1.1 Demonstrates knowledge and understanding of commonwealth, state and/or territory legislation and common law pertinent to nursing practice
1.2 Fulfills the duty of care in the undertaking of EN practice
1.3 Demonstrates knowledge of and implications for the NMBA standards, codes and guidelines, workplace policies and procedural guidelines applicable to enrolled nursing practice
1.4 Provide nursing care according to the agreed plan of care, professional standards, workplace policies and procedural guidelines
1.5 Identifies and clarifies EN responsibilities for aspects of delegated care working in collaboration with the RN and multidisciplinary health care team
1.6 Recognises own limitations in practice and competence and seeks guidance from the RN and help as necessary
1.7 Refrains from undertaking activities where competence has not been demonstrated and appropriate education, training and experience has not been undertaken
1.8 Acts to ensure safe outcomes for others by recognizing the need to protect people and reporting the risk of potential harm
1.9 When incidents of unsafe practice occur, report immediately to the RN and other persons in authority and, where appropriate, explores ways to prevent recurrence
1.10 Liaises and negotiates with the RN and other appropriate personnel to ensure that needs and rights of people in receipt of care are addressed and upheld

OBSERVATIONS:
Uses protocols/procedure/documentation to support enrolled nursing practice; promptly responds to unsafe practice; seen undertaking and responding appropriately

QUESTIONS:
When would you use/apply particular criteria/rules? (E.g. restraint/activities of daily living: documentation/consent/evaluation)

MEASUREMENTS:
Documents are appropriately utilised; documentation and reporting is evident;

Scenarios offered/other:
Restraint and its use/workplace injury and management & reporting

Standard 2. Practices nursing in a way that ensures the rights, confidentiality, dignity and respect of people are upheld
Indicators:
2.1. Places the people receiving care at the centre of care and supports them to make informed choices.
2.2. Practices in accordance with the NMBA standards codes and guidelines.
2.3. Demonstrates respect for others to whom care is provided regardless of ethnicity, culture, religion, age, gender, sexual preference, physical or mental state, differing values and beliefs.
2.4. Practices culturally safe care for (i) Aboriginal and Torres Strait Islander peoples; and (ii) people from all other cultures.
2.5. Forms therapeutic relationships with people receiving care and others recognising professional boundaries.
2.6. Maintains equitable care when addressing people’s differing values and beliefs.
2.7. Ensures privacy, dignity and confidentiality when providing care.
2.8. Clarifies with the RN and relevant members of the multi-disciplinary healthcare team when interventions or treatments appear unclear or inappropriate.
2.9. Reports incidents of unethical behaviour immediately to the person in authority and, where appropriate, explores ways to prevent recurrence.

2.10. Acknowledges and accommodates, wherever possible, preferences of people receiving nursing care.

**OBSERVATIONS:**
Clearly operates within professional boundaries/uses appropriate language/ communicates effectively with the nursing and multidisciplinary team and patients/ behaves in a non-threatening manner that makes peers comfortable

Uses appropriate language / communicates effectively individuals & groups (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; seen undertaking appropriate and timely competent care; maintains confidentiality; promotes patients individuality and independence; seeks advise when uncertain

**QUESTIONS:**
How would you respond to a conflict involving your values and beliefs and that of the patients?
How might you respond to patients’ request? How might your responses reflect the rights of individuals?
What strategies would you use engage a patient? How can you be honesty and upfront regarding a patients wellbeing;
How would identify if cultural practice is required?

**MEASUREMENTS:**
Does student make clear challenges to scope of practice?
Documentation e.g. such as progress notes these are accurately written; seeks assistance and consults other team members
Evidence of comfort whilst working/talking with clients of different ages/cultures etc.; appropriate use of language and dress

**Scenarios offered/other:**
Professionalism/policy and guidelines
Communication/ respect & dignity/problem solving.

**Standard 3. Accepts accountability and responsibility for own actions**

**Indicators:**
3.1. Practices within the EN scope of practice relevant to the context of practice, legislation, own educational preparation and experience.
3.2. Demonstrates responsibility and accountability for nursing care provided.
3.3. Recognises the RN as the person responsible to assist EN decision-making and provision of nursing care.
3.4. Collaborates with the RN to ensure delegated responsibilities are commensurate with own scope of practice.
3.5. Clarifies own role and responsibilities with supervising RN in the context of the healthcare setting within which they practice.
3.6. Consults with the RN and other members of the multidisciplinary healthcare team to facilitate the provision of accurate information, and enable informed decisions by others.
3.7. Provides care within scope of practice as part of multidisciplinary healthcare team, and with supervision of a RN.
3.8. Provides support and supervision to assistants in nursing (however titled) and to others providing care, such as EN students, to ensure care is provided as outlined within the plan of care and according to institutional policies, protocols and guidelines.
3.9. Promotes the safety of self and others in all aspects of nursing practice.

**OBSERVATIONS:**
Clearly operates within professional boundaries/accepts accountability and responsibility for own actions/ communicates, defers and accepts delegation when appropriate to registered nurses and multidisciplinary team members

**QUESTIONS:**
How might you respond to a registered nurses’ request? How might your response reflect the differing delegations between EN’s and RN’s?
**MEASUREMENTS:**
Awareness of policy/procedure; follows delegated instructions; Understands the differences in accountability and responsibility of an enrolled nurse and registered nurse; explores policy/procedure or asks questions of registered nurses when faced with new skill/situation.
Risk assessment; reporting risk issues immediately;

**Provision of Care**

**Standard 4. Interprets information from a range of sources in order to contribute to planning appropriate care**

**Indicators:**
1. Uses a range of skills and data gathering techniques including observation, interview, physical examination and measurement.
2. Accurately collects, interprets, utilises, monitors and reports information regarding the health and functional status of people receiving care to achieve identified health and care outcomes.
3. Develops, monitors and maintains a plan of care in collaboration with the RN, multidisciplinary team and others.
4. Uses health care technology appropriately according to workplace guidelines.

**OBSERVATIONS:**
Appropriately collects and reports patients data: documents/hands-over relevant information (for all patients); collaboratively produces a plan to assist/guide the management of care Follows agreed care plans; can formulate and evaluate an appropriate care plan and communicate this with the registered nurse;

**QUESTIONS:**
Explore how to plan and prioritise care: Are you able to prioritise patient(s) in your care? When should you seek clarification on a particular plan of care? (E.g. restraint/medicine administration: documentation/consent/evaluation): Are the patient and family satisfied with the care? How would you know?

**MEASUREMENTS:**
Documents are appropriately utilised to show a clear plan of care to manage patients; and in an appropriate time frame; identifies needs of patient and/or progress

**Standard 5. Collaborates with the RN, the person receiving care and the healthcare team when developing plans of care**

**Indicators:**
1. Develops and promotes positive professional working relationships with members of the multi-disciplinary team.
2. Collaborates with members of the multi-disciplinary healthcare team in the provision of nursing care.
3. Contributes to the development of care plans in conjunction with the multidisciplinary healthcare team, the person receiving care and appropriate others.
4. Manages and prioritises workload in accordance with people’s care plans.
5. Clarifies orders for nursing care with the RN when unclear.
6. Contributes to and collaborates in decision-making through participation in multidisciplinary healthcare team meetings and case conferences.

**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; Follows and evaluates care and/or treatment plan at start of period of duty and during span of care; constructively 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

**QUESTIONS:**
What documentation id required for referral/assessment and ongoing care & treatment leading to discharge; what are the roles of the RN and of others in the IDHCT;

**MEASUREMENTS:**
Uses appropriate language and documentation to communicate with the Interdisciplinary Health Care Team (IDHCT); Accurate documentation for referral/assessment and ongoing care & treatment leading to discharge; using correct documentation and referral methods; Being clear about the RNs role and the role of others in the IDHCT;

**Scenarios offered/other:**
Communicator / coordinator; Respect/confidently-competently-appropriately; role clarity
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;

**Standard 6: Provides skilled and timely care to people whilst promoting their independence and involvement in care decision–making**

**Indicators:**

6.1. Provides care to people who are unable to meet their own physical and/or mental health needs.
6.2. Participates with the RN in evaluation of the person’s progress toward expected outcomes and the reformulation of plans of care.
6.3. Promotes active engagement and the independence of people receiving care within the health care setting by involving them as active participants in care, where appropriate.
6.4. Demonstrates currency and competency in the safe use of healthcare technology.
6.5. Exercises time management and workload prioritisation.
6.6. Recognises when the physical or mental health of a person receiving care is deteriorating, reports, documents and seeks appropriate assistance.

**OBSERVATIONS:**
Student initiates conversation/interactions appropriately (privacy / safety / quiet) and adjusts care as required; when patient is unwell the level of care/basic needs are being met (within reason); continuity of care/communication; demonstrates appropriate level of knowledge of clinical nursing practice; enhancing and growing communication skills repertoire; empathetic; willingness to learn and to be polite and respectful; checks for satisfaction (colleagues and patients); uses language and appropriate cultural approaches to meet the needs of the patient in terms of care and health education information

**QUESTIONS:**
How do you establish that you have been able to give appropriate comfort and care to patients? How do you gain consent and agreement for care given? How do you maintain privacy and confidentiality? How do you gauge a patient’s level of understanding re health education you have given them?

**MEASUREMENTS:**
Evidence of comfort whilst working/talking with clients of different ages/cultures etc.: appropriate use of language; identification of the need for additional support/guidance. Clinical practices commensurate with practitioner level (beginning); Responds appropriately to feedback from patients and clients; Questions peers and patients to learn more.

**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.
Standard 7: Communicates and uses documentation to inform and report care

Indicators:
7.1. Collects data, reviews and documents the health and functional status of the person receiving care accurately and clearly.
7.2. Interprets and reports the health and functional status of people receiving care to the RN and appropriate members of the multidisciplinary healthcare team as soon as practicable.
7.3. Uses a variety of communication methods to engage appropriately with others and documents accordingly.
7.4. Prepares and delivers written and verbal care reports such as clinical handover, as a part of the multidisciplinary healthcare team

**OBSERVATIONS:**
Follows and evaluates care and/or treatment plan at start of period of duty and during span of care; constructively 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

**QUESTIONS:**
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/EN ratios in a timely and appropriate manner; 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; Knows when care to be delivered is outside scope of 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;

**Reflective and Analytical Practice**

Standard 8: Provides nursing care that is informed by research evidence

Indicators:
8.1. Refers to the RN to guide decision-making.
8.2. Seeks additional knowledge/information when presented with unfamiliar situations.
8.3. Incorporates evidence for best practice as guided by the RN or other appropriate health professionals.
8.4. Uses problem-solving incorporating logic, analysis and a sound argument when planning and providing care.
8.5. Demonstrates analytical skills through accessing and evaluating healthcare information and quality improvement activities.
8.6. Consults with the RN and other relevant health professionals and resources to improve current practice.

**OBSERVATIONS:**
Knows and verbalises critical appraisal of situations in a supportive manner: Questions practice of self; understands own learning needs; utilises reflective practice; role models; accesses journals & databases / evidence through research and policies/procedures; Appears confident/comfortable in work; uses preceptor for support & debriefing; uses an established communication model; recognises own limitations/scope of practice; open to guidance by others; 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 to?
**MEASUREMENTS:**
Self education; attends in-services/development seminars; evidence of reflection and appropriate use of models; analyses orders to be given; feedback on patient education/consumers/carers; follows guidelines; Seeks clarity of orders;

**Scenarios offered/other**
Attends in-services/short course participation

**Standard 9: Practises within safety and quality improvement guidelines and standards**

**Indicators:**
9.1. Participates in quality improvement programs and accreditation standards activities as relevant to the context of practice.
9.2. Within the multi-disciplinary team, contributes and consults in analysing risk and implementing strategies to minimise risk.
9.3. Reports and documents safety breaches and hazards according to legislative requirements and institutional policies and procedures.
9.4. Practices safely within legislative requirements, safety policies, protocols and guidelines.

**OBSERVATIONS:** Evidence of working within a safe practice framework; promptly responds to unsafe practice; joining/engaging/communicating behaviours; enhancing and growing communication skills repertoire; empathetic & knowledgeable practice within social context; willingness to learn and to be polite and respectful;

**QUESTIONS:** What strategies would you use engage a patient? How can you be honesty and upfront regarding a patients wellbeing; How would identify if cultural practice is required?

**MEASUREMENTS:**
Risk assessment; reporting risk issues immediately; Evidence of comfort whilst working/talking with clients of different ages/cultures etc.; appropriate use of language and dress

**Standard 10: Engages in ongoing development of self as a professional**

**Indicators:**
10.2. Recognises the need for, and participates in, continuing professional and skills development in accordance with the NMBA’s Continuous professional development registration standard.
10.3. Identifies learning needs through critical reflection and consideration of evidence-based practice in consultation with the RNs and the multidisciplinary healthcare team.
10.4. Contributes to and supports the professional development of others.
10.5. Uses professional supports and resources such as clinical supervision that facilitate professional development and personal wellbeing.
10.6. Promotes a positive professional image.

**OBSERVATIONS:** Evidence of working within a safe practice framework; promptly responds to unsafe practice; joining/engaging/communicating behaviours; enhancing and growing communication skills repertoire; empathetic & knowledgeable practice within social context; willingness to learn and to be polite and respectful;

**QUESTIONS:** What strategies would you use engage a patient? How can you be honesty and upfront regarding a patients wellbeing; How would identify if cultural practice is required?

**MEASUREMENTS:**
Risk assessment; reporting risk issues immediately; Evidence of comfort whilst working/talking with clients of different ages/cultures etc.; appropriate use of language and dress
# 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>
<td>Ability to communicate with patients and staff at a social level</td>
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<tr>
<td>Ability to communicate with patients and staff about nursing procedures</td>
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</tr>
<tr>
<td>Ability to communicate with patient and staff about medical procedures</td>
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<tr>
<td>Ability to participate in discussions with patient and staff</td>
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<tr>
<td>Knowing the right words or terms to express thinking to patients and staff</td>
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<tr>
<td><strong>Written Communication</strong></td>
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<tr>
<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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<tr>
<td>Ability to correctly use nursing terminology</td>
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<tr>
<td><strong>Responding to verbal communication</strong></td>
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<tr>
<td>Responds to verbal communication appropriately</td>
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<tr>
<td>Responds to verbal request accurately</td>
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<tr>
<td>Asking another person to repeat what he or she said as required</td>
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Please provide additional comments in the space below

---

Key

Students who are assessed as limited or developing should be referred to their unit coordinator to discuss what remedial practices have been attempted by clinical teacher/ facilitator and what further action is required. Students should be reassessed at regular intervals with success or failure of remedial actions noted.

<table>
<thead>
<tr>
<th>Limited 1</th>
<th>Developing 2</th>
<th>Satisfactory 3</th>
<th>Good 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns about being unsafe because of lack of ability and clarity of communication.</td>
<td>Refers to being safe when supervised and supported with communication.</td>
<td>Refers to being safe and knowledgeable most of the time.</td>
<td>Refers to being safe &amp; knowledgeable; efficient &amp; coordinated; displays confidence with activities of communication.</td>
</tr>
<tr>
<td>Continuous verbal cues required.</td>
<td>Requires some prompts and cues when articulating care and progress.</td>
<td>Requires occasional prompts when articulating patient care and progress.</td>
<td>Establishes good therapeutic techniques and interactions with the multidisciplinary team and patient.</td>
</tr>
<tr>
<td>Numerous errors of expression, pronunciation and incorrect terminology (health literacy).</td>
<td>Some errors of expression, pronunciation and use of incorrect terminology (health literacy).</td>
<td>Therapeutic communication and social communication established.</td>
<td>Able to articulate patient care and progress.</td>
</tr>
<tr>
<td>Inability to respond to verbal requests, constant requests for explanation or clarification.</td>
<td>Some delay in response to verbal requests, requires some explanation or clarification.</td>
<td>Social communication established.</td>
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<tr>
<td>Social communication or therapeutic communication not established.</td>
<td>Social communication established.</td>
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</table>
Assessment Tool - Third Party Report

Third Party Feedback (evidence that is given by the students’ clinical supervisor, preceptor, clinical facilitator or educator) is a practical assessment of students to supporting their competence.

As the third party, you are able to provide information of the students knowledge, skills and attitude, based on your knowledge and experience of their actual work performance for the period of their clinical placement in your health facility/organisation.

The students’s preceptor, clinical facilitator, or clinical educator is the best person to validate/assess a student’s performance during their clinical placement.

Competency based assessment is a process of collecting evidence about someone’s knowledge and skills, and assessing that against a set of agreed elements and performance criteria. The assessments forms part of the clinical assessment portfolio of evidence that is collected to ensure the outcomes meet the required level of knowledge and skills for the unit.

The information you provide is used to support other evidence obtained from the:

- Clinical assessment portfolio
- Academic assessments
- Observations during clinical placement
- Clinical Teaching Block
- OSCA’s

This ensures that the final result of a student’s competency in relation to their scope of practice is valid, reliable and fair.

The list below outlines the workplace activities for which third party validation is required. Based on your experience of this students work, you will be asked to indicate whether you believe that they have the appropriate skills and knowledge in the areas listed, and can perform these activities to the standards of the health facility/organisation.

If you are not satisfied with the students performance in a particular area, or have concerns about any aspect of the assessment it should be should discussed with the clinical facilitator and or the unit co-ordinator.
### Third Party Report: HLTWHS300A Contribute to WHS processes

<table>
<thead>
<tr>
<th>Candidate Name</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Unit of competency</th>
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<tbody>
<tr>
<td>HLTWHS300A Contribute to WHS processes</td>
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</tbody>
</table>

#### Purpose: The purpose of this instrument is to collect evidence of the students’ ability to apply essential skills and knowledge in the workplace during their clinical placement

<table>
<thead>
<tr>
<th>Performance and Knowledge Evidence</th>
<th>Where, when and how were the skills demonstrated or undertaken</th>
<th>Date</th>
<th>Supervisor initial &amp; Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Student must have demonstrated evidence in relation to state/territory WHS regulations, codes of practice and workplace procedures:</td>
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<tr>
<td>• WHS inspection of the work area</td>
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<tr>
<td>• conduct a workplace risk assessment and record results</td>
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<tr>
<td>• consistently apply workplace safety procedures in day to day activities</td>
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<tr>
<td>• follow workplace procedures for reporting hazards</td>
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<tr>
<td>• follow workplace procedures for a simulated emergency situation</td>
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</tbody>
</table>

#### Instructions: The person who signs this evidence collection method will be confirming that the student has applied essential skills and knowledge during their clinical placement. As the supervisor/ clinical facilitator/preceptor or clinical educator, your role in this process is to confirm that the student has applied these skills to the standard required by your health facility/organisation.

#### Feedback from the Preceptor/Clinical facilitator/Supervisor/Clinical Educator:

<table>
<thead>
<tr>
<th>Name &amp; Signature of Workplace Clinical Supervisor:</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>Name &amp; Signature of Unit coordinator</th>
<th>Date:</th>
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</table>
# Third Party Report: HLTIN301C Comply with infection control policies and procedures

<table>
<thead>
<tr>
<th>Candidate Name</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Unit of competency</th>
<th>HLTIN301C Comply with infection control policies and procedures</th>
</tr>
</thead>
</table>

**Purpose:** The purpose of this instrument is to collect evidence of the students’ ability to apply essential skills and knowledge in the workplace during their clinical placement.

**Instructions:** The person who signs this evidence collection method will be confirming that the student has applied essential skills and knowledge during their clinical placement. As the supervisor/clinical facilitator/preceptor or clinical educator, your role in this process is to confirm that the student has applied these skills to the standard required by your health facility/organisation.

## Performance and Knowledge Evidence

<table>
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<tr>
<th>Where, when and how were the skills demonstrated or undertaken</th>
<th>Date</th>
<th>Supervisor initial &amp; Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Student must have demonstrated the ability to undertake the following procedures:</td>
<td></td>
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</tr>
<tr>
<td>• Consistent application of hand washing, personal hygiene and personal protection protocols</td>
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<td></td>
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<tr>
<td>• Consistently apply clean and sterile techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• consistently apply protocols to limit contamination</td>
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</tr>
</tbody>
</table>

| The Student must effectively manage contingencies in the context of the identified work role, this includes the ability to: |      |                            |
|   • apply standard precautions |      |                            |
|   • apply additional precautions when standard precautions are not sufficient |      |                            |
|   • take opportunities to address waste minimization, environmental responsibility and sustainable practices |      |                            |

## Feedback from the Preceptor/Clinical facilitator/Supervisor/Clinical Educator:

<table>
<thead>
<tr>
<th>Name &amp; Signature of Workplace Clinical Supervisor:</th>
<th>Date:</th>
<th>Name &amp; Signature of Unit coordinator</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
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</table>
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 Not Yet Competent grade for the Clinical Assessment Portfolio. This decision is based on the student’s inability to meet the NMBA Enrolled Nurse Standards for Practice within their Scope of Practice for the relevant 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.

Student Name:  
Student Number:  
Clinical Venue:  
Clinical venue contact name:  
Contact Number:  

RE: HLTEN508B/HLTEN515B Learning Agreement

Dates:

This Learning Agreement identifies areas of clinical practice and professionalism which require improvement and development by you to successfully complete unit HLTEN508B/HLTEN515B Clinical competency requirements are in accordance with the NMBA enrolled nurse standards for practice and the code of conduct as outlined for CDU Diploma of Nursing students.

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

<table>
<thead>
<tr>
<th>Professional &amp; collaborative practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Functions in accordance with law, policies and procedures affecting enrolled nursing practice</td>
</tr>
<tr>
<td>2. Practice’s nursing in a way that ensures the rights, confidentiality, dignity and respect of people are upheld</td>
</tr>
<tr>
<td>3. Accepts accountability and responsibility for own actions within enrolled nursing practice</td>
</tr>
</tbody>
</table>
**Provision of care**

1. Interprets information from a range of sources in order to contribute to planning appropriate care

2. Collaborates with the RN, the person receiving care and the healthcare team when developing plans of care

3. Provides skilled and timely care to people receiving care and others whilst promoting their independence and involvement in care decision-making

**Reflective and analytic practice**

1. Provides nursing care that is informed by research evidence

2. Practices within safety and quality improvement guidelines and standards

3. Engages in ongoing development of self as a professional
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 ‘Not Yet Competent’ grade for the Clinical Assessment Portfolio. This decision is based on the student’s inability to meet the NMBA Standards for Practice within their Scope of Practice for the relevant level of study.

Aims of Learning Agreement:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Strategies / resources to achieve aim:________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Time frame:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

To successfully complete this component of the clinical unit, named student must meet the areas identified in this Learning Agreement and complete all other requirements of the clinical unit. Failure to successfully complete and submit this Learning Agreement will result in a NOT YET COMPETENT grade for the clinical unit.

RN signature:______________________________________________________________

RN name printed:___________________________________________________________

Designation:______________________________________________________________

Date:_____________________________________________________________________

I have read and understood the requirements of this Learning Agreement.

Student name:_____________________________________________________________

Student signature:__________________________________________________________

Date:_____________________________________________________________________

Unit Coordinator name:_____________________________________________________

Unit Coordinator signature:___________________________________________________

Date:_____________________________________________________________________

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.
FLOWCHART FOR CLINICAL PLACEMENT UNITS

For the reference of Nursing Academics, Staff, and Diploma of Nursing Students

COMMENCE PLACEMENT

CLINICAL APPRAISAL

Progress determined as **satisfactory** by Agency/Facility, clinical supervisors, educators, preceptors and Unit Coordinators in accordance with the NMBA Competencies, facility guidelines and Scope of Practice

**PLACEMENT COMPLETED**

Required clinical hours completed and Clinical Portfolio submitted to appropriate CDU unit coordinator within two weeks of completion of placement

All elements assessed as **satisfactory** and a grade is recorded

Student **proceeds** to the next level of study or if course complete grade and transcript signed and forwarded to AHPRA

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

Feedback provided to student

**Assessment graded as unsatisfactory**

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

Learning Agreement **achieved**

Learning Agreement **NOT achieved by set date**

**Not Yet Competent recorded for unit**

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

**UNSAFE PRACTICE**

Refer to additional note

Student **removed** from clinical placement

**PLEASE NOTE**

Unsafe practice can include any student action which may incorporate:
- Not achieving unit level standard
- Not achieving scope of practice
- Not demonstrating professional conduct

CDU remains responsible for the ultimate outcome of the workplace assessment