

## Australian Nursing Standards Assessment Tool (ANSAT) 2025-30 session

<b>Student name:</b>	<b>WPL Subject (circle relevant):</b>	NRS173 80 hours	NRS276 160 hours
<b>Student number:</b>	NRS282 160 hours	NRS386 200 hours	NRS398 200 hours
<b>Subject Convener:</b>	<b>Subject convener contact:</b>		
<i>Checklist – student to ensure all areas are complete prior to submission</i>			
Formative assessment & feedback (pp. 2-3) <input type="checkbox"/>		Summative assessment & feedback (pp. 4-6) <input type="checkbox"/>	

WPL hours completed (Record date in DD/MM/YY format; hours excludes meal breaks)											
Facility/Hospital:				Ward / Unit:				Phone Number:			
Week 1 Dates	DD/MM/YY						Week 2 Dates				
Hours							Hours				
RN initials							RN initials				
Week 3 Dates							Week 4 Dates				
Hours							Hours				
RN initials							RN initials				
‘Hours’ Code:                      8 = 8 hour shift    S/L = Sick leave    P/H = Public Holiday    GI = Graduate Interview										Total	

Facility/Hospital:				Ward / Unit:				Phone Number:			
Week 5 Dates							Week 6 Dates				
Hours							Hours				
RN initials							RN initials				
Week 7 Dates							Week 8 Dates				
Hours							Hours				
RN initials							RN initials				
‘Hours’ Code:                      8 = 8 hour shift    S/L = Sick leave    P/H = Public Holiday    GI = Graduate Interview										Total	

CSU OFFICE USE ONLY - Grade for WPL (Marker to circle one)			
SY	TA	GP	US
<b>Marker Name:</b>		<b>Marker Signature:</b>	<b>Date:</b>

*A rating 1 and/or 2 indicates that the standard has not been achieved:*

Standards for practice assessment items	Circle one number					
<b>1. Thinks critically and analyses nursing practice</b>						
Complies and practices according to relevant legislation and local policy	1	2	3	4	5	N/A
Uses an ethical framework to guide decision-making and practice	1	2	3	4	5	N/A
Demonstrates respect for individual and cultural (including Aboriginal and Torres Strait Islander) preference and differences	1	2	3	4	5	N/A
Sources and critically evaluates relevant literature and research evidence to deliver quality practice	1	2	3	4	5	N/A
Maintains the use of clear and accurate documentation	1	2	3	4	5	N/A
<b>2. Engages in therapeutic and professional relationships</b>						
Communicates effectively to maintain personal and professional boundaries	1	2	3	4	5	N/A
Collaborates with the health care team and others to share knowledge that promotes person centred care	1	2	3	4	5	N/A
Participates as an active member of the healthcare team to achieve optimum health outcomes	1	2	3	4	5	N/A
Demonstrates respect for a person's rights and wishes and advocates on their behalf	1	2	3	4	5	N/A
<b>3. Maintains the capability for practice</b>						
Demonstrates commitment to life-long learning of self and others	1	2	3	4	5	N/A
Reflects on practice and responds to feedback for continuing professional development	1	2	3	4	5	N/A
Demonstrates skills in health education to enable people to make decisions and take action about their health	1	2	3	4	5	N/A
Recognises and responds appropriately when own or other's capability for practice is impaired	1	2	3	4	5	N/A
Demonstrates accountability for decisions and actions appropriate to their role	1	2	3	4	5	N/A
<b>4. Comprehensively conducts assessments</b>						
Completes comprehensive and systematic assessments using appropriate and available sources	1	2	3	4	5	N/A
Accurately analyses and interprets assessment data to inform practices	1	2	3	4	5	N/A
<b>5. Develops a plan for nursing practice</b>						
Collaboratively constructs a plan informed by the patient/client assessment	1	2	3	4	5	N/A
Plans care in partnership with individuals/significant others/health care team to achieve expected outcomes	1	2	3	4	5	N/A
<b>6. Provides safe, appropriate and responsive quality nursing practice</b>						
Delivers safe and effective care within their scope of practice to meet outcomes	1	2	3	4	5	N/A
Provides effective supervision and delegates care safely within their role and scope of practice	1	2	3	4	5	N/A
Recognises and responds to practice that may be below expected organisational, legal or regulatory standards	1	2	3	4	5	N/A
<b>7. Evaluates outcomes to inform nursing practice</b>						
Monitors progress toward expected goals and health outcomes	1	2	3	4	5	N/A
Modifies plan according to evaluation of goals and outcomes in consultation with the health care team and others	1	2	3	4	5	N/A
<b>GLOBAL RATING SCALE</b> - rate the overall performance of this student in the clinical unit relative to their stage of practice:						
<input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Limited <input type="checkbox"/> Satisfactory <input type="checkbox"/> Good <input type="checkbox"/> Excellent						

RN Assessor name: <hr/> RN Assessor AHPRA number: <hr/> RN Assessor Signature & Date: <hr/> Student Name: <hr/> Student Number: <hr/> Student Signature & Date: <hr/>	<p><b>Learning agreement required?</b></p> <p>If student scores 1 or 2 in any area please contact Subject Convenor urgently</p> <p style="font-size: 1.2em; font-weight: bold; margin: 10px 0;">YES      NO</p> <p>(circle appropriate response)</p>
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Assessor to complete

1. What is the student doing well, and how can this be sustained and expanded?

2. What can be improved, and how will this be achieved? (please frame this as SMART goals)

RN Assessor  
Name:

RN Assessor  
AHPRA number:

RN Assessor  
Signature  
& Date

**STUDENT COMMENTS** (*critically reflect on your own performance so far during this experience, not the facility itself*)

Student to complete

Student  
Name:

Student  
Number:

Student  
Signature  
& Date:

**Summative self assessment**  
(complete before meeting with your assessor)

Student to complete

1. What were your most significant achievements during this placement? What skills, knowledge, or attitudes have you increased?

2. To what extent have you met the learning goals identified in your formative assessment? What evidence do you have to support your view on this?

3. How have your experiences on this placement shaped your future practice as a Registered Nurse?

Student  
Name:

Student  
Number:

Student  
Signature:

Date:

# Summative assessment

(To be completed at the end of the placement)

A rating 1 and/or 2 indicates that the standard has not been achieved:

Standards for practice assessment items	Circle one number					
<b>1. Thinks critically and analyses nursing practice</b>						
Complies and practices according to relevant legislation and local policy	1	2	3	4	5	N/A
Uses an ethical framework to guide decision-making and practice	1	2	3	4	5	N/A
Demonstrates respect for individual and cultural (including Aboriginal and Torres Strait Islander) preference and differences	1	2	3	4	5	N/A
Sources and critically evaluates relevant literature and research evidence to deliver quality practice	1	2	3	4	5	N/A
Maintains the use of clear and accurate documentation	1	2	3	4	5	N/A
<b>2. Engages in therapeutic and professional relationships</b>						
Communicates effectively to maintain personal and professional boundaries	1	2	3	4	5	N/A
Collaborates with the health care team and others to share knowledge that promotes person centred care	1	2	3	4	5	N/A
Participates as an active member of the healthcare team to achieve optimum health outcomes	1	2	3	4	5	N/A
Demonstrates respect for a person's rights and wishes and advocates on their behalf	1	2	3	4	5	N/A
<b>3. Maintains the capability for practice</b>						
Demonstrates commitment to life-long learning of self and others	1	2	3	4	5	N/A
Reflects on practice and responds to feedback for continuing professional development	1	2	3	4	5	N/A
Demonstrates skills in health education to enable people to make decisions and take action about their health	1	2	3	4	5	N/A
Recognises and responds appropriately when own or other's capability for practice is impaired	1	2	3	4	5	N/A
Demonstrates accountability for decisions and actions appropriate to their role	1	2	3	4	5	N/A
<b>4. Comprehensively conducts assessments</b>						
Completes comprehensive and systematic assessments using appropriate and available sources	1	2	3	4	5	N/A
Accurately analyses and interprets assessment data to inform practices	1	2	3	4	5	N/A
<b>5. Develops a plan for nursing practice</b>						
Collaboratively constructs a plan informed by the patient/client assessment	1	2	3	4	5	N/A
Plans care in partnership with individuals/significant others/health care team to achieve expected outcomes	1	2	3	4	5	N/A
<b>6. Provides safe, appropriate and responsive quality nursing practice</b>						
Delivers safe and effective care within their scope of practice to meet outcomes	1	2	3	4	5	N/A
Provides effective supervision and delegates care safely within their role and scope of practice	1	2	3	4	5	N/A
Recognises and responds to practice that may be below expected organisational, legal or regulatory standards	1	2	3	4	5	N/A
<b>7. Evaluates outcomes to inform nursing practice</b>						
Monitors progress toward expected goals and health outcomes	1	2	3	4	5	N/A
Modifies plan according to evaluation of goals and outcomes in consultation with the health care team and others	1	2	3	4	5	N/A
<b>GLOBAL RATING SCALE</b> - rate the overall performance of this student in the clinical unit relative to their stage of practice:						
<input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Limited <input type="checkbox"/> Satisfactory <input type="checkbox"/> Good <input type="checkbox"/> Excellent						

RN Assessor Name:	<p align="center"><b>Has the student performed to an acceptable standard?</b></p> <p align="center">If a student scores 1 or 2 in any area assessor must circle 'NO'</p> <p align="center"><b>YES    NO</b></p> <p align="center">(circle appropriate response)</p>
RN Assessor AHPRA Number:	
RN Assessor Signature & Date:	
Student name:	
Student Number:	
Student Signature & Date:	

## Summative assessment feedback

1. Thinks critically and analyses nursing practice

2. Engages in therapeutic and professional relationships

3. Maintains capability for practice

4. Comprehensively conducts assessments

5. Develops a plan for nursing practice

6. Provides safe, appropriate and responsive quality nursing practice

7. Evaluates outcomes to inform nursing practice

**RN Assessor  
name:**

**RN Assessor  
AHPRA Number:**

**RN Assessor  
Signature & Date:**

**Student  
name**

**Student  
Number:**

**Student  
Signature & Date:**

## Step 1 - Formative Assessment

### a. Meet with your assessor

You must meet with your designated assessor halfway through your placement to complete the Formative Assessment on pages 4 and 5. The goal of this assessment is to assist you in identifying the areas you are performing well, to allow you to expand on your strengths and to make plans to address the areas that need improvement.

Suppose you score '1' or '2' in any category (did not perform the behaviour or performed at a level below the acceptable standard). In that case, the facilitator needs to contact the Subject Convener urgently to allow time to develop a learning contract. This is not a disciplinary process but rather an opportunity to create a structured plan to help you meet the acceptable standard by the end of the placement.

### Notes for RN Assessors about the Formative and Summative Assessments

- All items must be scored
  - Circle only one number for each item
  - Evaluate the student's performance against the minimum practice level expected for their level of education – use the 'Behavioural Cues' provided in the as a guide.
  - Expected behaviours and practices not performed \*\*
1. Expected behaviours and practices performed below the acceptable/satisfactory standard \*\*
  2. Expected behaviours and practices performed at a satisfactory/pass standard
  3. Expected behaviours and practices performed at a proficient standard
  4. Expected behaviours and practices performed at an excellent standard
- N/A Not assessed. Circle N/A only if the student has not had an opportunity to demonstrate the behaviour

\*\*Note: a rating 1 &/or 2 indicates that the standard has not been achieved. Email the Subject Convener as soon as possible to arrange a learning contract.

### b. Develop SMART goals

Once the facilitator has identified your learning needs with you, this needs to be framed in a SMART Goal. SMART goals provide you with meaningful feedback and something you can work towards. The difference between the two examples below is that the SMART goal approach has been taken in the second example. It has a specific activity (administering oral medications) that is measurable (number of prompts included, number of patients, and must be on same shift); achievable (if the student has learned about medication administration and is competent to practice this skill); relevant to the subject learning outcomes; and has a time limit (within one week).

Non-specific goal	SMART goal
Jessica will be better at administering medications	Jessica will be able to administer oral medications to three different people with supervision (but no prompting required) within one shift this week

### c. Self assessment and critical reflection

The final part of the formative assessment requires you to provide a critically reflective comment about your performance. You are required to use a recognised model of reflection to develop your self assessment section of the ANSAT. There are many different models of reflection but they share common features. The first step of reflection is usually to describe what has happened.

Identifying exactly what makes this an incident worth reflecting on is crucial at this stage. A low level of reflection would describe this starting point.

Next, you will need to reflect on the situation and relate what you have learned to it - how is theory relevant? Recognising and challenging your own assumptions, feelings, and lack of knowledge is also important - what were you able to contribute to the situation? Is there anything you didn't bring to the situation (knowledge, openness) that may have made it different?

As you identify what you have learned and what you should change for future situations, you will be able to make sense of all of these factors. Finally, to conclude a reflection, identify areas that will change - for example, practices, ways of seeing things, beliefs, values. This is the deepest level of reflection.

Here are several examples where the student has not been critically reflective:

*Example 1: I loved this ward. Everyone has been lovely and I have learned so much.*

*Example 2: I am hopeless. I am not getting anything right. I am so lost.*

*Example 3: I have been able to give medications. I have looked after 2 patients today.*

In the first example, the student is highly positive about the ward, but the reflection is not critical and not focused on performance. In the second example, the student is feeling overwhelmed (and should contact the Subject Convener for support urgently), and the comments have no focus on what the student is doing well (there is always something!). The third example is descriptive and not critical, stating what happened but not making any judgments (failing to identify positive or negative aspects).

*Example 4: While I have been able to give oral medications with a lot of prompting and guidance, I need to improve on my capability in this skill and rely less on prompting from the RN. I will continue to work on this by reviewing the subject material and practicing as much as possible for the rest of this placement.*

In Example 4, the student has identified good and not-so-good things about their practice and has identified some actions they can take in response to this reflection.

## Step 2 – Summative assessment

Towards the end of the placement, you will have another meeting with the assessor to reflect on the remainder of your placement. Firstly, you must respond to the questions guiding self-reflection before meeting with the facilitator.

The facilitator will then grade your performance against the Registered Nurse Standards for practice (NMBA, 2016) and provide feedback about how you have met these throughout your placement (refer to Behavioural cues in Appendix).

Feedback should include the extent to which the student has met the SMART goals developed in the formative assessment and strategies for how they may continue to improve their practice in future placements/work.

The student must score a '3' or higher in all areas to complete the placement. When a student scores '1' or '2' in any of the areas, this must be reviewed by the Subject Convener.

## Step 3 – Submitting the ANSAT

Finally, scan the completed ANSAT and submit following the instructions in the Subject Outline. The submitted ANSAT must be a true copy of the original with no alternations. It must be a high quality replica such as that achieved using a flatbed scanner or photocopier. CamScanner and Adobe Scan smartphone apps are also acceptable.

The file submitted to EASTS must be a single PDF that includes all pages of the ANSAT. Before submission you must ensure that all sections of the ANSAT have been completed and incomplete submissions will not be marked as satisfactory.



## Bachelor of Nursing Student scope of practice

All skills must be performed under the supervision of a registered nurse. Students must not directly undertake skills not listed for the subject they are attending placement. Students may observe other skills and clinical activities to support knowledge development.

NRS162 Workplace Learning 1	No placement
<p><b>Knowledge &amp; Attitudes</b></p> <ul style="list-style-type: none"> <li>Normal anatomy and physiology of the nervous, cardiovascular, haematological, lymphatic, pulmonary and immune systems</li> <li>Clinical Reasoning – beginning to understand the clinical significance of abnormal assessment findings and when to escalate care</li> <li>Mindful communication</li> <li>Caring in practice</li> <li>Culturally safe care</li> <li>Professional comportment</li> <li>Locating evidence for practice</li> <li>Legal principles of consent, privacy and confidentiality, professional boundaries and documentation</li> <li>Contexts where nurses work and roles of interprofessional team members</li> </ul>	<p><b>Skills from NRS163</b></p> <ul style="list-style-type: none"> <li>Infection control – hand washing, standard and additional precautions</li> <li>Health assessment and screening, including vital signs, level of consciousness</li> <li>BGL and urinalysis</li> <li>Assistance with mobilisation and pressure area care, including falls screening and prevention</li> <li>Basic assistance with ADLs – teeth, hair, setting up for shower</li> <li>Basic life support</li> <li>Documentation – recording vital signs and basic assessment information</li> </ul>
NRS173 Workplace Learning 2	80 hours (two weeks)
<p><b>Knowledge &amp; Attitudes</b></p> <ul style="list-style-type: none"> <li>Normal anatomy and physiology of the integumentary, musculoskeletal, endocrine, urinary and reproductive systems;</li> <li>Pathophysiology of integumentary, cardiovascular, respiratory, endocrine, exocrine and fluid balance disorders;</li> <li>Interprofessional and intraprofessional collaboration,</li> <li>Quality improvement, responding to incidents</li> <li>End of life care, including legal considerations</li> <li>Assessment types and settings – primary, secondary survey, focused assessment, assessment frameworks, risk assessment</li> <li>Using the clinical reasoning cycle to plan and evaluate care</li> <li>Patient care for comfort, dignity and healing</li> <li>Wound assessment and care</li> <li>Principles of medication administration, including basic pharmacology</li> </ul>	<p><b>Skills from NRS163: Clinical Reasoning 1, with the addition of:</b></p> <ul style="list-style-type: none"> <li>Nursing assessments and risk screening, including pre- and post-operative</li> <li>Admissions</li> <li>Assist with discharge planning, including patient education</li> <li>Documentation of assessment findings, basic progress notes (co-signed)</li> <li>Handover using framework</li> </ul> <p><b>Only following satisfactory NRS174 OSCE and at facility discretion:</b></p> <ul style="list-style-type: none"> <li>Basic wound assessment and dressing</li> <li>Medication administration: <ul style="list-style-type: none"> <li>topical medications</li> <li>oral medications</li> <li>subcutaneous injections</li> <li>intramuscular injections</li> </ul> </li> </ul>
NRS276: Nursing Workplace Learning 3	160 hours (four weeks)
<p><b>Knowledge &amp; Attitudes</b></p> <ul style="list-style-type: none"> <li>Pathophysiology of infection, inflammation, immune, musculoskeletal, gastrointestinal, endocrine, renal and reproductive disorders</li> <li>Applying the clinical reasoning cycle to people, families and communities</li> <li>Transpersonal teaching</li> <li>Cultural safety</li> <li>Caring for vulnerable people across the lifespan</li> <li>Use of evidence in practice</li> <li>Focused assessment and management of the neurological, cardiovascular, respiratory and endocrine</li> <li>Planning and implementing nursing care for people with neurological, cardiovascular, respiratory and endocrine health challenges, including use of the clinical reasoning cycle</li> </ul>	<p><b>Skills from NRS163 with the addition of skills from NRS174 CR 2 :</b></p> <ul style="list-style-type: none"> <li>Assessment and management of peripheral IV access, including removal</li> <li>Administration of peripheral IV fluids and medications</li> <li>Focused assessment and management of the neurological system – GCS, neuro obs, cranial nerve assessment, log rolling</li> <li>Cardiovascular assessment – 12 lead ECG, neurovascular assessment, chest pain assessment</li> <li>Respiratory assessment and care – lung sounds, inhalational medications, oxygen administration;</li> <li>Endocrine assessment and care – administration of insulin, management of hypoglycaemia</li> <li>1 patient load in Week 4</li> </ul>
NRS282 Nursing Workplace Learning 4	160 hours (four weeks)
<p><b>Knowledge &amp; Attitudes</b></p> <ul style="list-style-type: none"> <li>History, culture and knowledges of Aboriginal and Torres Strait Islander peoples</li> <li>Advanced pharmacology</li> <li>Links between organisational policies and guidelines, research and practice</li> <li>Advocacy – legal and ethical principles</li> <li>Focused assessment of the gastrointestinal, renal, reproductive and musculoskeletal systems</li> <li>Planning and implementing nursing care for people with renal, reproductive and musculoskeletal health challenges, including use of the clinical reasoning cycle to plan and prioritise care</li> <li>Pain assessment and care Advanced wound assessment and care</li> </ul>	<p><b>Skills from NRS163, NRS174 with the addition of NRS277 CR 3:</b></p> <ul style="list-style-type: none"> <li>Assessment and management of Central Venous Access Devices (CVADs, including dressings, accessing and removal;</li> <li>Administration of blood products (2 RNs must still complete checking and documentation)</li> <li>Comprehensive pain assessment</li> <li>Administration of opioid analgesia, including PCA (2 RNs must still complete checking and documentation)</li> <li>Abdominal assessment</li> <li>Insertion and management of Salem sump and nasogastric tubes</li> <li>Management of TPN</li> <li>Drain, staple and suture care and removal</li> <li>Stomal care</li> <li>IDC insertion, care and removal</li> <li>Complex wound dressings</li> <li>2 patient load from the start of Week 3</li> </ul>
NRS386 Nursing Workplace Learning 5	200 hours (five weeks)
<p><b>Knowledge &amp; Attitudes</b></p> <ul style="list-style-type: none"> <li>Organisational models of care</li> <li>Regional, national and global health priorities</li> <li>Social determinants of health</li> <li>Leadership, delegation and mentoring</li> <li>Nursing culture &amp; professional comportment</li> <li>Strategies for interprofessional communication</li> <li>Technology in practice</li> <li>Rural and remote care environments</li> <li>Assessment and care of older persons</li> <li>Assessment and management of complex respiratory presentations</li> <li>Assessment and management of complex cardiovascular presentations</li> <li>Assessment and management of complex mental health presentations</li> </ul>	<p><b>Skills from NRS163, NRS174, NRS27, with the addition of skills NRS283</b></p> <ul style="list-style-type: none"> <li>Paediatric medication and fluid administration</li> <li>Assessment and management of complex respiratory presentations – advanced oxygen therapy, chest drain management</li> <li>Mental health assessment</li> <li>Delirium assessment and screening</li> <li>3 patient load from Week 2 onwards</li> </ul>
NRS398 Nursing Workplace Learning 6	200 hours (five weeks)
<p><b>Knowledge and Attitudes</b></p> <ul style="list-style-type: none"> <li>Pathophysiology of stress, cancer and ageing</li> <li>Pathophysiology of chronic health challenges</li> <li>Pharmacological management of chronic health challenges</li> <li>Models of care for people with chronic health challenges</li> <li>Planning, implementing and evaluating care for people with chronic and complex health challenges</li> <li>End of life care – legal and ethical implications</li> </ul>	<p>There are no new skills for this placement. The focus of this placement is on the consolidation of knowledge and skills from previous subjects. Students are still required to be supervised by a registered nurse, but minimal prompting should be required for most tasks.</p> <p>Students should be assigned a 4-patient load throughout the placement, whenever possible.</p>



ANSAT Behavioural Cues

ANSAT 2016 Behavioural Cues

- **1. THINKS CRITICALLY AND ANALYSES NURSING PRACTICE**
- Compiles and practices according to relevant legislation and local policy
- Follows policies and procedures of the facility/organisation (e.g. workplace health and safety / infection control policies)
- Maintains patient/client confidentiality
- Arrives fit to work
- Arrives punctually and leaves at agreed time
- Calls appropriate personnel to report intended absence
- Wears an identification badge and identifies self
- Observes uniform/dress code
- Maintains appropriate professional boundaries with patients/clients and carers
- Uses an ethical framework to guide their decision making and practice
- Understands and respects patients'/clients' rights
- Allows sufficient time to discuss care provision with patient/clients
- Refers patients/clients to a more senior staff member for consent when appropriate
- Seeks assistance to resolve situations involving moral/ethical conflict
- Applies ethical principles and reasoning in all health care activities
- Demonstrates respect for individual and cultural (including Aboriginal & Torres Strait Islander) lore, preference and differences
- Practices sensitively in the cultural context
- Understands and respects individual and cultural diversity
- Involves family/others appropriately to ensure cultural/spiritual needs are met
- Sources and critically evaluates relevant literature and research evidence to deliver quality practice
- Locates relevant current evidence (e.g. clinical practice guidelines and systematic reviews, databases, texts)
- Clarifies understanding and application of evidence with peers or other relevant staff
- Applies evidence to clinical practice appropriately

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- Participates in quality activities when possible (e.g. assists with clinical audit, journal club)
- Shares evidence with others
- Maintains the use of clear and accurate documentation
- Uses suitable language and avoids jargon
- Writes legibly and accurately (e.g. correct spelling, approved abbreviations)
- Records information according to organisational guidelines and local policy
- 2. ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS**
- Communicates effectively to maintain personal and professional boundaries
- Introduces self to patient/client and other health care team members,
- Greets others appropriately
- Listens carefully and is sensitive to patient/client and carer views
- Provides clear instructions in all activities
- Uses a range of communication strategies to optimise patient/client rapport and understanding (e.g. hearing impairment, non-English speaking, cognitive impairment, consideration of non-verbal communication)
- Communication with patient/client is conducted in a manner and environment that demonstrates consideration of confidentiality, privacy and patient's/client's sensitivities
- Collaborates with health care team and others to share knowledge that promotes person-centred care
- Demonstrates positive and productive working relationships with colleagues
- Uses knowledge of other health care team roles to develop collegial networks
- Demonstrates a collaborative approach to practice
- Identifies appropriate educational resources (including other health professionals)
- Prioritises safety problems

- Participates as an active member of the healthcare team to achieve optimum health outcomes
- Collaborates with the health care team and patient/client to achieve optimal outcomes
- Contributes appropriately in team meetings
- Maintains effective communication with clinical supervisors and peers
- Works collaboratively and respectfully with support staff
- Demonstrates respect for a person's rights and wishes and advocates on their behalf
- Advocates for the patient/client when dealing with other health care teams
- Identifies and explains practices which conflict with the rights/wishes of individuals/groups
- Uses available resources in a reasonable manner
- Ensures privacy and confidentiality in the provision of care
- 3. MAINTAINS THE CAPABILITY FOR PRACTICE**
- Demonstrates commitment to lifelong learning of self and others
- Links course learning outcomes to own identified learning needs
- Seeks support from others in identifying learning needs
- Seeks and engages a diverse range of experiences to develop professional skills and knowledge
- Supports and encourages the learning of others
- Reflects on practice and responds to feedback for continuing professional development
- Reflects on activities completed to inform practice
- Plans professional development based on reflection of own practice
- Keeps written record of professional development activities
- Incorporates formal and informal feedback from colleagues into practice
- Demonstrates skills in health education to enable people to make decisions and take action about their health
- Assists patients/clients and carers to identify reliable and accurate health information



## ANSAT 2016 Behavioural Cues

- Patient/client care is based on knowledge and clinical reasoning
- Refers concerns to relevant health professionals to facilitate health care decisions/delivery
- Provides information using a range of strategies that demonstrate consideration of patient/client needs
- Prepares environment for patient/client education including necessary equipment
- Demonstrates skill in patient/client education (e.g. modifies approach to suit patient/client age group, uses principles of adult learning)
- Educates the patient/client in self-evaluation
- Recognises and takes appropriate action when capability for own practice is impaired
- Identifies when own/other's health/well-being affect safe practice
- Advises appropriate staff of circumstances that may impair adequate work performance
- Demonstrates appropriate self-care and other support strategies (e.g. stress management)
- Demonstrates accountability for decisions and actions appropriate to their role
- Provides care that ensures patient/client safety
- Provides rationales for care delivery and/or omissions
- Sources information to perform within role in a safe and skilled manner
- Complies with recognised standards of practice

## 4. COMPREHENSIVELY CONDUCTS ASSESSMENTS

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

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

## 5. DEVELOPS A PLAN FOR NURSING PRACTICE

- Collaboratively constructs a plan informed by the patient/client assessment
- Uses assessment data and best available evidence to construct a plan
- Completes relevant documentation to the required standard (e.g. patient/client record, care planner and assessment, statistical information)
- Considers organisation of planned care in relation to other procedures (e.g. pain medication, wound care, allied health therapies, other interventions)
- Plans and documents care to achieve expected outcomes with clear timeframes for evaluation
- Collaborates with the patient/client to prioritise and formulate short and long term goals
- Formulates goals that are specific, measurable, achievable and relevant, with specified timeframe
- Advises patient/client about the effects of health care

## 6. PROVIDES SAFE, APPROPRIATE AND RESPONSIVE QUALITY NURSING PRACTICE

- Delivers safe and effective care within their scope of practice to meet outcomes
- Performs health care interventions at appropriate and safe standard
- Complies with workplace guidelines on patient/client handling
- Monitors patient/client safety during assessment and care provision

- Uses resources effectively and efficiently
- Responds effectively to rapidly changing patient/client situations
- Provides effective supervision and delegates safely within their role and scope of practice
- Accepts and delegates care according to own or other's scope of practice
- Seeks clarification when directions/decisions are unclear
- Identifies areas of own or other's practice that require direct/indirect supervision
- Recognises unexpected outcomes and responds appropriately

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

## 7. EVALUATES OUTCOMES TO INFORM NURSING PRACTICE

- Monitors progress towards expected goals and health outcomes
- Refers patient/client on to other professional/s
- Begins discharge planning in collaboration with the health care team at the time of the initial episode of care
- Monitors patient/client safety and outcomes during health care delivery
- Records and communicates patient/client outcomes where appropriate
- Modifies plan according to evaluation of goals and outcomes in consultation with relevant health care team and others
- Questions patient/client or caregiver to confirm level of understanding
- Updates care plans/documentation to reflect changes in care
- Uses appropriate resources to evaluate effectiveness of planned care/treatment

