

NAME: UNIVERSITY: WARD: DATES:



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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Standard 1: Thinks Critically and Ar	alyses Nursing Practice	1	2	3	4	5	
 Respect and cultural sensitivity 	 Documentation 						
 Critical thinking & reasoning 							
 Understanding of patient & condition 	1						
Standard 2: Engages in Therapeutic	and Professional Relationships	1	2	3	4	5	
 Professional interactions and bounded 	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 							
Standard 4: Comprehensively Condu	ıcts Assessments	1	2	3	4	5	
 Head-to-toe / systematic patient ass 	essment						
Interpretation and analysis of finding	gs						
Standard 5: Develops a Plan for Nur	sing Practice	1	2	3	4	5	
• Formulation of plan of care for shift	 Considerations for 						
Consideration of medical and allied h	nealth needs discharge						
Standard 6: Provides Safe, Appropri	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	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	t + stra	tegie	<u>s</u>			

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	1					

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Respect and cultural sensitivity	Documentation	-	_		7	,
Critical thinking & reasoning	- Documentation					
Understanding of patient & condition						
Standard 2: Engages in Therapeutic and Prof	essional Relationships	1	2	3	4	5
 Professional interactions and boundaries 	 Advocacy for 					
 Liaising and collaboration with team 	patient's needs					
Standard 3: Maintains Capability for Practice	?	1	2	3	4	5
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• Head-to-toe / systematic patient assessment						
 Interpretation and analysis of findings 						
Standard 5: Develops a Plan for Nursing Prac	tice	1	2	3	4	5
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Standard 6: Provides Safe, Appropriate and F	Responsive Care	1	2	3	4	5
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Standard 2: Engages in Therapeutic and P	rofessional Relationships	1	2	3	4	5
Professional interactions and boundaries	 Advocacy for 					
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Formulation of plan of care for shift	 Considerations for 					
Consideration of medical and allied health						
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Self-directed learning						
 Accountability for self and others 						
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Head-to-toe / systematic patient as			_		-	
 Interpretation and analysis of finding 						
Standard 5: Develops a Plan for Nursing Practice			2	3	4	5
Formulation of plan of care for shift	-					
Consideration of medical and allied	*					
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Date: Preceptor:		ivo.	от ра	<u>tient</u>	<u>s:</u>		
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Time management	Medication	on knowledge					
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 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	nform 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		
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<u>Date:</u> <u>Preceptor:</u>			от ра	tient	<u>s:</u>	
Standard 1: Thinks Critically and And	alyses Nursing Practice	1	2	3	4	5
 Respect and cultural sensitivity 	 Documentation 					
Critical thinking & reasoning						
• Understanding of patient & condition						
Standard 2: Engages in Therapeutic of	and Professional Relationships	1	2	3	4	5
Professional interactions and boundary	ries • 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	cts Assessments	1	2	3	4	5
 Head-to-toe / systematic patient asse 	essment					
Interpretation and analysis of findings	S					
Standard 5: Develops a Plan for Nursing Practice			2	3	4	5
• Formulation of plan of care for shift	 Considerations for 					
Consideration of medical and allied he	ealth needs discharge					
Standard 6: Provides Safe, Appropria	te and Responsive Care	1	2	3	4	5
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 Alters plan accordingly 	term impact and goals					
New skills learnt:			•			•
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New Skills learnt.						
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Incorporates formal and informal feedback from colleagues

nto practice activities

Keeps written record of professional development

Demonstrates skills in health education to enable people

Assists patients/clients and carers to identify reliable and

accurate health information

to make decisions and take action about their health

Plans professional development based on reflection of own

Reflects on practice and responds to feedback for Reflects on activities completed to inform practice

continuing professional development

Supports and encourages the learning of others

develop professional skills and knowledge

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
- Maintains appropriate professional boundaries with Observes uniform/dress code

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
- moral/ethical conflict
- Applies ethical principles and reasoning in all health care
- (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)

Participates as an active member of the healthcare team

Collaborates with the health care team and patient/client

to achieve optimum health outcomes

- 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

Works collaboratively and respectfully with support staff

Maintains effective communication with clinical

supervisors and peers

Contributes appropriately in team meetings

to achieve optimal outcomes

Demonstrates respect for a person's rights and wishes

Advocates for the patient/client when dealing with other

health care teams

and advocates on their behalf

Identifies and explains practices which conflict with the

ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS

- Communicates effectively to maintain personal and professional boundaries
- Uses available resources in a reasonable manner rights/wishes of individuals/groups Introduces self to patient/client and other health care team

Ensures privacy and confidentiality in the provision of care

- 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

Links course learning outcomes to own identified learning

and others

Seeks support from others in identifying learning needs

Seeks and engages a diverse range of experiences to

Demonstrates commitment to lifelong learning of self

MAINTAINS THE CAPABILITY FOR PRACTICE

- 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
- other health professionals) Prioritises safety problems



ANSAT Behavioural Cues

- 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
- Demonstrates skill in patient/client education (e.g. Prepares environment for patient/client education including necessary equipment
- Educates the patient/client in self-evaluation

principles of adult learning)

modifies approach to suit patient/client age group, uses

- Recognises and takes appropriate action when capability
- Identifies when own/other's health/well-being affect safe

Advises appropriate staff of circumstances that may impair

- Demonstrates appropriate self-care and other support strategies (e.g. stress management) adequate work performance
- Demonstrates accountability for decisions and actions
- Provides care that ensures patient/client safety appropriate to their role
- 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

- using appropriate and available sources Completes comprehensive and systematic assessments
- 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 techniques during the assessment process information without embarrassment or hesitation

- Accurately analyses and interprets assessment data to
- Prioritises important assessment findings
- Demonstrates application of knowledge to selection of
- accessing other information, medical records, test results Seeks and interprets supplementary information, (e.g. health care strategies (e.g. compares findings to normal) as appropriate)
- 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

Recognises unexpected outcomes and responds

direct/indirect supervision

appropriately

 Identifies areas of own or other's practice that require Seeks clarification when directions/decisions are unclea Accepts and delegates care according to own or other's

scope of practice

within their role and scope of practice

Provides effective supervision and delegates safely

- Collaboratively constructs a plan informed by the
- Uses assessment data and best available evidence to construct a plan
- Completes relevant documentation to the required
- Considers organisation of planned care in relation to other procedures (e.g. pain medication, wound care, allied health therapies, other interventions)
- 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
- 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 standard
- Complies with workplace guidelines on patient/client
- Monitors patient/client safety during assessment and care provision

- Uses resources effectively and efficiently Responds effectively to rapidly changing patient/client

- assessment, statistical information) standard (e.g. patient/client record, care planner and

- Advises patient/client about the effects of health care Formulates goals that are specific, measurable, achievable

PRACTICE **EVALUATES OUTCOMES TO INFORM NURSING**

Clarifies care delivery which may appear inappropriate

Identifies and responds to incidents of unsafe or

Recognise and responds to practice that may be below

expected organisational, legal or regulatory standards

unprofessional practice

- Monitors progress towards expected goals and health
- Refers patient/client on to other professional/s
- care team at the time of the initial episode of care Begins discharge planning in collaboration with the health
- care delivery 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
- understanding Questions patient/client or caregiver to confirm level of
- 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.

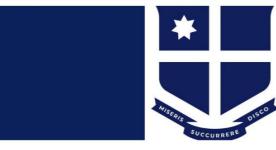
Tips for self-reflection:

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

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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.