

Australian Nursing Standards Assessment Tool (ANSAT)
Generic ANSAT

Student name:	WPL Subject (circle relevant):	NUR105 160 hours	NUR202 160 hours
Student number:	NUR205 160 hours	NUR302 160 hours	NUR305 200 hours
Subject Convener:	Subject convener contact:		
<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	
Marker Name:	Marker Signature:	Date:		

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

Standards for practice assessment items	Circle one number					
1. Thinks critically and analyses nursing practice						
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
2. Engages in therapeutic and professional relationships						
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
3. Maintains the capability for practice						
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
4. Comprehensively conducts assessments						
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
5. Develops a plan for nursing practice						
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
6. Provides safe, appropriate and responsive quality nursing practice						
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
7. Evaluates outcomes to inform nursing practice						
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
GLOBAL RATING SCALE - 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:	Learning agreement required? If student scores 1 or 2 in any area please contact Subject Convenor urgently	
RN Assessor AHPRA number:		
RN Assessor Signature & Date:		
Student Name		
Student Number		
Student Signature & Date		
YES NO (circle appropriate response)		

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 Name:	Student Number:	Student Signature & Date:
---------------	-----------------	---------------------------

Summative self assessment

(complete before meeting with your assessor)

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

GLOBAL RATING SCALE - rate the overall performance of this student in the clinical unit relative to their stage of practice:

Unsatisfactory Limited Satisfactory Good Excellent

RN Assessor Name:	Has the student performed to an acceptable standard? If a student scores 1 or 2 in any area assessor must circle 'NO' YES NO (circle appropriate response)
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 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 attend placement for. Student may observe other skills and clinical activities to support knowledge development.

NUR105: PEP 1	
<ul style="list-style-type: none"> Primary and secondary survey Vital signs assessment including BGL & urinalysis Assist person with activities of daily living Medication preparation & administration via oral, topical, subcutaneous, intramuscular routes including S4 & S8 medications Infection control- hand hygiene, standard and additional precautions, PPE Removal of basic sutures and PVC Basic wound assessment and dressing Pressure area care Apply the Paediatric Assessment Triangle Perform 12 lead ECG Undertake pre-procedure preparation and assessment, post-procedure head-to-toe assessment and post-operative wash 	<ul style="list-style-type: none"> Oxygen supplementation via non-invasive oxygen devices Undertake basic safe swallowing assessment Apply patient safety frameworks, policies and procedures Basic documentation – recording progress notes, vital signs and assessments Undertake and respond to risk assessments Escalate patient's/person's care Maintain professional boundaries Legal principles of consent, privacy, and confidentiality Mobilise people safety including manual handling, spinal precautions and collar care End of life care 1 patient load
NUR202: PEP 2	
<ul style="list-style-type: none"> Identify anatomy & safety concepts of PIVCs & CVADs Medication administration of IV medications & fluids, including fluid assessment, patient controlled analgesia, patient education Respiratory assessment & intervention, mechanics & concepts of HFNP and NIV, and intercostal catheter Cardiovascular assessment & intervention including basic ECG interpretation, telemetry, pacemakers & ICDs Neurological assessment and intervention, including cranial nerve assessment 	<ul style="list-style-type: none"> Pain assessment and intervention Evaluate fluid balance Begin to interpret electrolyte pathology Identify anatomy, procedure & safety concepts for phlebotomy Identify components & procedure for point of care testing Implement time management skills Provide handover using ISBAR, IMIST 1-2 patient load
NUR205: PEP3	
<ul style="list-style-type: none"> Dressing changes & infection prevention of CVADs Endocrine and exocrine assessment and interventions including sliding scale insulin, insulin pumps, and rapid infusion devices Gastrointestinal assessment and intervention including NGT insertion and uses, newly formed stoma care, Salem sumps, TPN Immune system assessment and intervention including application of sepsis pathway, reverse barrier procedures and pathology interpretation Integumentary assessment and intervention including complex wounds, dehisced wounds, VAC, low suction dressings and analysis of common rashes Musculoskeletal assessment 	<ul style="list-style-type: none"> Renal assessment and intervention including female only IDC insertion, care, and removal, suprapubic catheter and urostomy considerations, and pathology Blood product preparation and administration including understanding of filters, clotting factors, pathology, PRBC, FFP, plasma and albumin Communication with vulnerable people including consent and mandatory reporting Evaluate outcomes of medical administration and nursing interventions 2-3 patient load
NUR302: PEP 4	
<ul style="list-style-type: none"> Identification and care of deteriorating person Complex respiratory interventions, such as tracheostomy (adults), oropharyngeal and nasopharyngeal airways Supporting Basic and Advanced Life Support Peripheral IVC insertion Critical understanding of multiple underlying pathophysiology Develop comprehensive person-centred plans for care 	<ul style="list-style-type: none"> Basic care coordination in the emergency department Mental health assessment and care Discharge planning Complex communication including handover and to multidisciplinary teams Coordinate intra- or inter-hospital transfers 3-4 patient load
NUR305: PEP 5	
<ul style="list-style-type: none"> Apply all skills and knowledge learned to date across varied care contexts Apply leadership skills Plan person-centred, holistic assessment and interventions across a range of varied contexts Safely delegate tasks to AIN, ward person, EEN or other team members 	<ul style="list-style-type: none"> Basic coordination of care through the operating theatre, mental health facilities, residential aged care facilities, primary and community health, rural and remote, justice health, telehealth, defence force, etc. 4 patient load



ANSAT Behavioural Cues

<p>Participates as an active member of the healthcare team to achieve optimum health outcomes</p> <ul style="list-style-type: none"> • 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
<p>Demonstrates respect for a person's rights and wishes and advocates on their behalf</p> <ul style="list-style-type: none"> • 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
<p>Maintains the use of clear and accurate documentation</p> <ul style="list-style-type: none"> • 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
<p>ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS</p> <ul style="list-style-type: none"> • 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

<p>MAINTAINS THE CAPABILITY FOR PRACTICE</p> <ul style="list-style-type: none"> • 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
<p>ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS</p> <ul style="list-style-type: none"> • 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
<p>MAINTAINS THE CAPABILITY FOR PRACTICE</p> <ul style="list-style-type: none"> • 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

<p>1. THINKS CRITICALLY AND ANALYSES NURSING PRACTICE</p> <ul style="list-style-type: none"> • <u>Considers and prioritises according to relevant legislation and local policy</u> • <u>Follows policies and procedures of the facility/organisation (e.g. workplace health and safety / infection control policies)</u> • <u>Maintains patient/client confidentiality</u> • <u>Arrives fit to work</u> • <u>Arrives punctually and leaves at agreed time</u> • <u>Calls appropriate personnel to report intended absence</u> • <u>Wears an identification badge and identifies self</u> • <u>Observes uniform/dress code</u> • <u>Maintains appropriate professional boundaries with patients/clients and carers</u> • <u>Uses an ethical framework to guide their decision making and practice</u> • <u>Understands and respects patients'/clients' rights</u> • <u>Allows sufficient time to discuss care provision with patient/clients</u> • <u>Refers patients/clients to a more senior staff member for consent when appropriate</u> • <u>Seeks assistance to resolve situations involving moral/ethical conflict</u> • <u>Applies ethical principles and reasoning in all health care activities</u> • <u>Demonstrates respect for individual and cultural including Aboriginal & Torres Strait Islander) preference and differences</u> • <u>Practices sensitively in the cultural context</u> • <u>Understands and respects individual and cultural diversity</u> • <u>Involves family/others appropriately to ensure cultural/spiritual needs are met</u> • <u>Sources and critically evaluates relevant literature and research evidence to deliver quality practice</u> • <u>Locates relevant current evidence (e.g. clinical practice Guidelines and systematic reviews, databases, texts)</u> • <u>Clarifies understanding and application of evidence with peers or other relevant staff</u> • <u>Applies evidence to clinical practice appropriately</u>





ANSAT 2016 Behavioural Outcomes

- 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 concerns for own practice is imagined**
 - 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
 - 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
- 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
 - **Modifies plan according to evolution 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

