Catherine McAuley School of Nursing and Midwifery
University College Cork
&
Bon Secours Hospital
Cork University Hospital
Mercy University Hospital
South Infirmary Victoria University Hospital

BSc (Hons) Nursing (General)

ASSESSMENT OF COMPETENCE BOOKLET

NU3082 General Nursing Practice
NU4087 General Nursing Practice

2012 INTAKE
(YEARS THREE AND FOUR)

Note: The Student is responsible for returning this document in its original form either in person or by registered post to the School of Nursing and Midwifery, UCC, on the dates specified by the School. Failure to do so may result in failing the Practice Placement Module. Please ensure that you sign for the submission of the document if you return it in person. Students submitting the document by registered post should, in their own interest, make a photocopy of the document before posting. Except in the case of a document lost in the post, photocopied documents will not be accepted.

Student's Name: _____

Student ID: _____

Health Service Provider: _____

If found, please return this document to the School of Nursing and Midwifery, University College Cork.

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SCHOOL OF NURSING AND MIDWIFERY, UCC AND PARTICIPATING HEALTH SERVICE PROVIDERS

SAMPLE PRACTICE PLACEMENT AGREEMENT 2014

INTRODUCTION

As a **Nursing** student you are studying to obtain a University Degree that will allow you to register with Nursing and Midwifery Board of Ireland (NMBI) (formerly An Bord Altranais (ABA)), and upon registration, to work as a Registered Nurse. During your study you will gain practice experiences in various health care settings, interacting with individuals[1], members of staff[2], and other health care professionals. It is therefore essential that you agree with the conditions set out below to ensure that you can learn effectively and become a competent nurse. These conditions are based upon NMBI's (formerly ABA) (2005) Requirements and Standards for Nurse Registration Education Programmes, NMBI's (formerly ABA) (2000) Code of Professional Conduct, and University College Cork's (UCC) Student Information Booklet. Failure to comply with the conditions set out in this agreement, which you will be asked to sign, may result in you not being allowed to continue in your BSc Nursing programme.

School of Nursing and Midwifery/
Participating Health Service Providers

****

Student Name: _____

Student ID Number: _____

I AGREE THAT:

1. I will listen to individuals and respect their views, treat individuals politely and considerately, and respect their privacy, dignity, and their right to refuse to take part in teaching.

2. I will act according to NMBI's (formerly ABA) Code of Professional Conduct.

3. My views about a person's lifestyle, culture, beliefs, race, colour, gender, sexuality, age, social status, or perceived economic worth will not prejudice my interaction with individuals, members of staff, or fellow students.

4. I will respect and uphold an individual's trust in me.

5. I will always make clear to individuals that I am a nursing student and not a registered nurse.

6. I will maintain appropriate standards of dress, cleanliness and appearance.

7. I will wear a health service provider identity badge with my name clearly identified.

8. I will familiarise myself and comply with the Health Service Provider's values, policies and procedures.

9. I have read and understood the guidelines as set out in the Practice Placement Guidelines Booklet.

10. I understand and accept to be bound by the principle of confidentiality of individuals' records and data. I will therefore take all necessary precautions to ensure that any personal data concerning individuals, which I have learned by virtue of my position as a nursing student, will be kept confidential. I confirm that I will not discuss individuals with any other party outside the clinical setting, except anonymously. When recording data or discussing care outside the clinical setting I will ensure that individuals cannot be identified by others. I will respect all Health Service Providers' and individuals' records.

[1] 'Individual' also refers to patient, client, resident, significant other, colleague, other health care professional

[2] 'Member of staff' refers to both academic and health service personnel.

11. I have read and understand the BSc Programme Grievance and Disciplinary Procedures (available on the School of Nursing and Midwifery webpage i.e. www.ucc.ie/en/nursingmidwifery//)

12. I understand that if I have (or if I develop) an impairment or condition that may impact in any way on my ability to learn, perform safely in the clinical environment or affect the welfare of myself or others, that it is my responsibility to share this with an appropriate person in the clinical setting (e.g. Allocations Liaison Officer, Clinical Placement Coordinator, Staff Nurse, Staff Midwife). I accept that only through disclosure of this impairment/condition can an appropriate plan of support to reach the required clinical learning outcomes/competencies be explored.

13. If I am returning from a period of illness/hospitalisation/surgery, it is expected that I report this to the Allocation Liaison Officer (attached to my Health Service Provider) as I may be required to attend the occupational health department prior to accessing my clinical placement.

14. I understand and accept that any dispute between parties in relation to this Agreement, outside of UCC's and NMBI's (formally ABA) relevant regulations, may be referred to the BSc Nursing's Joint Disciplinary Committee for a decision.

15. I confirm that I shall endeavour to recognise my own limitations and shall seek help/support when my level of experience is inadequate to handle a situation (whether on my own or with others), or when I perceive that my level of experience may be inadequate to handle a situation.

16. I shall conduct myself in a professional and responsible manner in all my actions and communications (verbal, written and electronic including text, e-mail or social communication media).

17. I will attend all scheduled teaching sessions and all scheduled clinical placements, as I understand these are requirements for satisfactory programme completion. If I am unable to attend any theoretical element of the programme, I will provide a written explanation to the Attendance Monitoring Executive Assistant in G.03. If I am unable to attend my scheduled clinical placement, I will act according to Local Health Service Provider Guidelines and the Practice Placement Agreement, and will inform the relevant personnel in a timely manner e.g. Clinical Placement Coordinator and Clinical Nurse Manager, as appropriate.

By my signature hereunder I confirm that I have read and understood all the above conditions and that I agree to comply with ALL of these for the duration of the BSc Programme.

Student Signature: _____ Date: _____/_____/_____

****

Signed on behalf of the Health Service Provider:

Health Service Provider: _____
Please print name

Director of Nursing/Nominee: _____
Please print name

Signature:_____ Date: _____/_____/_____

****

Signed on behalf of University College Cork:

Head of School of Nursing and Midwifery/Nominee: _____
Please print name

Signature:_____ Date: _____/_____/_____

CLINICAL PLACEMENT DETAILS

STUDENT NAME: ____

ID NUMBER: ______________ **YEAR OF ENTRY TO BSc:** ____________

PRACTICE PLACEMENT AREA: ________________________________
(e.g. medical / surgical/community /Public Health Nursing etc.)

Allocation Dates: **From:** ____________ **To:** _________

No. of Weeks Allocated: __________ No. of Weeks Completed: ____________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ________________________________

Allocation Dates: **From:** ____________ **To:** _________

No. of Weeks Allocated: __________ No. of Weeks Completed: ____________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ________________________________

Allocation Dates: **From:** ____________ **To:** _________

No. of Weeks Allocated: __________ No. of Weeks Completed: ____________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ________________________________

Allocation Dates: **From:** ____________ **To:** _________

No. of Weeks Allocated: __________ No. of Weeks Completed: ____________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ________________________________

Allocation Dates: **From:** ____________ **To:** _________

No. of Weeks Allocated: __________ No. of Weeks Completed: ____________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

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Print Name *Signature*

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No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

PRACTICE PLACEMENT AREA: ____

Allocation Dates: **From:** _______________ **To:** ___________

No. of Weeks Allocated: ____________ No. of Weeks Completed: _______________

Clinical Assessor / Preceptor: ____
Print Name *Signature*

Total number of weeks completed in Practice Placement in Year Three: [ ]

Total number of weeks completed in Practice Placement in Year Four: [ ]

NU3082: STUDENT SELF-ASSESSMENT FORM – END OF YEAR 3

The following is a summary of my self-assessment for NU3082 General Nursing Practice. I confirm that all the required elements of my Clinical Practice Placements have been met and signed off as being complete as follows:

Name and Student ID on front cover of Booklet	**Yes ___**	**No __**
Clinical placements details completed	**Yes ___**	**No __**
Preceptor/Assessor Signatures completed	**Yes ___**	**No __**
Student declaration (P.8) signed	**Yes ___**	**No __**
Student & Preceptor/Assessor signatures/dates for all competencies achieved	**Yes ___**	**No___**
Student & Preceptor/Assessor signatures/dates for all Skills achieved	**Yes ___**	**No __**
Assessment of Practice Interviews completed & **ALL** signed with dates by student and Preceptors.	**Yes ___**	**No __**
Reflective Notes written up with dates and Preceptor/Assessor Signatures	**Yes ___**	**No __**
Reflection Time Record Sheet completed & signed (Year 3)	**Yes___**	**No __**

- ***Number of Competencies achieved:***

  At Identification level: _____

  At Internalisation level: _____

- ***Number of Skills achieved (excluding opportunistic & miscellaneous)***

  At Identification Level: _____

  At Internalisation Level: _____

_____ _____

Signed Date

NU4087: STUDENT SELF-ASSESSMENT FORM – END OF YEAR 4

The following is a summary of my self-assessment for NU4087 General Nursing Practice. I confirm that all the required elements of my Clinical Practice Placements have been met and signed off as being complete as follows:

Name and Student ID on front cover of Booklet	**Yes ___**	**No ___**
Clinical placements details completed	**Yes ___**	**No ___**
Preceptor/Assessor Signatures completed	**Yes ___**	**No ___**
Student declaration (P.8) signed	**Yes ___**	**No ___**
Student & Preceptor/Assessor signatures/dates for all competencies achieved	**Yes ___**	**No___**
Student & Preceptor/Assessor signatures/dates for all Skills achieved	**Yes ___**	**No __**
Assessment of Practice Interviews completed & **ALL** signed with dates by student and Preceptors.	**Yes ___**	**No___**
Reflective Notes written up with dates and Preceptor/Assessor Signatures	**Yes ___**	**No __**

Total Number of Competencies achieved:

At Identification level: _____

At Internalisation level: _____

Total Number of Skills achieved (excluding opportunistic & miscellaneous)

At Identification Level: _____

At Internalisation Level: _____

_____ _____

Signed Date

STUDENT DECLARATION - YEAR THREE

I declare that I have achieved all the signed competencies, skills and reflective notes through my own efforts, and that all signatures are the authentic signatures of the relevant named personnel.

Student Name (please print name): _____

Student Signature: _____

Date: _____

STUDENT DECLARATION - YEAR FOUR

I declare that I have achieved all the signed competencies, skills and reflective notes through my own efforts, and that all signatures are the authentic signatures of the relevant named personnel.

Student Name (please print name): _____

Student Signature: _____

Date: _____

Professional Behaviour and Standards

Nursing and Midwifery undergraduate programmes prepare students for entry onto a professional Register with the Nursing and Midwifery Bord of Ireland (NMBI) formally known as An Bord Altranais.

The Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais 2000) states that the "*nursing profession demands a high standard of professional behaviour from its members*". Thus any suspected forgery of a signature or other unprofessional tampering with the Assessment of Competence Booklet entries is deemed to be a very serious issue and will necessitate the invoking of the "Joint Health Service Provider and School of Nursing and Midwifery Disciplinary Procedures for Pre-registration BSc Nursing and BSc Midwifery students". Under this procedure, if a student is found to have signed/forged another person's signature, the disciplinary committee will recommend appropriate actions under the auspices of the joint disciplinary procedures. A minimum penalty as follows will apply: **A fail judgement for the clinical practice module will automatically be recorded for anybody who is found to have forged another person's signature** either while on placement in clinical practice or within their clinical learning assessment documentation.

If a situation exits where a student finds it difficult to access a preceptor or associate preceptor to sign their booklet, while on a placement area or within a short time frame of leaving a placement area, (three weeks maximum), the student is advised to discuss this in the first instance with their Clinical Placement Co-ordinator or Clinical Nurse/Midwife Manager or Associate Preceptor or Link Lecturer. If a difficulty continues to arise the student should make contact with the Branch Leader or Midwifery Co-ordinator to discuss the matter.

NOTE: Please refer to School of Nursing & Midwifery website where further information relating to the BSc Programme can be accessed. Specific guidelines relating to professional and clinical matters are available for your information on this website. It is important that each student takes the time to familiarise themselves with these matters at the commencement of each academic year.

Submission of NU3082/NU4087 Assessment of Competence Booklet

Students must submit their competency booklets at the agreed submission date.

Year Three

Approximate date for submission of 3rd year booklet is May 2015. Students will be notified in advance, by email, of the specific submission date. Hence, students must check their e-mails regularly while on clinical placement. Students **MUST** submit their booklet on the specified submission date for assessment. If a student is required to pay back time/complete extra clinical time following Summer Examinations (mid May), they must put a detailed note at the front of their competency booklet on submission. This should include (1) the number hours/weeks to pay back/complete and (2) when the book needs to be available to them again, so that it can be prioritised for review. Failure to complete the above may result in the competency booklet not being reviewed in time for collection.

Year Four

Approximate dates for submission of 4th year booklet are April/May 2015 (Mid-Term Review) and September 2015 (Final Submission). Students will be notified in advance, by email, of the specific submission dates. All students **must** submit their booklet for the **Mid-Term Review**; if a student is unable to submit on the specific date, they must notify their Practice Module Leader.

For the **Final Submission**, students **must** submit their booklet on the agreed submission date. For students who are unable to submit their booklet on the submission date, an Extension Request Form must be submitted in advance of the submission date to G.03, School of Nursing and Midwifery. The Extension Request Form must detail the reason for which an extension is required. Failure to complete the above **will** result in your Assessment of Competence Booklet not being processed in time for the relevant examination board. **In addition** to completing the Extension Request Form, if making up time/paying back time or doing additional time, students **must** consult with the Practice Module Leader to confirm whether or not they must also submit their booklet for review on the specified submission date.

The clinical modules NU3082 & NU4087 (Part B of BSc programme) are assessed when the Assessment of Competence booklets are examined. Students must also submit their time-sheets (Year 3 only) to the allocations office within two weeks of completion of the relevant clinical placement (Note: specific date of return of time-sheet is noted on the time-sheet).

In relation to the Assessment of Competence Booklet and similar to the Practice Placement Guidelines: "Entries made in error should be bracketed and have a single line drawn through them so that the original entry is still legible. Errors should be signed and dated. No attempt should be made to alter or erase the entry made in error. Erasure fluid should never be used. If an enquiry or litigation is initiated, then the record must not be altered in any way either by the addition of further entries or by altering an entry made in error". (Recording Clinical Practice Guidance to Nurses and Midwives, An Bord Altranais, November 2002, pg.12).

These extracts are taken directly from Recording Clinical Practice Guidance to Nurses and Midwives (November 2002).

Loss of Booklet: student responsibilities

The competency booklet remains the **responsibility** of the student during the completion of the clinical elements of the programme. Once the clinical module results have been successfully completed and ratified at an examination board in year 4, the booklet is maintained on file in the School of Nursing and Midwifery, UCC, thereafter, as a permanent record of student attainment of the clinical elements of the programme.
The competency booklet contains most of the evidence of attainment of the requirements for passing the clinical module in each of the years of the BSc programme. It is each student's individual responsibility to ensure that they photocopy the relevant sections of their booklet after completion of each placement and retain such photocopies in a safe manner. Thus, in the rare event of a booklet being stolen (or lost etc) the student has some evidence of what had been attained up to the time of the loss of the booklet. If your booklet is lost or stolen, please make contact with your Practice Module Leader and Clinical Placement Co-ordinator(s). In the event of a booklet being misplaced it is the student's responsibility to compile the evidence of having completed all the relevant competencies and skills etc and present such evidence to the practice module leader by the dates specified in the assignment submission grid.

Evidence of having completed all the clinical module requirements verified by preceptor/associate preceptor signatures is required for students to PASS the clinical module.

Extra Clinical Time for Extended Leave

If a student has been absent from clinical placement for a continuous year they are recommended to undertake a minimum of two weeks medical/surgical clinical placement which is extra to NMBI requirements. This placement is to facilitate re-visiting of fundamental skills and learning outcomes.

Please refer to NU3082 and NU4087 module descriptors (at the end of this booklet) for further requirements for completion of the module.

ASSESSMENT OF COMPETENCE GUIDELINES

Introduction

The emphasis during practice placement experiences is on providing general nursing students with opportunities to engage in reflective nursing practice within a supportive learning environment, thereby enabling them to develop the attitudes, knowledge, and skills necessary for thoughtful, efficient and effective nursing practice.

The assessment of a student's practice is organised around the following six domains: Five domains as developed by An Bord Altranais (2005), and a sixth domain, domain F, which has been developed within the School of Nursing and Midwifery. The sixth domain consists of essential nursing skills. This domain needs to be considered and assessed in conjunction with the other domains.

A. Professional and ethical practice
B. Holistic approaches to care and the integration of knowledge
C. Interpersonal relationships
D. Organisation and management of care
E. Personal and professional development
F. Skills in General Nursing

Each domain has a number of competencies and each competency has a number of indicators. The student's development of competence during her/his 4-year programme will be assessed against criteria based on Steinaker and Bell's (1979) experiential learning taxonomy. This taxonomy has 5 levels of learning: exposure, participation, identification, internalisation and dissemination. By the end of the second year of the programme, the student must have achieved participation level (see the Clinical Learning Outcomes Booklet for further details). This Assessment of Competence Booklet refers only to the levels of identification and internalization, and is designed to assist in the assessment of the student's learning during the Supernumerary Placements and the Rostered Practice Placement experiences in Year 3 and Year 4. By the end of the programme, the student is required to be competent at internalisation level. The focus in Years Three and Four then is on assisting the student to achieve competencies required for entry to the NMBI Register. Competence is defined as the ability of the Registered Nurse to practise safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice (ABA, 2000). These competencies will develop as the student identifies with and internalises nursing practice situations over a period of time.

Identification

Steinaker and Bell (1979) define this level in the following terms:

> *"At this level the student actively participates in the experience using and testing data, indicating that the initial learning experience has been achieved. The student combines the organisational, emotional and intellectual context of a learning experience. The student begins to identify personally with the experience, recognises the organisation and structure of the experience, gains a deeper insight into its value, and is able to express recognition of her/his own achievement."*

An Bord Altranais (2005)[3] interpreted Steinaker & Bell's (1979) taxonomy[4] in the following manner as regards ***Identification*** in a nursing and healthcare context.

> *"The student now shows the ability to participate in the delivery of care under supervision on a more sustained basis with less prompting and greater confidence. The student shows a greater ability to communicate effectively,*

[3] An Bord Altranais (2005) (3rd Edition) Requirements and Standards for Nurse Registration Education Programmes *An Bord Altranais:* Dublin , Ireland
[4] Steinaker, N. and Bell, R., (1979) The Experiential Taxonomy: A New Approach to Teaching and Learning New York: Academic Press

and demonstrates a wish to acquire further information. The student is able to analyse and interpret information, demonstrating a problem solving skills and knowledge base to meet different situations."

Internalisation

Steinaker and Bell (1979) define this level in the following terms:

> *"The student is an active and self-directive individual in the learning experience, with progress no longer controlled from the outside. Experiences are incorporated and further reinforced in the student thus becoming a part of unconscious problem solving. The highest level of internalisation has been achieved when an experience touches and continues to influence the lifestyle of a student."*

An Bord Altranais (2000)[5] interpreted Steinaker & Bell's (1979) taxonomy[6] in the following manner as regards ***Internalisation*** in a nursing and healthcare context.

> *"The student is able to explain the rationale for her/his nursing action. The student requires less supervision whilst caring for a group of individuals, and is able to transfer knowledge to new situations. The student seeks and applies new knowledge and research findings, and demonstrates the ability to use problem solving skills, critical analysis and evaluation."*

It is important to recognise that practice placement experiences differ from student to student. There are differences in the order and sequence, but also differences in the length of the various experiences. Some experiences are assessed, others are not. The context of learning in Year Three and Four, as outlined above, therefore needs to be interpreted flexibly.

[5] An Bord Altranais (2000) (2nd Edition) Requirements and Standards for Nurse Registration Education Programmes Dublin Stationery Office

[6] Steinaker, N. and Bell, R., (1979) The Experiential Taxonomy: A New Approach to Teaching and Learning New York: Academic Press

ADAPTED STEINAKER AND BELL'S (1979) EXPERIENTIAL TAXONOMY

Steinaker and Bell's (1979) first four levels (exposure, participation, identification and internalisation) of their experiential taxonomy have been adopted to guide and assist both the students and preceptors in the assessment of the students' learning outcomes (Years One and Two) and competencies (Year Three and Four). The framework presented below is based on an in-depth examination of Steinaker and Bell's 1979 text '*The Experiential Taxonomy: A New Approach to Teaching and Learning'*. The guiding principle in developing the framework has been to retain as far as possible the language used by Steinaker and Bell. Please note that the dissemination level is included for information purposes only. It is suggested that this level may be adopted when assessing the practice of students (Registered Nurses) who undertake Higher Diploma programmes.

Taxonomy = A classification of organisms into groups based on similarities of structure or origin (Collins English Dictionary, 1999)

Experience = "A hierarchy of stimuli, interaction, activity and response within a scope of sequentially related events beginning with exposure and culminating in dissemination" (Steinaker and Bell, 1979:9). "Experience is cyclic as is life" (Steinaker and Bell, 1979:33).

EXPOSURE Level	**Sub categories of Exposure Level**	**Examples of Activities at Exposure Level**	**Implications for Students**	**Implications for Preceptors**	**Guidance for Assessment of Practice**
The process of becoming consciousness of an experience. The invitation to an experience where extrinsic forms of motivation are used to: • gain and focus attention • reduce anxiety and • establish in the student a willingness to participate further	*Sensory* The student is exposed to an experience Leading to a *Response* The student interacts with the experience Leading to *Readiness* The student accepts the experience and anticipates participation in it.	Uses audio or visual materials Observes examples to illustrate a principle, concept or skill Locates resources Listens to facts or principles being presented Views situations, objects, roles Asks fundamental / naïve questions Recognises changing relationships between previously used words, images, activities	The student uses all 5 senses: • Seeing • Hearing • Smelling • Touching • Tasting The student reacts, recognises and notices with a degree of controlled thought	The preceptor: • Motivates the student • Focuses attention on the experience • Keeps the student's anxiety within bounds • Maintains the student's confidence	Observe and sense the positive and/or negative reactions of the student Determine initial understanding and willingness to proceed

PARTICIPATION Level	Sub categories of the Participation Level	Examples of Activities at Participation Level	Implications for Students	Implications for Preceptors	Guidance for Assessment of Practice
The level at which the student decides to become physically a part of the experience **or** becomes an active participant (to replicate in some way to which the student has been exposed)	Representation (characterised by a feeling of discovery) Reproducing, mentally and/or physically, an experience either: • covertly - a private rehearsal or • overtly - in a small/large group interaction. *Leading to* Modification (characterised by cognitive confirmation) With the input of past personal activities the experience develops and grows (the student defines a beginning frame of reference) The student becomes an active participant	Participates in structured data gathering activities Discusses and reviews data presented Avails of opportunities to practice an observed event Participates in hands-on activities Reacts to new, difficult or unusual occurrence	The student engages in mental and/or physical activities: <u>Mental Activities</u> • Visualising • Modelling • Recalling • Role playing ('walking through') of experiences <u>Physical Activities</u> • Exploring • Manipulating • Collecting, discussing and inferring from available data relevant to the experience	The preceptor: acts as a catalyst for the student's progress provides initial guidance and supportive feedback bridges gap between what the student already knows and what the student needs to know encourages the student to think critically about the experience	Examine and judge the designed and implemented learning activities Ask questions that demonstrate understanding and ability to succeed Determine whether the student's knowledge and skills need further advancement **or** need to revise learning activities

IDENTIFICATION Level	Sub categories of the Identification Level	Examples of Activities at Identification Level	Implications for Students	Implications for Preceptors	Guidance for Assessment of Practice
This is an interacting level at which the student actively participates in the experience using and testing data, indicating that the initial learning experience has been achieved The student combines the organisational, emotional and intellectual context of a learning experience The student begins to identify personally with the experience, recognises the organisation and structure of the experience, gains a deeper insight into its value, and is able to express recognition of own achievement	Reinforcement As the experience is modified/repeated, it is reinforced through a unconscious decision to identify with the experience Emotional The student identifies emotionally with the experience. It becomes "my experience" Personal The student moves from an emotional identification to an intellectual commitment. Involves a rational decision to identify Sharing Begins to share the experience with others as an important factor in life	Employs procedures to practice and combine psychomotor, cognitive and affective activities and skills, linking theory to practice Engages in student or preceptor led discussions, supported by evidence Organises activities, selects data and retrieves data Documents data accurately and chronologically Focuses in on specific subject areas Presents and / or demonstrate learning to peers	The student experiments by applying, associating, classifying, categorising and Evaluating data The student engages in investigative, interpretive and problem solving activities	The preceptor: Acts as a resource leader prompting the student to use data Provides corrective feedback to reinforce learning Constantly analyses the student's difficulties/ deficiencies and selects additional learning resources and/or instruction methods	Use appropriate standardised measures and / or preceptor-made criteria to evaluate learning The student demonstrates that agreed learning has been achieved Verify the correctness of the course of learning

INTERNALISATION Level	Sub categories of the Internalisation Level	Examples of Activities at Internalisation Level	Implications for Students	Implications for Preceptors	Guidance for Assessment of Practice
At this level the student is viewed as an active and self-directive individual in the learning experience, with progress no longer controlled from the outside. Experiences are incorporated and further reinforced in the student thus becoming a part of unconscious problem solving The highest level of internalisation has been achieved when an experience touches and continues to influence the lifestyle of a student.	Expansion The experience enlarges into many aspects of the student's life, changing attitudes, beliefs and activities. Intrinsic (Fusion) The experience characterizes the student's life-style in a more consistent manner.	Engages in activities in which the student evaluates similarities and differences between experiences Challenges the student to think at higher cognitive levels Avails of opportunities to transfer learning experiences to new situations Provides opportunities for the student to develop her/his own 'style' Becomes actively involved in seminar activities for groups of students to resolve activities of mutual interest, present case studies, examine aspects of care experiences	The student begins to generalise and create new uses for various aspects of their learning The student develops, reinforces, modifies and evaluates concepts, and transfers these to other experiences The student develops the skills of: Analysing, transferring appreciating, enquiring and debating experiences with self and others	The preceptor: Provides situations where the student has more control yet practices within limits set by the preceptor Conducts periodic review of learning, showing sensitivity to the student's needs Conducts wider and deeper probing of learning Provides solution focused problem solving experiences initially, gradually progressing to more complex experiences	Use rating scales, check lists, questionnaires, and/or interviews etc. Devise situations for the student to demonstrate growth in their learning experiences Determine student's awareness, values and beliefs and discuss areas of concern for improvement

DISSEMINATION Level (Postgraduate level)	**Sub categories of the Dissemination Level**	**Examples of Activities at Dissemination Level**	**Implications for Students**	**Implications for Preceptors**	**Guidance for Assessment of Practice**
At this level the student has more control to choose learning activities. It involves primarily a voluntary, outward expression and reflects the degree of transfer, of reward, and of motivation achieved by the student	Informational The student sees the experience as beneficial, and feels strongly enough to attempt to inspire and motivate others through descriptive and personalised sharing **Advocacy** Student sees the experience as imperative for others. Continued devotion to search for direct and indirect influence	Engages in political & debating activities Presents cases / philosophies Structures/organises student-led seminars and presentations, illustrating advantage or excellence of a specific process or approach Facilitates peer teaching and counselling Produces materials (videos, drama, poetry, leaflets) to influence ideas, structures and systems Publishes papers Designs courses Participates in recruiting activities	Assumes most of the teaching role Becomes the resource, presenter, demonstrator, motivator, developer and the critic of the outcomes of experiences Reorganises accumulated data to meet learning outcomes and to express feelings and ideas Act as professional, coach and/or leader	The preceptor: Acts as a critic Provides corrective, supportive and informational feedback Sustains the experience to facilitate further learning/development beyond the existing setting Provides a variety of methods whereby the student can express the experience	Determine adequate measures of achievement based on learning objectives Ensure evaluation design includes provision to determine how well the student feels the objectives have been achieved .

The Content: Domains, Competencies, and Indicators

1. The assessment of practice is organised around domains (ABA 2005). Each domain has a number of competencies and each competency has a number of indicators.
2. The competencies are assessed against the ***identification*** and ***internalisation*** level, based on Steinaker and Bell's (1979) experiential learning taxonomy.
3. The Students must achieve a minimum of 8 competencies plus 40 skills ***at identification or internalisation level*** as part of the requirements for passing the 3rd year practice placement module NU3082 in accordance with Marks and Standards (all practice placement experiences are contained within this module).
4. Students must have achieved ALL competencies (13) at Identification and Internalisation Level by the end of the final placement in Year 4, as part of the requirements for passing NU4087.
5. Each competency/skill achieved must be signed and dated by the student and the preceptor[7]. A competency can only be achieved if all the indicators, which represent the competency, have been assessed.
6. In the case of a student who has not met all the indicators in relation to a competency during a placement, the preceptor should initial and date the indicator(s) met to enable the student to follow up the outstanding indicators in subsequent placements. The preceptor in these subsequent placements will then be aware which indicators the student has 'worked' on so far.
7. Where competencies/skills have been achieved, it is important that the student continues to demonstrate these within subsequent placements.
8. Students should have ample opportunities to achieve the competencies/skills.

The Process of Assessment

1. The student and the preceptor agree at the 1st meeting (beginning of the placement) the specific competencies the student can best work on and achieve. These should be identified and listed in the commencement of placement interview form. The preceptor decides whether a competency can be assessed within the time frame in which the student has had appropriate learning opportunities to avail her/himself of. The CPC may be a useful resource in this regard.
2. The student, preceptor and CPC may wish to consider the learning opportunities available, the student's prior clinical placement experience and the student's course booklet for the academic input to assist in the identification of learning needs and the achievement of competencies/skills.
3. The agreed number of competencies should be determined by the nature and length of the practice placement experience. Competencies and skills may need to be revisited, as appropriate, by the student.
4. The student and preceptor should schedule the next Mid-Placement or End of Placement Interview at first meeting.
5. The student and the preceptor meet for mid placement interview for assessment and review of learning. A mid-placement interview is **not** required for placements of up to and including 3 weeks duration. However, if a student is viewed by the preceptor as not progressing towards agreed competencies, the student must be advised of this at the earliest opportunity during the placement.
6. Preceptors can adopt a variety of methods to assess the competencies. This may be through direct observation, feedback from staff, interview, discussion, assessment of documentation, or any other evidence that is considered to be relevant.
7. The student is encouraged when not working with their preceptor to ensure that other registered nurses comment on their clinical performance in notes page for Preceptors/Associate Preceptors/Staff Nurses/CPC/CNMs.
8. The student is expected to self-assess as an integral part of the assessment process.
9. Students may be encouraged to revisit skills and competencies where indicated.
10. The student is required to write Reflective Notes **(using the Gibbs' Cycle),** and provide other sources of evidence to assist in the assessment process. Evidence can be in the form of care-plans, specific assessments undertaken, feedback from patients/clients, and/or appraisal of own skill development
11. The student is encouraged to keep a personal diary of his/her learning experiences, which s/he may wish draw on in meetings with preceptors, Clinical Placement Co-ordinators[8] (CPC) and link

[7] In the absence of a preceptor, a designated assessor undertakes this function.

lecturers. Keeping a personal diary may help to refine reflective writing skills and help students to select situations that can be used when writing reflective notes. Reflective Notes must be completed and shown to Preceptor on or before final interview. Each reflective note must be dated and signed by both student and Preceptor. The CPC can review the reflective notes and offer advice and guidance as appropriate.

12. The student and the Preceptor/Associate Preceptor **must** meet for end of placement interview for assessment, review of learning and sign off on students competencies achieved and/or competencies/skills revisited during making up time.
13. The student must make some concluding comments in the end of placement interview form.
14. The Preceptor is required to make some concluding comments at the end of each assessment that evaluate the student's achievement of agreed competencies/skills/other.

Additional Support

1. Additional support may be required if a Preceptor/Associate preceptor/CPC/other member of staff has a concern about a student's achievement of competencies, clinical skills or if a student is not conducting themselves in a professional and responsible manner and/or not working within their agreed Practice Placement Agreement (PPA).
2. This concern must be 'flagged' to the student by the Preceptor/Associate preceptor/CPC/other member of staff at the earliest opportunity. This can be done at any time e.g. before, during, or after the mid interview or at any time in a practice placement.
3. The Preceptor/Associate preceptor and/or other relevant personnel request a meeting with the student as soon as possible to address this concern. Depending on the nature of the concern the Link Lecturer (LL) may also attend. The purpose of this meeting is to:
    I. ascertain the student's view of their practice and progress
    II. highlight to the student by giving specific examples of the concerns which the Preceptor/CPC and/or relevant personnel have in relation to their competencies, skills, professional nursing practice/other.
    III. give constructive feedback and direction by giving 2 or 3 specific guidelines to the student on what they need to do or work on to address the identified issue(s) or concern(s).
    IV. Specify a date to review the learning/practice concern with the student/Preceptor/other
4. The nature of the concern, feedback and direction given with review date of next meeting or other outcome of meeting must be documented in the Mid interview or Additional Interview Section.
5. The student needs to be given a reasonable amount of time (for example a minimum of one week) to address the concerns highlighted, where possible. If after this time the original concern(s) remain, an SLP/other mechanism[9] may be introduced in advance of their final interview. [In exceptional circumstances however, an SLP/other mechanism may need to be introduced immediately e.g. student performing outside their scope of practice and/or patient safety concerns].
6. At this meeting, however, depending on the nature of the concern and following some discussion, there is a possibility that the need for a Supportive Learning Plan (SLP) or other mechanism may be suggested to the student to assist with their practice/learning issues or to address professional matters. The LL, if not present at the Additional interview may be informed by the CPC that an Additional interview has occurred. If an SLP/other mechanism is suggested then the L.L. and Practice Module Leader are informed of the need to arrange a meeting as appropriate.
7. The SLP is initiated with the agreement of the student. If a student refuses an SLP, the CPC must arrange a meeting with the student, preceptor, CPC and LL. to discuss the matter. This can be done at mid interview or as an additional interview. Here the student's reasons for refusing an SLP must be documented as well as advice given and signed by all present. The student is made aware of the implications of this i.e. they may not achieve Pass and Progression requirements for NU3082/NU4087.

[8]In placement areas where a CPC is not attached, the preceptor makes contact with the relevant link Lecturer.
[9] Other mechanism for example may include disciplinary procedures, fitness to practice, occupational health

8. Where a final interview has been completed and a concern is raised after this interview an additional interview **must** be conducted with the student, preceptor/associate preceptor/ CPC and LL. The student must be given constructive feedback and direction by giving 2 or 3 specific guidelines on what they need to do or work on to address the identified concern(s). This must be documented and signed by all present. This is carried forward into the next placement and the student must inform their preceptor of the open additional interview at the outset of the next clinical placement.

Please refer to section on Supportive Learning Plan Guidelines (page 152 for more detail)

Other Student-specific Guidance

1. The student **must ensure** that the Booklet is at hand/available at each day of the placement. - **including during making up time**.
2. The student maintains the Booklet in a neat and workable order during the two years of its use.
3. The student is responsible for ensuring that the achieved competencies at identification and internalisation levels, skills, reflective notes, interviews and practice placement details are signed prior to completion of the practice placement. Where this is not possible the student must negotiate an agreed date with the preceptor/associate preceptor/CNM and complete the interview within a **three week time-frame** of finishing the clinical placement.
4. The student returns the Booklet to the School of Nursing and Midwifery, UCC at scheduled dates as outlined by the School of Nursing and Midwifery.

Commencement of Placement Interview

The student and preceptor meet to explore learning needs and opportunities, so that specified competencies can be identified, practised and achieved. These should be identified and listed in the commencement of placement interview form as (a) a guide to structuring the practice experience, and (b) as a guide for discussion at the Mid Placement Interview (if the placement is longer than 3 weeks) and Final Interviews.

Mid Placement Interview

*(A mid-placement interview is **not** required for placements of up to and including 3 weeks' duration. However, if a student is viewed by the preceptor as not progressing towards agreed competencies, the student must be advised of this at the earliest opportunity during placement.)*

Where a mid-placement interview is required, the student and preceptor meet to review relevant aspects of the learning experiences and opportunities to date, and to assess progress. The student and the preceptor discuss and reflect upon the students' learning needs, with particular emphasis on those areas that require particular attention. It is important that students should not learn of identified concerns at the end of the placement without having had the opportunity to reflect on those aspects of their learning, which require particular attention. On this basis, further opportunities are identified to meet specific competencies. These are documented, and form the basis of discussion at the end of placement assessment and interview. The achievement of specific competencies is recorded.

End of Placement Interview

The student and preceptor/assessor must meet for an End of Placement Interview to assess and discuss the student's learning, their overall placement experience and to identify future learning needs. Students should request feedback from their Preceptor/Associate Preceptor about their performance in order to gain insight on their achievements/ability and with identifying areas for future learning and development. Both student and Preceptor/Associate Preceptor must make some concluding comments in the End of placement interview.

Please refer to section on Assessment of Competence Interviews (page 93) for more details.

References

An Bord Altranais (2000) (2nd Edition) Requirements and Standards for Nurse Registration Education Programmes Dublin Stationery Office

Steinaker, N. and Bell, R., (1979) The Experiential Taxonomy: A New Approach to Teaching and Learning New York: Academic Press.

COMPETENCIES YEARS THREE AND FOUR
REQUIREMENTS FOR PASS AND PROGRESSION

Please read this in conjunction with relevant module descriptor and the BSc programme marks and standards both of which are available on the UCC examinations webpage. This table describes the pass progression requirements for years 3 and 4 of the BSc General Nursing Programme.

	Third year of programme (16 supernumerary clinical placement weeks) NU3082 Pass progression requirements (Year 3)	**Fourth year of programme (36 weeks Internship and 1 Supernumerary Clinical Placement) NU4087 Pass progression requirements (Year 4)**
General Nursing students	• Completion of scheduled hours • A minimum of **8** competencies at Identification or Internalisation level by the Summer Examination Board as part requirements for passing NU3082 • A minimum of 40 (mandatory and opportunistic) skills at either identification and/or internalisation level • Completion of relevant sections of the assessment of competence booklet e.g.(placement details, reflective notes, interviews, student declaration and student self-assessment)	• Completion of scheduled hours • Remaining competencies and skills (at both identification and internalisation level) by the fourth year Autumn Examination Board as part requirements for passing NU4087 • Completion of relevant sections of the assessment of competence booklet e.g.(placement details, reflective notes, interviews, student declaration and student self-assessment)

LEVEL	**STAGE OF ACHIEVEMENT**
Identification	The student actively participates in the experience using and testing data, indicating that the initial learning experience has been achieved. The student combines the organisational, emotional and intellectual context of a learning experience. The student begins to identify personally with the experience, recognises the organisation and structure of the experience, gains a deeper insight into its value, and is able to express recognition of own achievement.
Internalisation	At this level, the student is viewed as an active and self-directive individual in the learning experience, with progress no longer controlled from the outside. Experiences are incorporated and further reinforced in the student thus becoming a part of unconscious problem solving. The highest level of internalisation has been achieved when an experience touches and continues to influence the lifestyle of a student.

Cues for Steinaker and Bells Taxonomy of Learning.

YEAR 3 - IDENTIFICATION LEVEL

The student / intern demonstrate:

- active participation in delivering and evaluating nursing care with less prompting and increased confidence
- greater ability to communicate effectively, demonstrating a wish to acquire further information
- ability to reflect on own communication skills
- ability to analyse and interpret information
- ability to apply problem solving skills and underlying knowledge to different situations
- ability to manage small case loads of patients (with minimal supervision)

YEAR 4 - INTERNALISATION LEVEL

The intern demonstrates:

- self-direction in prioritizing and delivering nursing care
- effective communication skills
- ability to seek and apply new knowledge and research findings
- ability to transfer knowledge to new clinical areas and to junior colleagues
- ability to increase own professional development by way of reflection and enquiry
- ability to apply problem solving and critical analysis skills and to evaluate a situation.
- ability to manage the care of the same case load of patients as qualified staff (with minimal supervision)

COMPETENCIES Years THREE and FOUR DOMAINS

DOMAIN A: PROFESSIONAL AND ETHICAL PRACTICE

Competency 1 **Student practices in accordance with legislation affecting nursing practice and integrates accurate and comprehensive knowledge of the following professional guidelines for practice**

Indicators:

1. An Bord Altranais *Code of Professional Conduct* (April 2000)
2. An Bord Altranais *Scope of Nursing and Midwifery Practice Framework* (April 2000)
3. An Bord Altranais *Guidance to Nurses and Midwives on Medication Management* (July 2007)
4. An Bord Altranais *Recording Clinical Practice: Guidance to Nurses and* Midwives (November 2002
5. An Bord Altranais *Guidelines on the Key Points that may be Considered when Developing a Quality Clinical Learning Environment* (An Bord Altranais, April, 2003)
6. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

Competency 2 **Student practices within the philosophies, policies, protocols and clinical guidelines of the local Health Service Provider taking cognisance of professional guidelines for practice**

Indicators:

1. Communicates knowledge of philosophies, policies, protocols and clinical guidelines of the local Health Service Provider
2. Demonstrates application of local philosophies, policies, protocols and clinical guidelines when providing nursing care to patients/clients
3. Practices within the criteria as specified in the Practice Placement Agreement, see Appendix 2
4. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

Competency 3 **Student practices within a framework that ensures respect and confidentiality with all individuals**

Indicators:

1. Actively promotes confidentiality with respect to patients, clients and all members of the health care team
2. Practices within the boundaries of confidentiality in its application to professional nursing practice
3. Respects and ensures confidentiality and security of written, verbal and electronic information acquired in a professional capacity.
4. Formulates, structures and documents nursing care taking account of legal and ethical considerations.
5. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

Competency 4 **Student practices in an anti-discriminatory way, acknowledging differences in beliefs and values of individuals or groups**

Indicators:

1. Maintains, supports and acknowledges the rights of individuals or groups in the health care setting
2. Demonstrates sensitivity and respect for the values and beliefs of individuals and groups
3. Provides care that demonstrates sensitivity to the diversity of patients/clients
4. Acts as an advocate for the rights of individuals/clients/groups
5. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with **patients/clients, family members** **and** members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

DOMAIN B: HOLISTIC APPROACHES TO CARE AND THE INTEGRATION OF KNOWLEDGE

A. ASSESSMENT

Competency 5 **Student undertakes and documents a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of the patient/client**

***Indicators*:**

1. Demonstrates the ability to apply relevant knowledge to the nursing assessment process
2. Utilises a holistic assessment framework using subjective and objective data.[10]
3. Demonstrates the ability to document the assessment process.
4. Analyses and interprets data accurately to inform nursing care.
5. Conducts the assessment process of nursing care in collaboration with patients/clients.
6. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with **patients/clients, family members** and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

B. PLANNING

Competency 6 **Student formulates and documents a plan of nursing care in collaboration with the patient/client, significant others and members of the healthcare team**

Indicators

1. Demonstrates the ability to apply relevant knowledge to the planning process of individual patient care
2. Demonstrates the ability to document the planning process of nursing care.
3. Plans nursing care with consideration for the actual and potential needs of patients/clients.

[10] **Objective data :** Information that can be directly measured by the nurse e.g. temperature, weight, pulse, blood pressure

Subjective data: Information that the patient gives to the nurse or the nurse interprets from observation and non-verbal cues

4. Reflects the uniqueness of the individual patient/client in the mutual approach to care planning and setting outcomes.
5. Determines priorities in planning whilst differentiating between immediate, intermediate and long-term needs.
6. Identifies expected outcomes that are achievable, measurable and set within a particular time frame.
7. Empowers patients/clients to be participative in their own health care and to make informed choices
8. Plans for discharge/transfer of patient/client and follow-up care requirements.
9. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with **patients/clients, family members** and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

C. IMPLEMENTATION

Competency 7 Student implements and documents planned individual nursing care/interventions to achieve the identified outcomes in collaboration with the patient/client, significant other and members of the health care team

Indicators:

1. Demonstrates the ability to apply relevant knowledge to the implementation of planned nursing care
2. Delivers nursing care in accordance with the individuals care plan and within the student's current scope of practice
3. Demonstrates accurate, safe, comprehensive and effective nursing care for the patient/client
4. Provides for the physical, psychological, social and spiritual comfort needs of each individual patient/client
5. Maintains and enhances the dignity, integrity and privacy of each individual patient/client
6. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with **patients/clients, family members** and members of the interdisciplinary health care team within the context of this competency
7. Demonstrates the ability to document the implementation process of nursing care.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

D. EVALUATION

Competency 8 Student evaluates and documents the patient/client's progress toward expected outcomes of nursing care/interventions

Indicators:

1. Demonstrates the ability to apply relevant knowledge to the evaluative process of nursing care
2. Collaborates with patient/client, significant others and members of the health care team in the evaluation process
3. Analyses and revises expected outcomes, nursing care/interventions and priorities in accordance with changes in the patient's/client's condition, needs and circumstances
4. Determines further outcomes and nursing care/ interventions in accordance with evaluation data
5. Evaluates the effectiveness of nursing care/interventions in achieving the planned outcomes
6. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with **patients/clients, family members** and members of the interdisciplinary health care team within the context of this competency
7. Demonstrates the ability to document the evaluation process of nursing care.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

DOMAIN C: INTERPERSONAL RELATIONSHIPS

Competency 9 Student establishes, maintains and enhances a caring interpersonal relationship with patients/clients, significant others and members of the health care team in a sensitive, professional and tactful manner

***Indicators*:**

1. Initiates, develops and terminates therapeutic relationships with patients/clients and significant others using appropriate communication and interpersonal skills
2. Assists and encourages patients/clients and significant others to communicate needs and to make informed decisions
3. Responds appropriately to patient/client and significant others questions, requests and problems
4. Communicates in a manner that is empowering to the patient/client and/or significant other
5. Demonstrates effective professional and collaborative working relationship with all members of the health care team
6. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

DOMAIN D: ORGANISATION AND MANAGEMENT OF CARE

Competency 10 Facilitates the co-ordination of care to ensure that the patient/client care is appropriate, effective and consistent

Indicators:

1. Demonstrates the ability to work as a team member, respecting and valuing each members unique role
2. Manages time effectively while demonstrating ability to prioritise patient/client care
3. Selects and utilises resources effectively and efficiently
4. Participates in relevant ward management activities
5. Attends and contributes to ward rounds/case conferences/ multidisciplinary meetings and provides feedback in the co-ordination of patient/client care
6. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency
7. Demonstrate the appropriate use of written documentation

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

Competency 11 Student effectively plans and manages the delivery of evidenced based nursing care within their scope of professional practice

Indicators:

1. Utilises methods to demonstrate quality assurance and quality management
2. Demonstrates critical analysis, problem solving and decision making skills
3. Communicates knowledge of evidence-based practice in its application to nursing care to take account of research findings, clinical expertise and patient/client preferences
4. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

Competency 12 **Student creates and utilises opportunities to promote health and well-being of patients/clients**

Indicators:

1. Consults with patients/clients to identify their needs and desires for health promotion advice
2. Provides relevant and current health information to patients, clients and groups in a form which facilitates their understanding and acknowledges choice/individual preference
3. Seeks specialist/expert advice as appropriate
4. Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

DOMAIN E: PERSONAL AND PROFESSIONAL DEVELOPMENT

Competency 13 **Student demonstrates a commitment to enhance the personal and professional development of self and peers**

Indicators:

1. Acknowledges and demonstrates the need for continuing professional development in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.
2. Student identifies own professional development needs and takes measures to develop own Competence.
3. Actively seeks out learning opportunities.
4. Accepts responsibility for consequences of own actions or omissions.
5. Contributes to the learning experiences of colleagues through the sharing of information and knowledge.
6. Acts as a role model for junior colleagues through support, encouragement, supervision and teaching where possible.
7. Shares experiences with colleagues and individuals in order to identify the additional knowledge and skills needed to manage unfamiliar or professionally challenging situations.
8 Reflects on own strengths and weaknesses in the learning process and takes appropriate measures to address the latter.
9 Demonstrate professional behaviours of accountability, implement appropriate patient care, and effectively communicate with patients/clients, family members and members of the interdisciplinary health care team within the context of this competency.

Indicators:

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				

DOMAIN F: SKILLS IN GENERAL NURSING

Introduction:
The competencies and their indicators within this domain consist of a variety of nursing skills. It is essential that these be approached in tandem with the other domains within this Booklet. The assessment of clinical skills incorporates the student's application of knowledge, psychomotor ability and maintenance of the therapeutic relationship.

1. Where new skills are introduced, i.e. skills that were not included in the 1st and 2nd year CLO Booklet, there is scope for these to be achieved first at *Exposure* and then at *Participation* level, before developing to *Identification* and *Internalisation*.

2. Students must achieve a minimum of 40 skills (inclusive of opportunistic skills) at either identification or internalisation level by the Summer Examination Board of Year Three.

3. It is vital that **skills should be revisited** as often as possible with negotiation between student and preceptor/clinical placement co-ordinator. See extra boxes below for this purpose.

CLINICAL SKILL 1: OBSERVATIONS & RECORDINGS

SKILL: Blood Glucose Monitoring

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Blood Pressure (Manual)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Blood Pressure (Automated)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Temperature

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Pulse manual

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Oxygen Saturation

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Respirations

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Neurological Observations & Glasgow Coma Scale

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Neurovascular Assessment of extremity

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Use of National Early Warning Score (NEWS)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 2: PAIN MANAGEMENT

SKILL: Assessment of pain with pain assessment tool

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of pain using pharmacological methods

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of pain using non-pharmacological methods

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 3: AIRWAY MANAGEMENT

SKILL: Assessment and observation of airway patency

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Positioning of patient to maintain airway patency

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Appropriate use of airway suctioning equipment

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of a patient with a tracheostomy and/or laryngectomy (Opportunistic)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

If the opportunity to achieve the above did not arise by your last placement please discuss this skill with your preceptor.

Discussion regarding Tracheostomy/ laryngectomy				

CLINICAL SKILL 4: CARDIOPULMONARY RESUSCITATION

SKILL: Responds appropriately to a cardiac/respiratory arrest situation (Opportunistic)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

If the opportunity to achieve the above did not arise by your last placement please discuss this skill with your preceptor.

Discussion regarding CPR				

SKILL: Assist with the checking of the Cardiopulmonary Resuscitation trolley

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 5: PERSONAL CLEANSING AND DRESSING

SKILL: Assessment and Management of individualised hygiene needs

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Oral Health Assessment/Management (using tool where available)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Assist with eye care

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Assist with oral care

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Promote and maintain the Patient's Skin Integrity

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Use of Pressure Ulcer Risk Assessment/Grading Tools

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 6: MAINTAINING PATIENT SAFETY

SKILL: Application of all principles of safe moving & handling techniques

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Care and maintenance of equipment e.g. Thermometers, Blood Pressure Apparatus, Suction Machine etc.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Maintenance of a safe clinical environment

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Use of Risk Assessment Tools

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 7: INFECTION CONTROL

SKILL: Hand Hygiene

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Waste Management

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Isolation Nursing

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Application of principles of aseptic technique

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Assessment and maintenance of a clean clinical environment

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Apply principles of Standard Precautions

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 8: WOUND CARE

SKILL: Assessment and documentation of wound care

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Perform wound dressings

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Suture or clip removal

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Wound drain management

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Promotion of Wound Healing

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 9: HYDRATION AND NUTRITION

SKILL: Assisting with Hydration and Nutrition

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Observing and recording dietary intake

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL Assessing nutritional needs and abilities

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of fluid balance

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Assessment and care of intravenous cannulae

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Insertion of nasogastric tube (Opportunistic)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of nasogastric drainage (Opportunistic)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of artificial feeding (e.g. NG, PEG)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 10: COLLECTION OF SPECIMENS

SKILL: Urinalysis

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Collection of faeces

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: 24hour urine collection *(Opportunistic)*

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Catheter specimen of urine

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Mid-stream specimen of urine

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Collection of Sputum

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Collection of Swabs

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 11: ELIMINATION

SKILL: Assessment and recording of patients' elimination pattern

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Recognising and recording deviations from usual elimination habits

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Management of elimination needs using a holistic approach

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Urinary catheterisation

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification (Opportunistic)				
Internalisation (Opportunistic)				
Revisit if applicable				
Revisit if applicable				

SKILL: Catheter care

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Stoma care (Opportunistic)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 12: MEDICATION MANAGEMENT

***Please note that medication management is only done under the direct supervision of the registered nurse**

SKILL: Safe practices in relation to storage of prescribed medication

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice of management and storage of controlled drugs

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to blood and blood product transfusion

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Calculation of oral medication dosages

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Oral Preparations

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Subcutaneous injections

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Intramuscular injections

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Instillation preparations (eye drops)

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of topical preparation

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Rectal Preparations

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Oxygen Therapy

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in relation to Administration of Nebuliser therapy

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 13: INTRAVENOUS FLUID MANAGEMENT SKILLS

To be conducted under DIRECT supervision of a Registered General Nurse (RGN)

SKILL: Safe practice in priming an intravenous line with normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in insertion of primed intravenous infusion administration set containing normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline correctly into intravenous fusion pump.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in calculation and setting of intravenous flow rate of normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline using roller clamp of an intravenous infusion administration set.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in calculation /adjustment of flow rate of an intravenous fusion of normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline using intravenous infusion pump.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Connection of primed intravenous infusion administration set containing normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline to peripheral venous cannula.

UNDER DIRECT SUPERVISION OF AN RGN

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in managing of intravenous infusion pump alerts/alarms delivering normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline.

A REGISTERED STAFF NURSE MUST BE CONTACTED IMMEDIATELY.

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Safe practice in replacement of completed intravenous infusion with prescribed follow-on infusion of normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline.

UNDER DIRECT SUPERVISION OF AN RGN

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

SKILL: Correct use of pause function/stop function of an intravenous infusion pump /rollerclamp delivering normal saline 0.9%, Hartmann's solution, dextrose 5% or dextrose saline. *note pause/stop function can be used when attending to patient hygiene, clothes change or elimination needs but infusion* **must not be restarted without direct supervision of a Registered Nurse.** *Pause/stop function can also be used in the event of suspected phlebitis or extravasation but a* **Registered Nurse must be consulted immediately.**

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure Yr 3				
Participation Yr 4				
Revisit if applicable				
Revisit if applicable				

CLINICAL SKILL 14: CARE OF THE DYING

SKILL: Demonstrates respect for the spiritual needs, beliefs and cultural practices of the patient and relatives

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Supports colleagues in caring for dying patients and bereaved families

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Supports families in their grief in a sensitive and compassionate manner

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Assists colleagues in carrying out Last Offices

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

If the opportunity to achieve the above did not arise by your last placement please discuss the above skills with your Preceptor.

Discussion regarding Care of dying				

CLINICAL SKILL 15: COMMUNICATION

SKILL: Participation in verbal patient handover at report time

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Participation in patient documentation

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Identification				
Internalisation				
Revisit if applicable				
Revisit if applicable				

SKILL: Apply ISBAR in professional communication

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Exposure				
Participation				
Revisit if applicable				

MISCELLANEOUS SKILLS

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

SKILL: ____

Level	Student Signature	Preceptor/Assessor Name	Preceptor/Assessor Signature	Date
Participation				
Revisit if applicable				
Revisit if applicable				

STUDENT REFLECTIVE NOTES: GUIDELINES

Frequently Asked Questions

1. **What is reflective learning?**
   Reflective learning is another way of learning. It is a process that enables you to learn from what you see and what you do during your clinical placements. The aim of reflection is to encourage you to examine and explore your behaviours, thoughts, feelings and attitudes about your clinical experiences.

   You must write at least one Reflective note in each Clinical placement area irrespective of duration for example:

   1 week in any one placement area = ONE reflective note
   1-3 weeks in any one placement area = ONE reflective note
   4-7weeks in any one placement area = TWO reflective notes

2. **Why do I need to reflect on my practice?**
   There are many reasons why you need to reflect on your practice. For example, **it** helps you to acknowledge your thoughts and feelings, thereby enabling you to scrutinize your practice. Following on from this it may prompt you to embrace new ideas and better ways of delivering nursing care. This helps to improve your nursing skills and make clearer links between theory and practice. Reflection assists you to identify your own learning needs and develop your practice further. Reflecting on practice will identify for you your own core decision making skills, help you to problem solve and assist you in developing your critical thinking skills.

3. **What should I reflect on?**
   You may reflect on anything that occurs during clinical placement. It may be an experience that went well, an experience that was particularly demanding, a very ordinary, everyday experience or an experience in which things did not go as planned. You may link your reflective notes back to any one of the Competencies or Domains that you have achieved or reflect broadly on an incident that occurred.

4. **How can I reflect?**
   - Use Gibbs Cycle (1988) **framework and use all stages of that framework.**
   - You may also find it helpful to refer **to lecture/practice notes on reflection.**
   - You might find it useful to use the headings within Gibbs' cycle to structure your reflective notes
   - Keeping **a reflective diary** may help to hone reflective writing skills and help you select situations that you can use when writing reflective notes. Use experiences that you feel comfortable with for your reflective notes.
   - **Start writing as early as possible**, in your own words. You may find it helpful to refer to the literature for examples of how to write reflectively e.g. Burns & Bulman (2000). While there is no right or wrong style of writing up your reflections, these guidelines may make it easier for you.
   - You should make reference to local policies, procedures and literature that have relevance to your reflective notes, particularly in the analysis section.
   - You need to **make time** to write up your reflections.
   - It may be helpful to write something, leave it, return to it later and then try to question different aspects of this experience.
   - Remember to maintain confidentiality and anonymity of the individual, staff and placement area.
   - **Your** CPCs, preceptors, link lecturer, and other students may advise you on structuring your reflective notes. It may help you to get started by talking through an experience with somebody
   - Remember reflection is a skill that you can develop, so the more you practice the better you will become. Also you may find that you will write less as your skills of reflection develop.

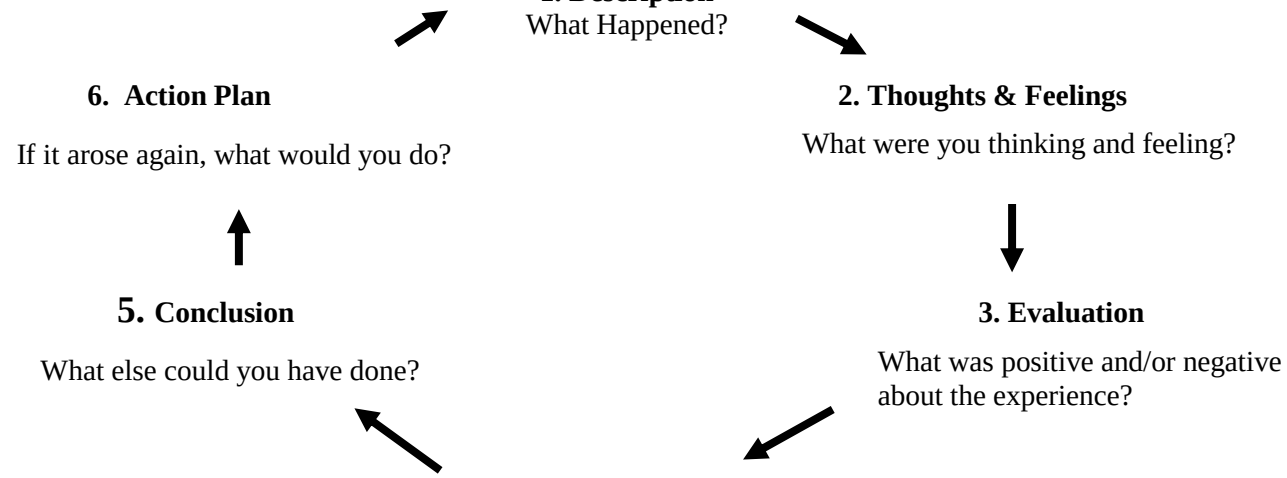
5. **Do I need to reflect when I am repeating time or making up time?**
   - Yes. It is important that you reflect on all clinical experiences. You must write reflective notes when repeating AND/OR making up time in clinical practice of 30 hours or more.

Note: All Reflective Notes are part of your assessment criteria and must be read and signed by the Preceptor prior to/or at the Final Interview. Typed reflective notes stapled to the competency booklet must have all the signatures and dates as in the competency booklet.

References

Bulman, C. & Schultz, S. (2004) Reflective practice in nursing 3rd Ed. Oxford: Blackwell.
Burns S and Bulman C (eds) (2000) Reflective Practice in Nursing~ the Growth of the Professional Practitioner *2* edn. London, Blackwell Science.
Gibbs, G. (l988) Learning by Doing A guide to Teaching and Learning' Methods. Oxford Polytechnic, Further Education Unit.

GIBBS REFLECTIVE CYCLE 1988



(Gibbs, 1988)

St**age 1: Description of the event/experience**
Describe an event/experience that you feel you would benefit from reflecting on. Include e.g. where you were; who else was there; what were you doing; what was the context of the event; what happened; what was your part in this; what was the result.

Stage 2: Thoughts / Feelings
At this stage try to recall and explore the things that were going on inside your head i.e. why does this event/experience stick in your mind. Include e.g. how you were feeling when the event started; what you were thinking about at the time; how did it make you feel; how did other people make you feel and how did you feel about the outcome of the event.

Stage 3: Evaluation
Try to evaluate or make a judgement about what has happened. Consider what was good/ positive about the experience and what was bad/ negative about the experience or what didn't go so well.

Stage 4: Analysis
Break the event/experience down into its component parts and ask more detailed questions relating to the last stage (evaluation). Explore for example; what went well; what did you do well; what did others do well; what went wrong or did not turn out how it should have done; in what way did you or others contribute to this. Here you also need to draw on your own knowledge; past experience; policies, literature, or research.

Stage 5: Conclusion
This differs from the evaluation stage in that now you have explored the issue from different angles and have a lot of information on which to base your judgement. It is here that you are likely to develop insight into your own and other people's behaviour in terms of how they contributed to the outcome of the event. Remember the purpose of reflection is to learn from an experience. Without detailed analysis and honest exploration that occurs during all the previous stages, it is unlikely that all aspects of the event/experience will be taken into account.

Stage 6: Action Plan
During this stage you should think about the possibility of encountering this event again and try to plan what you would do – would you act differently or would you be likely to do the same?
Here the cycle is tentatively completed and suggests that should the event occur again it will be the focus of another reflective cycle.

Reflections on writing this incident/activity/experience
What has been your most valuable learning from this incident/experience during this placement?

When writing your reflective account, ensure individual confidentiality & anonymity.
Description of the reflective account adapted from Jasper M 2003 Beginning Reflective Practice – Foundations in Nursing and Health Care Nelson Thornes. Cheltenham. P.77-82 (chapter 3)

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PLACEMENT AREA: _____

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ASSESSMENT OF COMPETENCE INTERVIEW(S)

Assessment of Competence Interview Forms are set out in the following pages:

Commencement of Placement Interview
At the Commencement of Placement Interview, the student and preceptor meet to explore learning needs and opportunities, so that specified competencies and skills can be identified, practised and achieved. These are then identified and listed in the commencement of placement interview form as (a) a guide to structuring the experience, and (b) as a guide for discussion at the Mid Placement Interview, or End of placement interview, as relevant.

Mid Placement Interview
(***Mid Placement Interviews are applicable only for placements of more than three weeks.)***
At the Mid Placement Interview, the student and preceptor meet to review relevant aspects of the learning experiences and opportunities to date, and to assess progress. The student and the preceptor discuss and reflect upon the students' learning needs, with particular emphasis on those areas that require particular attention. Feedback should be provided to the student in relation to this. It is important that students should not learn of identified concerns at the end of the placement without having had the opportunity to reflect on those aspects of their learning, which require particular attention. On this basis, further opportunities are identified to meet specific competencies. These are documented, and form the basis of discussion at the end of placement assessment and interview. The achievement of specific competencies is recorded.

End of Placement Interview
At the End of Placement Interview, the student and Preceptor meet to assess and discuss the student's learning, to discuss the overall placement experience, and to identify areas for future learning. The achievement of specific competencies is recorded. **Reflective notes are signed and dated by preceptor and student (to verify that they have been completed prior to the final interview).**

Additional interview section
This section can be used to highlight areas of concern by either the preceptor/CNM/CPC, before, during or after the mid-term interview or at any time in a practice placement.

Please refer to section on additional support (page 19) for more information.

Notes pages for preceptors/associate preceptors/staff nurse:
This section can be used by the above personnel to communicate with each other by documenting a student's progress and areas of concern.

***Please note if you require further interview forms, notes pages or miscellaneous skill pages, these can be downloaded from the UCC Nursing and Midwifery website.**

Please refer to section on Interviews (page 18) for more information

Assessment of COMPETENCE Interview(s) Form

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Student Signature: **Date:**

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Mid Placement Interview

Student Comments:

Preceptor/Assessor Feedback:

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End of Placement Interview

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Preceptor/Assessor Signature: **Date:**

End of Placement Interview

List Competencies Achieved:

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
Preceptor's concern about student's progress:
Decisions reached: **Student signature:** **Date:** **Preceptor/CPC signature:** **Date:**

NOTES PAGE FOR PRECEPTORS/ASSOCIATE PRECEPTORS/STUDENTS/STAFF NURSES/CPCS/CNMS
PLEASE DATE AND SIGN ALL ENTRIES

Assessment of COMPETENCE Interview(s) Form

Student Name: **Preceptor Name:**

Practice Placement Area: **Placement Dates:** ***From*** ***To***

Commencement of Placement Interview **Student has been orientated to the ward** ☐

Please identify and list the agreed Competency

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

Mid Placement Interview

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

End of Placement Interview

List Competencies Achieved:

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
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Decisions reached: **Student signature:** **Date:** **Preceptor/CPC signature:** **Date:**

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Assessment of COMPETENCE Interview(s) Form

Student Name: **Preceptor Name:**

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Commencement of Placement Interview **Student has been orientated to the ward** ☐

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Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

Mid Placement Interview

Student Comments:

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End of Placement Interview

List Competencies Achieved

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
Preceptor's concern about student's progress:
Decisions reached: **Student signature:** **Date:** **Preceptor/CPC signature:** **Date:**

NOTES PAGE FOR PRECEPTORS/ASSOCIATE PRECEPTORS/STUDENTS/STAFF NURSES/CPCS/CNMS
PLEASE DATE AND SIGN ALL ENTRIES

Assessment of COMPETENCE Interview(s) Form

Student Name: **Preceptor Name:**

Practice Placement Area: **Placement Dates:** ***From*** ***To***

Commencement of Placement Interview **Student has been orientated to the ward** ☐

Please identify and list the agreed Competency

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

Mid Placement Interview

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

End of Placement Interview

List Competencies Achieved:

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
Preceptor's concern about student's progress:
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PLEASE DATE AND SIGN ALL ENTRIES

Assessment of COMPETENCE Interview(s) Form

Student Name: **Preceptor Name:**

Practice Placement Area: **Placement Dates:** ***From*** ***To***

Commencement of Placement Interview **Student has been orientated to the ward** ☐

Please identify and list the agreed Competency

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

Mid Placement Interview

Student Comments:

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Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
Preceptor's concern about student's progress:
Decisions reached: **Student signature:** **Date:** **Preceptor/CPC signature:** **Date:**

NOTES PAGE FOR PRECEPTORS/ASSOCIATE PRECEPTORS/STUDENTS/STAFF NURSES/CPCS/CNMS

PLEASE DATE AND SIGN ALL ENTRIES

Assessment of COMPETENCE Interview(s) Form

Student Name: **Preceptor Name:**

Practice Placement Area: **Placement Dates:** ***From*** ***To***

Commencement of Placement Interview **Student has been orientated to the ward** ☐

Please identify and list the agreed Competency

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

Mid Placement Interview

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

End of Placement Interview

List Competencies Achieved:

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
Preceptor's concern about student's progress:
Decisions reached: **Student signature:** **Date:** **Preceptor/CPC signature:** **Date:**

NOTES PAGE FOR PRECEPTORS/ASSOCIATE PRECEPTORS/STUDENTS/STAFF NURSES/CPCS/CNMS
PLEASE DATE AND SIGN ALL ENTRIES

Assessment of COMPETENCE Interview(s) Form

Student Name: **Preceptor Name:**

Practice Placement Area: **Placement Dates:** ***From*** ***To***

Commencement of Placement Interview **Student has been orientated to the ward** ☐

Please identify and list the agreed Competency:

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

Mid Placement Interview

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor/Assessor Signature: **Date:**

End of Placement Interview

List Competencies Achieved:

Student Comments:

Preceptor/Assessor Feedback:

Student Signature: **Date:**

Preceptor// CNM/ Assessor Signature: **Date:**

ADDITIONAL INTERVIEW SECTION

Student's view of his/her progress:
Preceptor's concern about student's progress:
Decisions reached: **Student signature:** **Date:** **Preceptor/CPC signature:** **Date:**

NOTES PAGE FOR PRECEPTORS/ASSOCIATE PRECEPTORS/STUDENTS/STAFF NURSES/CPCS/CNMS

PLEASE DATE AND SIGN ALL ENTRIES

Supportive Mechanisms for Student Learning

Guidance for use of the additional interview page and supportive learning plan

1. The Additional Interview Page

Every effort is made to support and guide a student in achieving their competencies, some students may require additional support. One such mechanism is the Additional Interview page; located in the Competency Booklet in the Student Interviews section. This extra page can be used in the event that a preceptor identifies a concern in relation to a student's progression. This may or may not necessarily be related to earlier identified competencies. It is essential to record any concerns in an objective, and factual manner and this is signed and dated by the student and preceptor. The additional interview section may be completed prior to the initiation of an SLP. The student on commencing their next placement must inform his/her Preceptor, if an issue raised in the additional interview is still ongoing. CPC will inform CPC for next placement.

2. Supportive Learning Plan

- A supportive learning plan **(SLP)** is a structured mechanism to support a student who is not achieving the agreed competencies (refer to previous interviews documented) during a clinical practice placement.
- The use of an **SLP** may reflect either lack of achievement at a rate reasonable for the student's year of practice for that clinical area, or apparent loss of a students' earlier level of achievement.
- Please note that placement duration should have no bearing on the need to initiate a **SLP**.
- At all times during the process, each person will demonstrate respect for the dignity of others involved and maintain confidentiality

Please refer to section on "Additional Support" (page 19) for more information

SUPPORTIVE LEARNING PLAN: GUIDELINES

Guidance for use of a Supportive Learning Plan on Practice Placement

NB – See section on Additional Support (p.19) prior to initiating a supportive learning plan

Definition

A Supportive Learning Plan (SLP) is a structured mechanism to support a student who is not achieving the agreed competencies during a practice placement. The use of an SLP may reflect either lack of achievement of competencies/skills at a rate reasonable for that clinical area for the student's year of practice, or apparent loss of a student's earlier level of achievement. Please note that placement duration should have no bearing on the need to initiate an SLP. At all times during the process, each person will demonstrate respect for the dignity of others involved and maintain confidentiality.

Setting up a Supportive Learning Plan Meeting

The Preceptor must liaise with the Clinical Placement Coordinator[11], who will contact the area specific Link Lecturer regarding the need to initiate an SLP. The Clinical Placement Coordinator must liaise with the Link Lecturer to arrange a meeting of the relevant personnel, consisting of a minimum of four and a maximum of five personnel. This must include the Student, the Preceptor, the CPC, the Link Lecturer and/or the CNM. The student and other relevant personnel will be advised by the CPC in advance of the details of the meeting: the process, the purpose, the date, the time, the venue and persons to be present.

The Process of Conducting and Documenting the Supportive Learning Plan Meeting

Initial Meeting

Either the CPC or the link lecturer will chair the meeting and the other will record the process. All parties must be present at all meetings relating to the SLP. The student is invited to give a view of his/her progress. The Preceptor identifies (using examples / incidents) why he / she considers it necessary to implement an SLP and highlights the area of learning /clinical practice in need of support in facilitating the student to work towards achievement of their competencies at the appropriate level of the adapted Steinaker and Bell Taxonomy.

Any additional evidence is discussed by all present The student is given the opportunity to respond. The steps the student needs to take towards *Agreed Goals* must be clearly identified. The *Agreed Goals* must reflect the associated Domains, and outcomes specified in the COMPETENCY Booklet[12]. The SLP should also identify methods of achieving the identified competencies. A reasonable review date must be agreed and set to provide the student with an opportunity to discuss/demonstrate progress by that date, or for further supports to be put in place. The SLP must be signed and dated by both the Preceptor and student and names of other personnel present at meeting must be recorded in the SLP document.

The Link Lecturer informs the Branch Leader / Practice Placement Module Leader of the implementation of an SLP. The Link Lecturer will place a copy of the SLP in the Student's file. The original copy must remain in the student's COMPETENCY Booklet.

[11] Where CPCs are not in place, the Preceptor must liaise with the Clinical Development Coordinator

[12] Students can strive to achieve competencies outside of those identified within the SLP during their Clinical Placement.

Review Meeting:

At the review meeting, either the CPC or Link Lecturer will chair the meeting and the other will record the process. A judgment will be made by the preceptor, following discussion with all parties present, whether to continue or discontinue the SLP on the basis of progress made by the student. The section *Evaluations/Recommendations* is intended for use in conjunction with the review meeting. The SLP must be signed and dated by both the Preceptor and student and names of other personnel present at meeting must be recorded in the SLP document.

If an SLP is initiated during Year 3 and remains incomplete by the end of Year 3 though the student may pass the practice module, on commencement of Year 4 placement, a meeting will be held to review the SLP.

The Process of Notification

Student

The student on commencing their next placement must inform his/her Preceptor/CNM, if an SLP is in existence and is ongoing in Years 3 and 4, at the earliest opportunity.

The Clinical Placement Coordinator

The CPC must inform the Nurse Practice Development Coordinator if a student has an active SLP. The CPC must inform the CPC/CDC for the next practice placement. The CPC must liaise with the student at the commencement of the placement.

The Link Lecturer

The Link Lecturer must inform the Branch/Practice Module Leader in UCC as well as the Link Lecturer in the next placement of a student having an active SLP. The Link Lecturer and the CPC must liaise with the external hospital sites, in relation to a student going to, or leaving a placement with an active SLP. The Branch Leader / Practice Module Leader in consultation with the Allocations Officer/ Allocations Liaison Officer consider the suitability of the next placement in order for the student to achieve the SLP.

SLP Algorithm

Planning for SLP

- Preceptor/CNM/CPC identifies that a student is not achieving their competencies, clinical skills or a student is not conducting themselves in a professional and responsible manner and/or not working within their agreed Practice Placement Agreement (PPA).
- The student is advised and informed in advance of the scheduled SLP meeting of their preceptors/CNMs concerns.
- Preceptor/CNM liaises with CPC/CDC to discuss the ongoing concerns in relation to a student's failure to progress following additional support.
- CPC/CDC liaises with all relevant personnel (student, preceptor/CNM, CPC, LL) to arrange a meeting, giving details of the purpose, date, time and venue.

Initial Meeting

↓

- The CPC or LL will chair and open the meeting.
- The preceptor/CNM will introduce the learning/practice concern(s) identified at mid-interview or additional interview(s).
- The student is given an opportunity to discuss their view of their own learning/progress.
- An appropriate plan with agreed goals and support mechanisms are identified to help the student to achieve the learning/practice concern(s).
- A time frame is agreed and a review date set.
- The SLP is documented in the competency booklet and a copy is filed in the student's file in the School of Nursing and Midwifery, UCC.

Review Meeting

↓

- The student's progress is reviewed.
- The student gives his / her feedback.
- If learning/practice concern(s) has been achieved/completed the SLP is signed off and discontinued.
- If the student is failing to progress and the agreed goals have not been met and/or competencies achieved, a revised plan is formulated with a new review date within a reasonable timeframe.

On <u>closure</u> of an SLP, there is no requirement to notify future placement areas of the prior existence of an SLP, thus upholding confidentiality.

SUPPORTIVE LEARNING PLAN FOR PRACTICE PLACEMENT

Student Name: _____ Intake Year: _____
I.D Number: _____
Practice Placement Area: _____
Practice Placement Dates: From _____ To _____
Preceptor's Name & Grade: _____
Date_____

List all persons present:

_____

_____

Description of specific concern/s as described by Student and Preceptor.
(Link specific concerns with the Domains and the Competencies).

Agreed Goals
(Suggested and recommended methods to facilitate achievement of Competencies)

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____

List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

SUPPORTIVE LEARNING PLAN FOR PRACTICE PLACEMENT

Student Name: _____ Intake Year: _____
I.D Number: _____
Practice Placement Area: _____
Practice Placement Dates: From _____ To _____
Preceptor's Name & Grade: _____
Date_____

List all persons present:

_____

_____

Description of specific concern/s as described by Student and Preceptor. (Link specific concerns with the Domains and the Competencies).

Agreed Goals
(Suggested and recommended methods to facilitate achievement of Competencies)

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:_____
_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

SUPPORTIVE LEARNING PLAN FOR PRACTICE PLACEMENT

Student Name: _____ Intake Year: _____
I.D Number: _____
Practice Placement Area: _____
Practice Placement Dates: From _____ To _____
Preceptor's Name & Grade: _____
Date_____

List all persons present:

_____

_____

Description of specific concern/s as described by Student and Preceptor. (Link specific concerns with the Domains and the Competencies).

Agreed Goals
(Suggested and recommended methods to facilitate achievement of Competencies)

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

SUPPORTIVE LEARNING PLAN FOR PRACTICE PLACEMENT

Student Name: _____ Intake Year: _____
I.D Number: _____
Practice Placement Area: _____
Practice Placement Dates: From _____ To _____
Preceptor's Name & Grade: _____
Date_____

List all persons present:

_____

_____

Description of specific concern/s as described by Student and Preceptor. (Link specific concerns with the Domains and the Competencies).

Agreed Goals
(Suggested and recommended methods to facilitate achievement of Competencies)

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

REVIEW MEETING

Date of Review Meeting _____
List all persons present:

_____

_____

Review of student's progress and further recommendations:

Student Signature _____

Preceptor Signature _____

Link Lecturer Signature _____

CPC/CDC Signature _____

Review Date Agreed _____

BSc. Nursing Students

Reflection Time Record Sheet (3rd year students only)

Including an account of any of the following: Reflection/Self-Directed Study/Directed Learning/Problem Solving Activities

During clinical placements each student is expected to complete **5 hours** of reflective time per week, to augment their learning. This can be spent outside the practice placement area.

This is a record of how the student spent this time.

Student Name_____ **Student Number** _____

Date	Activity Theme/Reflection Topic	Student Signature	Total Hours

Student signature _____

Date _____

Student Name_____ Student Number _____

Date	Activity Theme/Reflection Topic	Student Signature	Total Hours

Student signature _____

Date _____

Student Name_____ Student Number _____

Date	Activity Theme/Reflection Topic	Student Signature	Total Hours

Student signature _____

Date _____

Student Name_____ Student Number _____

Date	Activity Theme/Reflection Topic	Student Signature	Total Hours

Student signature _____

Date _____

NU3082 General Nursing Practice: Assessment and Feedback Sheet

End of YEAR THREE

Assessment of your Competence Booklet demonstrates that all assessment requirements and documentation are:

COMPLETE _____ INCOMPLETE_____

If assessed as INCOMPLETE please *attend* to the following, as outlined below, immediately and resubmit by _____

Page Number(s)

Clinical Placement Details _____

Details of placement area in Reflective note(s) _____

Details of placement area in Interview Form(s) _____

Interview(s) not signed/dated by preceptor _____

Interview(s) not signed/dated by student _____

Reflective notes not written up/included _____

Reflective note(s) not signed/dated by preceptor _____

Reflective note(s) not always signed/dated by student _____

Clinical Skill(s) not signed/dated by preceptor _____

Clinical Skill(s) not signed/dated by student _____

Student declaration not signed _____

Reflective Time Record Sheet not signed/dated or activity theme/reflective topic filled in _____

Other (specify) _____

Comments:

Please take note of issue(s) ticked and comments above and ensure that all relevant corrections are made before resubmitting. If you have any queries please do not hesitate to contact the Practice Module Leader/Link Lecturer below.

_____ Date:

Practice Module Leader/Link Lecturer

NU4087 General Nursing Practice: Assessment and Feedback Sheet

Mid-Term Review

YEAR FOUR

On review of your booklet, some issues were identified as being incomplete. Please attend to these, as highlighted by the page numbers below, prior to final submission of booklet**.**

Page Number(s)

Clinical Placement Details _____

Details of placement area in Reflective note(s) _____

Details of placement area in Interview Form(s) _____

Interview(s) not signed/dated by preceptor _____

Interview(s) not signed/dated by student _____

Reflective notes not written up/included _____

Reflective note(s) not signed/dated by preceptor _____

Reflective note(s) not always signed/dated by student _____

Clinical Skill(s) not signed/dated by preceptor _____

Clinical Skill(s) not signed/dated by student _____

Student declaration not signed _____

Other (specify) _____

Comments:

Please take note of issue(s) ticked and comments above and ensure that all relevant corrections are made before resubmitting. If you have any queries please do not hesitate to contact Practice Module Leader/Link Lecturer below.

_____ Date:

Practice Module Leader/Link Lecturer

NU4087 General Nursing Practice: Assessment and Feedback Sheet

Final Submission

End of YEAR FOUR

Assessment of your Competence Booklet demonstrates that all assessment requirements and documentation are:

COMPLETE _____ INCOMPLETE_____

If assessed as INCOMPLETE please *attend* to the following, as outlined below, immediately and resubmit by _____

Page Number(s)

Clinical Placement Details _____

Details of placement area in Reflective note(s) _____

Details of placement area in Interview Form(s) _____

Interview(s) not signed/dated by preceptor _____

Interview(s) not signed/dated by student _____

Reflective notes not written up/included _____

Reflective note(s) not signed/dated by preceptor _____

Reflective note(s) not always signed/dated by student _____

Clinical Skill(s) not signed/dated by preceptor _____

Clinical Skill(s) not signed/dated by student _____

Student declaration not signed _____

Other (specify) _____

Comments:

Please take note of issue(s) ticked and comments above and ensure that all relevant corrections are made before resubmitting. If you have any queries please do not hesitate to contact the Practice Module Leader/Link Lecturer below.

_____ Date:

Practice Module Leader/Link Lecturer

What I have to do with my Competency Booklet at the end of Every Clinical Placement
(Irrespective of placement duration/repayment of time)

PERSONAL USE ONLY

Tick if completed

(1)	**Clinical Placement Details completed (area, dates, preceptor name, weeks)**	☐
(2)	**Interview page completed (preceptor name, area, placement dates)**	☐
(3)	**Interview(s) all signed/dated by preceptor**	☐
(4)	**Interview(s) all signed/dated by student**	☐
(5)	**Reflective Notes page completed (area, date, preceptor details)**	☐
(6)	**Reflective notes written up/included**	☐
(7)	**Reflective notes signed/dated by preceptor**	☐
(8)	**Reflective notes signed/dated by student**	☐
(9)	**Clinical Skills signed/dated by preceptor**	☐
(10)	**Clinical Skills signed/dated by student**	☐
(11)	**Competencies signed/dated by preceptor**	☐
(12)	**Competencies signed/dated by student**	☐
(13)	**Reflection Time Record Sheet completed (Year 3)**	☐
(14)	**Student declaration signed (end of year only)**	☐
(15)	**Self-Assessment Form completed/signed by student (end of year only)**	☐

If you encounter any difficulty regarding the achievement of your competencies or completion of competency booklet during your placement it is your, responsibility to bring this to the attention of the relevant personnel (Preceptor, CPC, Link Lecturer, Practice Module Leader, as appropriate).

APPENDIX ONE

PRACTICE MODULE DESCRIPTORS & PROGRAMME REGULATIONS

NU3082 General Nursing Practice

Credit Weighting: 10

Semester(s): Semesters 1 and 2.

No. of Students: Max 145.

Pre-requisite(s): Signing of Practice Placement Agreement.

Co-requisite(s): None

Teaching Method(s): 16weeks(s) Placements ((under supervision), Role Modelling and Reflection).

Module Co-ordinator: Ms Ann McAuliffe, School of Nursing & Midwifery.

Lecturer(s): Staff, School of Nursing & Midwifery, and participating Health Service Providers.

Module Objective: To facilitate students' learning (under supervision) in clinical practice with emphasis on attaining competencies and skills within five domains of clinical practice, as specified by An Bord Altranais. Students practice within the limits of individual scope of practice in the assumption of the role of a general nursing student working within diverse health care settings. Demonstrate proficiency of safe moving and handling, and cardiopulmonary resuscitation techniques.

Module Content: Clinical practice in general nursing units/contexts with an emphasis on five domains of clinical practice (1. professional/ethical practice, 2. holistic approaches to care and the integration of knowledge, 3. interpersonal relationships, 4. organisational and management of care and, 5. personal and professional development) and promoting health and well-being of patients/clients and their families. Attendance and participation in a safe moving and handling programme and successful completion of associated assessment. Cardiopulmonary resuscitation programme, (Basic Life Support (BLS) for health care providers, Irish Heart Foundation Programme). Modified Early Warning Score programme. Introduction and familiarisation with assessment of competence booklet and clinical placement procedures and processes. Evaluation of the clinical learning environment and practice placement processes

Learning Outcomes: On successful completion of this module, students should be able to:
· Engage in organisation and management of care showing increasing independence since year 2.
· Utilize investigative, interpretive and problem solving activities to enhance patient care.
· Combine psychomotor, cognitive and affective activities and skills, linking theory (evidence based) to practice.
· Demonstrate that agreed learning has been achieved to identification level.
· Promote health and well-being of patients/clients and their families.
· Engage in reflective nursing practice within a supportive learning environment.
· Demonstrate professionalism in all aspects of the nursing student role.
· Discuss the health and safety considerations of health care environments and the provision of safe health care practice.
· Discuss the concept of patient-centred care, which represents the patients preferences, values and needs within the context of their families, communities and the health care delivery systems.

Assessment: Assessment of Competence Booklet (Pass/Fail/Incomplete), Attendance in Clinical Practice (Pass/Fail/Incomplete), Safe Moving and Handling (Yes/No), BLS (Pass/Fail).

Compulsory Elements: A record of clinical hours will be kept. Required competencies and scheduled clinical hours must be completed prior to the Summer Examination Board in order to progress to Year 4. Failure to complete scheduled hours will result in failing the module, irrespective of having achieved the required number of competencies. The only acceptable proof of completion of scheduled clinical practice hours is the submission of a signed and completed original practice placement hours record sheet (time sheet) to the Allocations Office, UCC, as specified within the Assessment of Competence booklet.

Penalties (for late submission of Course/Project Work etc.): Work which is submitted late shall be assigned a mark of zero (or a Fail Judgement in the case of Pass/Fail modules).

Pass Standard and any Special Requirements for Passing Module: A Pass Judgement for achievement of competencies and skills and completion of the relevant sections of the Assessment of Competence booklet (i.e. relevant reflective notes, interviews, placement details, declaration), and a record of having completed scheduled clinical hours. A pass judgement for BLS and "yes" for attendance at Moving and Handling programme.

Formal Written Examination: No Formal Written Examination.

Requirements for Supplemental Examination: Students failing this module at the Summer Examination Board due to extenuating circumstances (e.g. sick leave) may have an Incomplete Placement Judgement (IP) recorded until the Autumn Examination Board, at which a Pass, Fail or Absent Judgement will be awarded. Students failing to achieve a pass judgement in Part B at the Autumn Examination Board will be required to repeat the year.

NU4087 General Nursing Practice

Please see Book of Modules (2015 – 2016) for NU4087 module descriptor
www.ucc.ie/modules/

NOTE: Please refer to BSc Programme regulations, Undergraduate Calendar entry and BSc Nursing/BSc Midwifery Marks & Standards