

PRECEPTOR BOOK

NAME:

UNIVERSITY:

WARD:

DATES:



HOSPITAL

Our aim is for you to have an enjoyable clinical placement experience that is well supported by your preceptor/s, ward staff and the education team.

As part of this support, we expect your preceptor/s to give you frequent verbal and written feedback. Please ensure your preceptor/s document their feedback every day in this log book.

This feedback is important for your development as a clinician. It is also important information for your nurse educator/s when creating accurate placement appraisals and providing you with overall feedback.

ANSAT Assessment Tool

This tool guides preceptors in completing your clinical assessment tool accurately.

<u>Scale</u>	<u>Definition</u>	<u>Examples</u>
1	Expectation behaviours and practices not preformed	 Unsatisfactory Unsafe Continuous verbal&/or physical direction required Not achieving minimum acceptable level of performance for the expected level of practice.
3 This is the passing standard	Expected behaviours and practices performed below acceptable/satisfactory standard. Expected behaviours and practices performed at a satisfactory/ passing standard	 Not yet satisfactory Demonstrates behaviours inconsistently Needs guidance to be safe Continuous verbal&/or physical direction required – as appropriate for year level Demonstrates behaviours consistently to a satisfactory and safe standard Occasional supportive cues required - as appropriate for year level
Stanuaru	Standard	 The student has met this standard regardless of their experience, place in the course or length of the placement.
4	Expected behaviours and practices performed at a proficient standard	 The student is comfortable and performs -above the minimum passing standard Practice performed at a safe standard Infrequent supportive cues required The student's performance is consistent, reliable and confident.
5	Expected behaviours and practices performed at an excellent standard	 Demonstrates most behaviours for the item well above minimum passing standard. Demonstrates greater independences in practice with safety a high priority Supportive cues rarely required Exhibits a level of excellence/ sophistication with respect to an item.

https://www.ansat.com.au/home/assessment-manual

Level of support	Description	Example
Supportive cues	When the supervisor	Student states: "This is an S8
	provides support such as	drug, we need to get that
	'that's right' or 'keep going'	checked out of the cupboard
	or the learner is asking	by another nurse, don't
	questions	we?"
Verbal cues	When the supervisor	Supervisor states: "There is
	provides a verbal prompt to	one more thing we need to
	the learner	check before giving this
		medication to the patient"
Physical cues	When the supervisor is	Supervisor checks the ID
	required to demonstrate	band of the patient if the
	how to do a skill or task	learner does not respond to
		the verbal cue

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Registered nurse standards for practice

- 1. Thinks critically and analyses nursing practice.
- 2. Engages in therapeutic and professional relationships.
- 3. Maintains the capability for practice.
- 4. Comprehensively conducts assessments.
- 5. Develops a plan for nursing practice.
- 6. Provides safe, appropriate and responsive quality nursing practice.
- 7. Evaluates outcomes to inform nursing practice.

**Please see pages 32 & 33 for ANSAT Behavioural Cues to assist in completing feedback

 $\frac{https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx$

EXAMPLE: DAILY WRITTEN FEEDBACK

Date:	02/08/19	Preceptor:	Jenny V	No.	No. of patients: 3			
Standar	d 1: Thinks Critically and Ana	llyses Nursing Pra	ctice	1	2	3	4	5
Respect	t and cultural sensitivity	• Docui	mentation			1		
• Critical	thinking & reasoning					•		
 Underst 	tanding of patient & condition							
Standar	d 2: Engages in Therapeutic a	nd Professional R	elationships	1	2	3	4	5
 Profess 	ional interactions and boundar	ies • A	Advocacy for			1		
 Liaising 	and collaboration with team	Į.	natient's needs					
Standard	d 3: Maintains Capability for	Practice		1	2	3	4	5
• Self-dire	ected learning						1	
• Accoun	tability for self and others						•	
Standar	d 4: Comprehensively Conduc	ts Assessments		1	2	3	4	5
• Head-to	o-toe / systematic patient asses	ssment				1		
• Interpre	etation and analysis of findings					•		
Standar	d 5: Develops a Plan for Nursi	ing Practice		1	2	3	4	5
• Formul	ation of plan of care for shift	•	Considerations for			1		
• Conside	eration of medical and allied he	ealth needs	discharge					
Standar	d 6: Provides Safe, Appropria	te and Responsive	e Care	1	2	3	4	5
• Works	within scope of practice	• Initiati	ve				1	
 Seeks a 	ppropriate supervision	• Delega	tion of care				•	
• Time m	anagement							
Standar	d 7: Evaluates Outcomes to In	form Nursing	Practice	1	2	3	4	5
• Review	s and reassess	• Consid	deration for long-			1		
 Alters p 	lan accordingly	term i	mpact and goals			•		
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New skills learnt:

Venepuncture, paging for RAPID r/v and following through with interventions

Areas that went well

- Successful venepuncture!
- Great self-directed learning
- Great initiative
- Good systems-based assessment + documentation
- Overcame nerves and discussed plan for patient in RAPID criteria with medical team

Areas for improvement + strategies

- Continue to develop critical thinking relate your assessment findings to patient's disease and treatment.
- Build confidence: You need to overcome your nerves to safely advocate for patients. With your buddy, plan the discussion you want to have with a member of the MDT i.e. be prepared with answers, information, etc.

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 Understanding of patient & condition 	1						
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 Professional interactions and bound 	aries • Advocacy for						
• Liaising and collaboration with team	patient's needs						
Standard 3: Maintains Capability for	r Practice	1	2	3	4	5	
Self-directed learning							
 Accountability for self and others 							
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Interpretation and analysis of finding	gs						
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Consideration of medical and allied h	nealth needs discharge						
Standard 6: Provides Safe, Appropri	ate and Responsive Care	1	2	3	4	5	
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Time management	 Medication knowledge 						
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Standard 4: Comprehensively Condu	cts Assessments	1	2	3	4	5
• Head-to-toe / systematic patient asse	essment					
 Interpretation and analysis of finding 	s					
Standard 5: Develops a Plan for Nurs	sing Practice	1	2	3	4	5
• Formulation of plan of care for shift	 Considerations for 					
 Consideration of medical and allied h 	ealth needs discharge					
Standard 6: Provides Safe, Approprie	ate and Responsive Care	1	2	3	4	5
 Works within scope of practice 	Initiative					
 Seeks appropriate supervision 	 Delegation of care 					
• Time management	 Medication knowledge 					
Standard 7: Evaluates Outcomes to I	Inform Nursing Practice	1	2	3	4	5
 Reviews and reassess 	 Consideration for long- 					
 Alters plan accordingly 	term impact and goals					
New skills learnt:						
Areas that went well	Areas for improvement	+ stra	tegie	s		

- .		No. of patients:				
Date:	Preceptor:	NO.	от ра	tient	<u>s:</u>	
Standard 1: Thinks Critically and Ana	lyses Nursing Practice	1	2	3	4	5
 Respect and cultural sensitivity 	 Documentation 					
Critical thinking & reasoning						
• Understanding of patient & condition						
Standard 2: Engages in Therapeutic a	nd Professional Relationships	1	2	3	4	5
 Professional interactions and boundar. 	ies • Advocacy for					
• Liaising and collaboration with team	patient's needs					
Standard 3: Maintains Capability for	Practice	1	2	3	4	5
Self-directed learning						
Accountability for self and others						
Standard 4: Comprehensively Conduc	ts Assessments	1	2	3	4	5
Head-to-toe / systematic patient asses						
 Interpretation and analysis of findings 						
Standard 5: Develops a Plan for Nursi	ng Practice	1	2	3	4	5
Formulation of plan of care for shift	 Considerations for 					
Consideration of medical and allied he	alth needs discharge					
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 Reviews and reassess 	 Consideration for long- 					
 Alters plan accordingly 	term impact and goals					
New skills learnt:						
Areas that went well	Areas for improvement	+ stra	tegie	c		
Areas that Went Wen	Areas for improvement	· 3tiu	tegie	<u> </u>		

ANSAT Behavioural Cues

1. THINKS CRITICALLY AND ANALYSES NURSING PRACTICE

- Complies and practices according to relevant legislation
- Follows policies and procedures of the facility/organisation le.g. workplace health and safety / infection control
- Maintains patient/client confidentiality

policies)

- 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 quide their decision making
- members. 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
 - Seeks assistance to resolve situations involving consent when appropriate
- Applies ethical principles and reasoning in all health care moral/ethical conflict
- (including Aboriginal & Torres Strait Islander) preference Demonstrates respect for individual and cultural
- Practices sensitively in the cultural context
- Understands and respects individual and cultural diversity
 - Involves family/others appropriately to ensure cultural/spiritual needs are met
- Sources and critically evaluates relevant literature and research evidence to deliver quality practice
- Clarifies understanding and application of evidence with guidelines and systematic reviews, databases, texts)

Locates relevant current evidence (e.g. clinical practice

Applies evidence to clinical practice appropriately peers or other relevant staff

- 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

ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS

- Communicates effectively to maintain personal and professional boundaries
- Introduces self to patient/client and other health care team
- Greets others appropriately
- Listens carefully and is sensitive to patient/client and carer
 - Provides clear instructions in all activities
- impairment, non-English speaking, cognitive impairment, patient/client rapport and understanding (e.g. hearing Uses a range of communication strategies to optimise
- manner and environment that demonstrates consideration of confidentiality, privacy and patient's/client's sensitivities Communication with patient/client is conducted in a consideration of non-verbal communication)
- 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
- Identifies appropriate educational resources (including Demonstrates a collaborative approach to practice
- Prioritises safety problems

other health professionals)

- 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
- Maintains effective communication with clinical Contributes appropriately in team meetings
- supervisors and peers
- Works collaboratively and respectfully with support staff
- Advocates for the patient/client when dealing with other Demonstrates respect for a person's rights and wishes and advocates on their behalf
- Identifies and explains practices which conflict with the rights/wishes of individuals/groups health care teams
- Ensures privacy and confidentiality in the provision of care Uses available resources in a reasonable manner
- MAINTAINS THE CAPABILITY FOR PRACTICE
- Demonstrates commitment to lifelong learning of self and others
- Links course learning outcomes to own identified learning
- Seeks support from others in identifying learning needs
 - Seeks and engages a diverse range of experiences to develop professional skills and knowledge
- Reflects on practice and responds to feedback for Supports and encourages the learning of others
- Plans professional development based on reflection of own Reflects on activities completed to inform practice continuing professional development
- Keeps written record of professional development activities
- Incorporates formal and informal feedback from colleagues nto 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



age

- Patient/client care is based on knowledge and clinical
- Refers concerns to relevant health professionals to facilitate health care decisions/delivery
- Prepares environment for patient/client education Provides information using a range of strategies that demonstrate consideration of patient/client needs
- Demonstrates skill in patient/client education (e.g. modifies approach to suit patient/client age group, uses principles of adult learning) including necessary equipment
- 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
- Advises appropriate staff of circumstances that may impair adequate work performance
- Demonstrates appropriate self-care and other support strategies (e.g. stress management)
- appropriate to their role Demonstrates accountability for decisions and actions
- 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

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
- Responds appropriately to important patient/client cues
- Completes assessment in acceptable time
- Demonstrates sensitive and appropriate physical
- Encourages patients/clients to provide complete information without embarrassment or hesitation techniques during the assessment process

provision

- Accurately analyses and interprets assessment data to
- 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. as appropriate) accessing other information, medical records, test results
- Structures systematic, safe and goal oriented health care patient's/client's health status accommodating any limitations imposed by

DEVELOPS A PLAN FOR NURSING PRACTICE

- patient/client assessment Collaboratively constructs a plan informed by the
- Uses assessment data and best available evidence to
- Completes relevant documentation to the required assessment, statistical information) standard (e.g. patient/client record, care planner and
- Considers organisation of planned care in relation to other therapies, other interventions) procedures (e.g. pain medication, wound care, allied health
- others/health care team to achieve expected outcomes Plans care in partnership with individuals/significant
- Collaborates with the patient/client to prioritise and formulate short and long term goals
- Advises patient/client about the effects of health care Formulates goals that are specific, measurable, achievable and relevant, with specified timeframe
- 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
- Complies with workplace guidelines on patient/client standard
- Monitors patient/client safety during assessment and care handling

- Uses resources effectively and efficiently
- Responds effectively to rapidly changing patient/client
- within their role and scope of practice Provides effective supervision and delegates safely
- 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

PRACTICE **EVALUATES OUTCOMES TO INFORM NURSING**

- Monitors progress towards expected goals and health
- 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
- Records and communicates patient/client outcomes where
- Modifies plan according to evaluation of goals and outcomes in consultation with relevant health care team
- Questions patient/client or caregiver to confirm level of understanding
- Updates care plans/documentation to reflect changes in
- planned care/treatment Uses appropriate resources to evaluate effectiveness of





Student Self-Reflection

Each day use the following spaces to reflect on your placement at Melbourne Health.

Tips for self-reflection:

- What did you do well?
- What areas would you like to improve on?
- Overall progress on achieving placement objectives
- Planning and reviewing daily objectives.





The Royal Melbourne Hospital

Thank you for completing your placement at The Royal Melbourne Hospital.

Please hand this in to your Clinical Nurse Educator at the middle and end of your clinical placement for your appraisals. You can then keep this booklet for your records.