Clinical Assessment Portfolio 2018

NUR343 Nursing Practice 3 - Mental Health Placement

BNRS - Bachelor Nursing
College of Nursing and Midwifery

Student Name: __________________________________________________________

Student Number: ________________________________________________________

Dates of Placement: From: ____________________________ to: __________________

Health Facility: _______________________________________________________

Unit Name: ___________________________________________________________

Nurse Unit Manager: ____________________________________________________

Contact Details: _______________________________________________________

*Student is reminded to keep the original copy for own records ____________________________
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 supervisor/teacher and 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 of Australia Competency Standards. All assessments must be witnessed by a Registered Nurse working in the health facility or the Clinical supervisor/teacher or Preceptor responsible 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.

1. **Attendance record:** This must be accurate and complete. Any absences must be reported to the health facility and the CDU 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 placement office 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 pass for the unit. The objectives and their associated strategies must fit within the appropriate 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 second week of my placement on the mental health unit I will take on a client load of one - two clients. My care will be based on knowledge of the client’s medical and psychiatric history and their current treatment regimes. I will endeavour to build a therapeutic relationship with the clients based on empathy and active listening. I will be able to assess and monitor the client’s behaviour and mental state and report any concerns to my preceptor. I will document my care and interactions with the client”.

   **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 standards. The objectives should increase **in complexity each week of placement.** The increased complexity parallels the increasing competence and familiarity with the role and responsibilities of a registered nurse.

   **Nursing Midwifery Board Australia Standards (NMBA):** 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. Example: Journal articles, specific text book chapters.

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

   The ANSAT feedback and assessment instrument is based on the Australian Nursing and Midwifery Council Competency Standards (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 Competency Standards. The instrument is based on Bondy’s work (1983). The grading scale is outlined on the following page.

**Grading scale for ANSAT Standards:**

<table>
<thead>
<tr>
<th>Students must attain a minimum rating of:</th>
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<tbody>
<tr>
<td>(NUR343): Satisfactory Level: third year scope</td>
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<table>
<thead>
<tr>
<th>Unsatisfactory (1)</th>
<th>Expected behaviours and practices not performed</th>
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<tbody>
<tr>
<td></td>
<td>Unsatisfactory: unsafe. Not achieving minimum acceptable level of performance for the expected level of practice. Demonstrate behaviours infrequently / rarely. Continuous verbal &amp; / or physical direction required.</td>
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<tr>
<th>Limited (2)</th>
<th>Expected behaviours and practices below acceptable/ satisfactory standard</th>
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<tbody>
<tr>
<td></td>
<td>Limited: Not yet satisfactory. Demonstrates behaviours inconsistently. Needs guidance to be safe. Frequent verbal &amp; / or physical direction required. Requires close supervision.</td>
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<tr>
<th>Satisfactory (3)</th>
<th>Expected behaviours and practices performed at a satisfactory / passing standards</th>
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<tbody>
<tr>
<td></td>
<td>Satisfactory: This is the passing standard. Demonstrates behaviours consistently to a satisfactory and safe standard. Occasional supportive cues required.</td>
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<tr>
<th>Good / Proficient (4)</th>
<th>Expected behaviours and practices performed at a proficient standard</th>
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<tbody>
<tr>
<td></td>
<td>Proficient: The student is comfortable and performs above the minimum passing standard with respect to an item. Practice performed at a safe standard. Infrequent supportive cues required. The student’s performance is consistent, reliable and confident.</td>
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<tr>
<th>Excellent (5)</th>
<th>Expected behaviours and practices performed at an excellent standard</th>
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<tr>
<td></td>
<td>Excellent: Demonstrates most behaviours for the item well above minimum passing standard. Demonstrates greater independence in practice with safety a high priority. Supportive cues rarely required. Exhibits a level of excellence / sophistication with respect to an item.</td>
</tr>
</tbody>
</table>

Source: Australian Nursing Standards Assessment Tool www.ansat.com.au

**Is the student currently progressing satisfactorily?**

Third year students must achieve minimum level of ‘Satisfactory’ in all NMBA Competencies Standards by the end of placement. If the student is graded below ‘Satisfactory’ in the Interim NMBA Feedback Assessment (p13) and with available evidence student appears unlikely to reach ‘Proficient’ by end of placement without intensive support or intervention the health facility should contact the Unit Coordinator for advice. Please refer to page 24 for Learning Agreement information. The feedback provided will allow extra supports to be put in place to assist the student.

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 unsafe, the health facility retains the right to ask the student to leave the placement.
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>Year</th>
<th>Prime lines or change bags (no additives)</th>
<th>Saline flush</th>
<th>Infusion</th>
<th>Additives, Including IV AB &amp; S8</th>
<th>Parenteral or TPN</th>
<th>Blood products and blood</th>
<th>S8 bolus &amp; IV</th>
<th>PCA</th>
<th>CVC</th>
<th>P I C C</th>
<th>Epidural</th>
<th>Telephone orders</th>
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<tbody>
<tr>
<td>1</td>
<td>YES</td>
<td>YES, S2, S4 and S8</td>
<td>YES</td>
<td>YES</td>
<td>YES, S2, S4 and S8</td>
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<td>3</td>
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<td>YES, S2, S4 and S8</td>
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<td>YES, S2, S4 and S8</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 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:

- S2, S4 and S8 telephone orders
- 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: Mel Dudson  Email: nur343unitcoord@cdu.edu.au  Phone: 08 8946 7735

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: Mel Dudson  Email: clinicalcoordination@cdu.edu.au  Phone: 08 8946 7735

SUBMISSION OF CLINICAL ASSESSMENT PORTFOLIO:

Submission: From semester 1 2017 the Clinical Assessment Portfolio is electronically submitted through NUR343 Assessment submission point in Learnline. Please read assessment instructions in the NUR343 Learnline site about submission requirements.

Due date:  The Clinical Assessment Portfolio is to be submitted within 10 working days of completion of the clinical placement. If the Clinical Assessment Portfolio is not submitted 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.

The original clinical assessment portfolio (paper) is kept by the student but must be available for verification if required by your unit coordinator.

Student recommended to make certified copies for their own records: Graduate positions often require certified copies of clinical placement assessment documentation. Students are advised to obtain a certified copy of their portfolio signed by a justice of peace for their records and to assist in graduate applications.

Students are no longer required to submit paper versions of their clinical assessment portfolio BUT they must have the original paper version available if required by CDU.
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 SB 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 this clinical unit.

☐ I have read and understood the information in the Clinical Placement Resource Manual 2018.

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

☐ I am fit to practice (please refer to fitness to practice document).

☐ I declare that the assessment material / documents I have submitted both in paper /electronic versions for this unit are original and unaltered. I understand a false declaration will be dealt with under the code of conduct and statutory law.

If patient confidentiality is breached, the penalty may include termination of placement and a fail grade. If false or altered documents are submitted the breach will be dealt with as a breach of academic integrity / code of conduct and statutory law.

Name (print): ____________________________________________

Student number: ____________________________________________

Signature: ___________________________ Date: ________________
1. ATTENDANCE RECORD:

A 100% attendance is required to complete practicum; 80 hours for NUR343 - Mental Health. 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 1st 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: no patient load; continuous supervision.</th>
<th>Year 2: Unit NUR 244 – Novice to Advanced beginner medium level supervision (50% patient load).</th>
<th>Year 3: Unit NUR 343/ 344/ 346 Advanced-beginner: minimal supervision (100% patient load).</th>
</tr>
</thead>
</table>
| Communicate and collaborates appropriately with colleagues, patients & carers/ families.  
  - Assist colleagues with patient care as appropriate  
  - 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 comfort  
  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  
  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  
  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  
  Apply knowledge of emergencies in the clinical setting and the maintenance & use of emergency & resuscitation equipment.  
  With close supervision: |
| & body alignment including:  
| Bed making  
| Positioning of patient  
| With supervision, apply the nursing process (assessment, planning, evidence-informed interventions, rationales and evaluation) in the administration of S2 oral medications.  
| • Articulate knowledge of legislation, charting and e-scribe medication administration contexts  
| • Discuss the pharmacokinetics & pharmacology of all medications to be administered by the student and RN  
| • Discuss evidence-based rationales for safe administration and management of oral medication (S2 only).  
| Help with continence management (daily care of indwelling catheters; use of commodes; continence pads, bedpans or urinals).  
| 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  
| Assist with care of a low acuity patient requiring isolation or barrier nursing.  
| 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.).  
| 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 (excluding restricted S4 & S8).  
| • Articulate knowledge of legislation, charting and e-scribe medication administration contexts  
| • Discuss the pharmacokinetics & pharmacology of all medications to be administered by the student and RN  
| • Discuss evidence-based ionales for safe administration and management of varying regimes including: oral, IM, nebulised, SC, ocular, aural, nasal, PR & PV PEG/gastrostomy, nasogastric tube  
| • Intravenous therapy regimes including IV antibiotics  
| 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  
| Perform primary and secondary survey of respiratory, neurological, cardiac, urinary & gastrointestinal system  
| assessments required for high acuity patients & in emergency settings  
| • Use the above data to provide evidence-informed nursing interventions which may include monitoring of patients & performing ECGs  
| • Provide evidence-based care of patients with tracheostomies, chest drains and central venous access devices (CVAD).  
| With supervision, assess patients’ responses to hydration treatments including:  
| • Intravenous infusions  
| • Venupuncture- to obtain blood sample for evaluation of hydration and haemodynamic status  
| • Blood or blood products  
| • Total parenteral nutrition  
| Discuss 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 illness and related problems  
| • Aggressive patients  
| • Withdrawal syndrome and / or dependency behaviours (including working with AOD team)  
| • Cognitively impaired patients  
| 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.  
| Discuss the rationales for these decisions.  
| 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.  
|
NUR 343 LEARNING OBJECTIVES:

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

1. Design, implement and evaluate contextually relevant plans of holistic nursing care that are underpinned by the integration of related bodies of knowledge and skills in problem solving and evidence-based decision making in the acute and mental health setting.

2. Minimize risk of harm to patients through both clinical reasoning and individual performance.

3. Apply relevant ethical, legal, cultural and professional practice principles to the provision of nursing care in both the acute and mental health settings.

4. Demonstrate effective communication at a professional standard, in both oral and written format, in the acute and mental health environment.

5. Demonstrate the ability to work as part of a team and in a self-directed manner in the acute and mental health settings.

6. Critically reflect on performance, taking feedback from others into account, and identify opportunities for further personal and/or professional development.
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. NUR343 requires a total of 8 objectives (two per week for the four week placement). Please select 3-5 NMBA standard criteria relevant to the objective (including the number and title). Example: 6.5. Practices in accordance with relevant policies, guidelines, standards, regulations and legislation.

Objective


NMBA Standard(s) objective links to:


Resources student will use to work towards achieving objective:


Reference list:


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. NUR343 requires a total of 8 objectives (two per week for the four week placement). Please select 3-5 NMBA standard criteria relevant to the objective (including the number and title). Example: 6.5. Practices in accordance with relevant policies, guidelines, standards, regulations and legislation

Objective


NMBA Standard(s) objective links to:


Resources student will use to work towards achieving objective:


Reference list:


Has the student successfully achieved their objective? Yes  No

RN signature: ___________________________ Date: ___________________________

RN name printed: ___________________________

Designation: ___________________________
# INTERIM ASSESSMENT

<table>
<thead>
<tr>
<th>Assessment Items</th>
<th>RN Circle one number and initial</th>
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<tbody>
<tr>
<td>1. Thinks critically and analyses nursing practice</td>
<td>1 2 3 4 5</td>
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<tr>
<td>• Complies and practices according to relevant legislation and policy</td>
<td>1 2 3 4 5</td>
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<tr>
<td>• Uses an ethical framework to guide decision making and practice</td>
<td>1 2 3 4 5</td>
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**GLOBAL RATING SCALE** - In your opinion as an assessor of student performance, relative to their stage of practice, the overall performance of this student in the clinical unit was:

- Unsatisfactory
- Limited
- Satisfactory
- Proficient
- Excellent

Student Name: (please print)  
Student ID:  
Date of Assessment:  
Agency Name:  

**Key**

1 = Expected behaviours and practices not performed  
2 = Expected behaviours and practices performed below the acceptable/satisfactory standard  
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**Note**: a rating 1 &/or 2 indicates that the statement has NOT been achieved

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Student Name: ___________________ Sign: ___________________ Date: _________  
Clinical supervisor/teacher or Educator: ______________ Sign: ________________ Date: ________ 
Preceptor/Registered Nurse: (please print) ______________ Sign: ________________ Date: ________
Clinical Preceptor/Supervisor or Educator Feedback:

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RN Signature: __________________________________   Date: ______________________

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

Unsatisfactory  [ ] Limited  [ ] Satisfactory  [ ] Proficient  [ ] Excellent  [ ]

Assessor scoring rules
✓ Circle ONLY ONE number for each item
✓ If a score falls between numbers on the scale the higher number will be used to calculate a total
✓ Evaluate the student’s performance against the MINIMUM competency level expected for their level of training. Please see assessors guide pp. 26-28.

Source: Australian Nursing Standards Assessment Tool v 2 www.ansat.com.au
**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. **NUR343 requires a total of 8 objectives (two per week for the four week placement).**

Please select **3-5 NMBA standard criteria** relevant to the objective (including the number and title). Example: 6.5. Practices in accordance with relevant policies, guidelines, standards, regulations and legislation

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Has the student successfully achieved their objective? Yes [ ]  No [ ]

RN signature: _____________________________  Date: __________

RN name printed: _____________________________

Designation: _____________________________
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1. THINKS CRITICALLY AND ANALYSES NURSING PRACTICE

➢ **Complies and practices according to relevant legislation and local policy**
  - Follows policies and procedures of the facility/organisation (e.g. workplace health and safety / infection control policies)

  - Maintains patient/client confidentiality
  - Arrives fit to work
  - Arrives punctually and leaves at agreed time
  - Calls appropriate personnel to report intended absence
  - Wears an identification badge and identifies self
  - Observes uniform/dress code
  - Maintains appropriate professional boundaries with patients/clients and carers

➢ *Uses an ethical framework to guide their decision making and practice*
  - Understands and respects patients'/clients’ rights
  - Allows sufficient time to discuss care provision with patient/clients
  - Refers patients/clients to a more senior staff member for consent when appropriate
  - Seeks assistance to resolve situations involving moral/ethical conflict
  - Applies ethical principles and reasoning in all health care activities

➢ **Demonstrates respect for individual and cultural (including Aboriginal & Torres Strait Islander) preference and differences**
  - Practices sensitively in the cultural context
  - Understands and respects individual and cultural diversity
  - Involves family/other appropriately to ensure cultural/spiritual needs are met

➢ **Sources and critically evaluates relevant literature and research evidence to deliver quality practice**
  - Locates relevant current evidence (e.g. clinical practice guidelines and systematic reviews, databases, texts)
  - Clarifies understanding and application of evidence with peers or other relevant staff
  - Applies evidence to clinical practice appropriately
  - Participates in quality activities when possible (e.g. assists with clinical audit, journal club)
  - Shares evidence with others

➢ **Maintains the use of clear and accurate documentation**
  - Uses suitable language and avoids jargon
  - Writes legibly and accurately (e.g. correct spelling, approved abbreviations)
  - Records information according to organisational guidelines and local policy

2. ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS

➢ **Communicates effectively to maintain personal and professional boundaries**
  - Introduces self to patient/client and other health care team members,
  - Greets others appropriately
  - Listens carefully and is sensitive to patient/client and carer views
  - Provides clear instructions in all activities
  - Uses a range of communication strategies to optimise patient/client rapport and understanding (e.g. hearing impairment, non-English speaking, cognitive impairment, consideration of non-verbal communication)
  - Communication with patient/client is conducted in a manner and environment that demonstrates consideration of confidentiality, privacy and patient’s/client’s sensitivities

➢ **Collaborates with health care team and others to share knowledge that promotes person-centred care**
  - Demonstrates positive and productive working relationships with colleagues
  - Uses knowledge of other health care team roles to develop collegial networks
  - Demonstrates a collaborative approach to practice
  - Identifies appropriate educational resources (including other health professionals)
  - Prioritises safety problems

➢ **Participates as an active member of the healthcare team to achieve optimum health outcomes**
  - Collaborates with the health care team and patient/client to achieve optimal outcomes
  - Contributes appropriately in team meetings
  - Maintains effective communication with clinical supervisors and peers
  - Works collaboratively and respectfully with support staff

➢ **Demonstrates respect for a person’s rights and wishes and advocates on their behalf**
  - Advocates for the patient/client when dealing with other health care teams
  - Identifies and explains practices which conflict with the rights/wishes of individuals/groups
  - Uses available resources in a reasonable manner
  - Ensures privacy and confidentiality in the provision of care
### 3. MAINTAINS THE CAPABILITY FOR PRACTICE

- **Demonstrates commitment to lifelong learning of self and others**
  - Links course learning outcomes to own identified learning needs
  - Seeks support from others in identifying learning needs
  - Seeks and engages a diverse range of experiences to develop professional skills and knowledge
  - Supports and encourages the learning of others

- **Reflects on practice and responds to feedback for continuing professional development**
  - Reflects on activities completed to inform practice
  - Plans professional development based on reflection of own practice
  - Keeps written record of professional development activities
  - Incorporates formal and informal feedback from colleagues into practice

- **Demonstrates skills in health education to enable people to make decisions and take action about their health**
  - Assists patients/clients and carers to identify reliable and accurate health information
  - Patient/client care is based on knowledge and clinical reasoning
  - Refers concerns to relevant health professionals to facilitate health care decisions/delivery
  - Provides information using a range of strategies that demonstrate consideration of patient/client needs
  - Prepares environment for patient/client education including necessary equipment
  - Demonstrates skill in patient/client education (e.g. modifies approach to suit patient/client age group, uses principles of adult learning)
  - Educates the patient/client in self-evaluation

- **Recognises and takes appropriate action when capability for own practice is impaired**
  - Identifies when own/other’s health/well-being affect safe practice
  - Advises appropriate staff of circumstances that may impair adequate work performance
  - Demonstrates appropriate self-care and other support strategies (e.g. stress management)

- **Demonstrates accountability for decisions and actions appropriate to their role**
  - Provides care that ensures patient/client safety
  - Provides rationales for care delivery and/or omissions
  - Sources information to perform within role in a safe and skilled manner
  - Complies with recognised standards of practice

### 4. COMPREHENSIVELY CONDUCTS ASSESSMENTS

- **Completes comprehensive and systematic assessments using appropriate and available sources**
  - Questions effectively to gain appropriate information
  - Politely controls the assessment to obtain relevant information
  - Responds appropriately to important patient/client cues
  - Completes assessment in acceptable time
  - Demonstrates sensitive and appropriate physical techniques during the assessment process
  - Encourages patients/clients to provide complete information without embarrassment or hesitation

- **Accurately analyses and interprets assessment data to inform practice**
  - Prioritises important assessment findings
  - Demonstrates application of knowledge to selection of health care strategies (e.g. compares findings to normal)
  - Seeks and interprets supplementary information, (e.g. accessing other information, medical records, test results as appropriate)
  - Structures systematic, safe and goal oriented health care accommodating any limitations imposed by patient’s/client’s health status

### 5. DEVELOPS A PLAN FOR NURSING PRACTICE

- **Collaboratively constructs a plan informed by the patient/client assessment**
  - Uses assessment data and best available evidence to construct a plan
  - Completes relevant documentation to the required standard (e.g. patient/client record, care planner and assessment, statistical information)
  - Considers organisation of planned care in relation to other procedures (e.g. pain medication, wound care, allied health therapies, other interventions)

- **Plans and documents care to achieve expected outcomes with clear timeframes for evaluation**
  - Collaborates with the patient/client to prioritise and formulate short and long term goals
  - Formulates goals that are specific, measurable, achievable and relevant, with specified timeframe
  - Advises patient/client about the effects of health care
### 6. PROVIDES SAFE, APPROPRIATE AND RESPONSIVE QUALITY NURSING PRACTICE

- **Delivers safe and effective care within their scope of practice to meet outcomes**
  - Performs health care interventions at appropriate and safe standard
  - Complies with workplace guidelines on patient/client handling
  - Monitors patient/client safety during assessment and care provision
  - Uses resources effectively and efficiently
  - Responds effectively to rapidly changing patient/client situations

- **Provides effective supervision and delegates safely within their role and scope of practice**
  - Accepts and delegates care according to own or other’s scope of practice
  - Seeks clarification when directions/decisions are unclear
  - Identifies areas of own or other’s practice that require direct/indirect supervision
  - Recognises unexpected outcomes and responds appropriately

- **Recognise and responds to practice that may be below expected organisational, legal or regulatory standards**
  - Identifies and responds to incidents of unsafe or unprofessional practice
  - Clarifies care delivery which may appear inappropriate

### 7. EVALUATES OUTCOMES TO INFORM NURSING PRACTICE

- **Monitors progress towards expected goals and health outcomes**
  - Refers patient/client on to other professional/s
  - Begins discharge planning in collaboration with the health care team at the time of the initial episode of care
  - Monitors patient/client safety and outcomes during health care delivery
  - Records and communicates patient/client outcomes where appropriate

- **Modifies plan according to evaluation of goals and outcomes in consultation with relevant health care team and others**
  - Questions patient/client or caregiver to confirm level of understanding
  - Updates care plans/documentation to reflect changes in care
  - Uses appropriate resources to evaluate effectiveness of planned care/treatment
FLOWCHART FOR CLINICAL PLACEMENT UNITS NUR125, NUR244, NUR343, NUR344 & NUR346

COMMENCE PLACEMENT

CLINICAL APPRAISAL - refer to unit and Portfolio requirements

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

Progress determined as unsatisfactory by Agency/Facility clinical supervisors, educators, preceptors and Unit Coordinators i.e.
- Not achieved year level standard
- Not achieving scope of practice
- Not demonstrating professional conduct
- Inability to think critically
- Inconsistent and unsafe practice
Feedback provided to student

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

All elements graded as satisfactory and a grade is recorded

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

Assessment elements graded as unsatisfactory

Option 1: Learning Agreement opportunity for the remainder of placement, or additional placement arranged as per Learning Agreement

Learning Agreement achieved

Option 2: UNSAFE PRACTICE NB* Refer to additional note An inability to think critically and perform consistently and safely

Student removed from clinical placement

FAIL recorded for unit

Learning Agreement NOT achieved by set date

Student to meet with the BN Program Manager/Director of Clinical Education to discuss course progression

CDU remains responsible for the ultimate outcome of the workplace assessment.