Federal Department of Nursing
Emirati Nurse & New Graduate
Development Section
Ministry of Health

PROfessional Development Program for the New Nurse Graduate

My Clinical Handbook

Name: _____

(as it appears in passport)

Civil Service No: _____

Date of Appointment:_____

Date of Orientation Started: _____

Date of Orientation Completed: _____

Program Preceptor(s): _____

Program Facilitator: _____

Others: _____

Facility: _____ **District:** _____

Ward/Unit:_____

Table of Contents Page

How To Use The Handbook

This Handbook is one of the tools designed in the Professional Development Program (PDP) to support (*over a six months period*) you as a New Nurse Graduate, as you commence on your nursing practice as an employee at the Ministry of Health Services.
This Handbook is your responsibility, to safe keep, to carry with you during your clinical practice. The content of this handbook should be shared with your facilitator, preceptor and your Unit Manager.

The key elements of this handbook focus on the following:

- Guidelines in table format, developed to support you in your General Orientation period in the first 2-4 weeks on commencing your nursing practice
- Clinical Skills Competency Tool, developed for you to be used as a guide when performing or learning a new skill in your clinical setting. The skill being performed or learned should be in conjunction with relevant policies and procedures of that facility you are practicing in.

The handbook will be used as an assessment tool by your facilitator//preceptor. It will enable them to give structured feedback and comments on your performance in a more comprehensive and objective way.

This tool is general and may be adapted to meet the needs of a specific facility, such as a primary health care center. Consideration should be taken with the individual differences between patients, such as their age, culture, gender, needs, their diagnosis and other related aspects impacting on their nursing care.

- The Reflective Diary and the Individual Professional Development Plan are two tools linked to each other. These tools have been designed to support you in the following:
  - Encouraging you to become self-aware and able to explain, evaluate, and reflect on your practice and decision-making.
  - Identifying your learning needs and planning with the support and guidance of your preceptor/facilitator on how to meet those needs.

Introduction

The Professional Development Program for Beginning Practitioner (PDBP) was initiated in June 1997 in response to the recognized need for the newly qualified nurse development in both clinical and professional aspects in the staff nurse role. The program is currently in its fifth year of implementation in more than thirteen MOH Hospitals.
The program aims to provide an educationally and clinically sound program to support new graduates in the transition from students to professionals and to facilitate their adaptation to the work environment.

A taskforce committee was formed in May 2001 to review and revise the current operational program. The review process took into consideration recommendations, formal and informal feedback from MOH facilities, Institutes of Nursing, New Nurse Graduates experience with the program and documented evaluation findings collated since the implementation period of the program in 1997.

Revising the program has been essential to enhance and improve the quality and usefulness of this program, so as to meet the challenges and the changes within our health care environment and to effectively meet the needs of the New Graduate entering the health care service in various clinical settings.

The revised program as of January 2003, will be referred to as:

"THE PROFESSIONAL DEVELOPMENT PROGRAM FOR THE NEW NURSE GRADUATE"

1. Mission Statement

The Federal Department of Nursing believes that all New Nurse Graduates* (graduate of an approved nursing education program), throughout the United Arab Emirates (UAE), should have access and opportunity for professional development. This can be achieved through a formal, comprehensive and supportive program, specifically designed to meet the professional and individual learning needs of such a target group as applied/implemented in various health care facilities.

This program promotes growth in professional attitude, knowledge and skills utilizing current and available resources and formal learning opportunities.
In accordance with the Ministry of Health (MOH) mission statement (Professional Code of Conduct, 2001) the program assists in providing optimum health for all people in the UAE, by promoting and ensuring excellence in health care practices through ongoing education.
Participants in the program are expected to strive for high standards of nursing care whilst sensitively honoring the values, rights and needs of others and self in a dignified way, taking careful cognizance of diversified, religious and cultural perspective in the UAE.
The program aspires to meet the needs, of its various stakeholders, for example;

- Professional learning needs of the NNG
- Health care delivery needs of MOH facilities
- Requirements of the MOH
- Provision for quality care in health care and community setting

2. Program Goal

To provide essential, structured and guided support to the New Nurse Graduate, reflecting on and assessing their professional development at the initiation of their career path and supporting their transition process to fully function as a professional nurse.

** New Nurse Graduate: Will be abbreviated as **NNG.***

3.Program Objectives

3.1 To enable the NNG to function optimally within practice by focusing first on her/his security and affiliate needs, such as belonging, feeling of comfort and acceptance.

3.2 To facilitate the identification, structuring and monitoring of clinical educational experiences that positively impact on attitude, knowledge and skills in the development of the NNG.

3.3 To enable participants in developing interpersonal and self-management skills and in coping with immediate/ demanding needs by utilizing, for example; reflection, feedback, guidance and professional support.

3.4 To enable the NNG to adapt to the role and function as a valuable and responsible team member within clinical practice.

"I Am Not Alone"

Target Group: New Nurse Graduate
The New Nurse Graduate from the Institute of Nursing, at the MOH, UAE or from an approved Nursing Education program from within or external to the UAE.
The NNG in her/his encountered novice clinical practice and environment is supported to meet the professional requirements as set out in this program. The NNG is expected to provide nursing care for clients/patients and recipients of care of all ages with common and predictable health problems. She/he is prepared to practice with the level of supervision normally provided in health care settings. NNG is not prepared, but may have the potential to provide nursing care for clients with complex health problems requiring specialized nursing care.

The following are some quotes of how others perceive NNG's and how they perceive themselves

"……*they have this enormous learning curve when they qualify and come into the ward…...after six months you suddenly realize that they have managed to absorb a phenomenal amount of information by the end of that year…….. But that year for them must be hell on* earth'.
(Runliman et al., 1998, p. 102)

'……..I felt tired, not organized in my work, too much to do, I am confused and can't manage my work……'
(NNG, 2000, 2 months into clinical experience)

'…….my independent training helped so much, since I was appointed on the same ward, the staff welcomed me, as if I was one of them……' (NNG, 2002, 4 months clinical experience)

'……..*I was confused, the first few days, I didn't know which case belonged to which Dr…….I started then to write everything down, now after 5 months, I gave up writing down the cases, since it's all in my head*…….' (NNG, 2001)

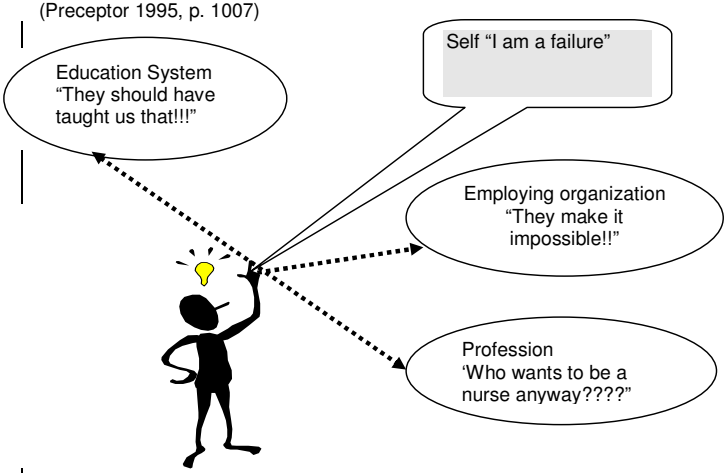
'…….*They asked me if I know how to calculate medication, I just felt like a student*……' ' (NNG, 2002)

Preceptoring

'…….*I think that (preceptoring) enhances my role. I do not actually see it as a difficult burden, I actually see it as part of my role. I look on it positively*……'
(Preceptor, 1995, p. 1006)

'……*I was really apprehensive about taking her (NNG) with me……watching me…..that made me feel a bit more…well I have got to do this properly and right!*
(Preceptor, MOH Facility, 1999)

'….*It (Preceptoring) had made me realize that I can't afford not to keep myself up to date and develop myself…..!*
(Preceptor 1995, p. 1007)



This resulting disillusionment and frustration may cause the neophyte nurse to experience a delayed adjustment period to the role of staff nurse

General Orientation

Macro/micro orientation: This element introduces you to the facilities expectations of the staff nurse role in relation to the care and nursing practice they provide. You will be familiarized with rules and regulations set by MOH, policies and procedures, protocols developed by the facility and unit routines. This represents defined sets of expectations on how you as a staff nurse will function, complete certain tasks or activities and respond to specific situations in delivering patient care. Additional written documents and ongoing educational activities will support your learning needs in this phase.

Form A

Guide to Facilitate Organizational Orientation

Topics	Facilitator / Preceptor Initials	Resources utilized	NNG Initials	Comments
General Information				
• Organizational chart				
• Nursing Services				
• Hospital Layout				
• Quality process				
• Communication mechanism				
• **Employee Policies**				
• MOH rules and regulation				
• Staff Health				
Human Resource Issues				
• Job transfer				
• Promotion				
General Safety Information				
• Infection control				
• Policies and procedures				
• Universal precautions				
• Aseptic techniques				
• Body mechanics				
• Work-related accidents				
Others				

Comments:

Form B

Checklist – Documentation of Non-Clinical Topics Covered During Orientation Period

Topics	Facilitator / Preceptor Initials	Resources utilized	NNG Initials	Comments
General Information				
Register				
Ward daily reports				
Sick calls by staff				
Nursing Unit				
Physical layout				
Unit communication system				
Location & use of equipment				
Location of supplies				
Emergency trolley				
Time schedules / Duty Roster				
Special request / Days off / Holidays				
Charting guidelines				
Nursing record				
Discharge planning				
Patient Care Reports				
Patient charts				
Notification forms				
Incident reports				
Responsibility releases				
Patient census / Condition reports				
Discharge sheet				
Code / CPR team				
Surgery consent forms				
Preoperative checklist				
Intake / Output & other				

observation forms				
Others				

Comments:

Clinical Skills Competency Tool

Clinical Skills Competency Tool

Competency in nursing practice is quite broad and may be difficult to demonstrate in a short period of time. This Clinical Skills Competency Tool is designed to assess your ability to communicate with the patient, to problem solve and to manage time and resources available to their care and to complete the procedure as efficiently as possible.
Through observation and over a reasonable time frame your preceptor is able to determine your competence.

The criteria set for completion of a skill is meant as a guide for you and your preceptor to monitor your progress.
A brief description of these criteria is as follows:

- **Competent**: indicates that you are able to complete the skill efficiently and without support from your preceptor
- **Requires supervision**: indicates that you are able to complete the procedure, but may require direction and guidance
- **Requires development**: indicates that you are unable to complete the skill without assistance from your preceptor.
- **Unable to perform at present**: indicates inability to perform the skill.

Evidence of Achievement of Core Psychomotor Skills

Criteria for self-assessment:

1. Unfamiliar
2. Able to perform with assistance
3. Repeat performance necessary
4. Competent

Formatted: Bullets and Numbering

Criteria for validation[1]:

1. Unable to perform at present
2. Requires supervision
3. Requires development
4. Competent/Independent Performance

Formatted: Bullets and Numbering

Validation[1]: is a process that ensures that the criteria accurately reflects the desired behavior for that competency in that area. This process offers clear and measurable descriptions of those expectations. (Alspach, 1995)

FORM C

Competency Statement: ❖ Demonstrates accurate, precise and complete documentation of patient/client information				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt.[2]/Date**
Complies with FDON policy no. NA-D-001, July 1998, "Documentation: General Principles and Legal requirements"				
Reports accurate, brief & complete patient client information				
Writes entries in a neat, legible and correct spelling				
Records patient/client information in stipulated color ink as per hospital policy				
Records patient/client information at the time of the procedure, using the 24 hour clock				
Signs all client/patient information entries in accordance with facility policy				
Uses only officially authorized abbreviations				
Records statement from patients/clients & family members exactly				
Records information reported to physicians, nursing colleagues and other health care professional precisely				
Records all care rendered to the patient/client				
Records all health education given to the patient and/relatives				

Ppt.[2] Abbreviation for preceptor

Competency Statement: ❖ Demonstrates accurate, precise and complete documentation of patient/client information (cont'd)				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Documents all incidents as per hospital policy & procedure guidelines				
Uses graphic records & flow charts to document relevant information				
Draws a single straight line from end of entry to the document margin to prevent further entries				
Enters late entries onto new line & indicates with 'late entry'				
Deals with errors made while reporting in accordance with facility policy				
Maintains confidentiality of patient/clients medical records				
Organizes all documents in a secure manner				
Other				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Demonstrates the procedure for admitting patients on the unit				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Obtains admission baseline data that include each of the following:				
• Vital signs				
• Height / weight				
• Reason(s) for admission				
• Allergies				
• Current medication(s)				
Nursing history				
Completes physical assessment form				
Assists in executing admission orders				
Formulates nursing diagnosis and prioritize				
Develops a patient care plan based on assessment of the patient's condition. Discusses plan and follows upon with preceptor				
Documents and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively assess patient's physical status				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gathers equipment and prepares equipment and environment				
Evidence of therapeutic interaction with patient e.g. explains procedure to patient				
Obtains a thorough nursing history				
Explores chief complaint with the patient (if more than one presenting problem they are explored in a systematic manner)				
Washes hands				
Conducts a systematic physical assessment of the patient: • Obtains vital signs, height, weight • Inspects patient throughout the physical assessment • Assesses: • Neuro-muscular functioning • Skin/dermatological condition • Cardiac functioning • Respiratory functioning • Gastrointestinal functioning • Bladder (palpate for distention)				
Documents and reports the gathered data in a systematic manner				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to assess a patient's mental status on admission (mental status assessment is done as part of the general history taking				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Considers clinical status patient's age, culture and language when assessing mental status				
Demonstrates understanding of these factors which impact on patient's ability to process information and respond to questions				
Gives the patient a clear explanation of the procedure				
Assesses general appearance and each of the following: • Level of consciousness • Mood and behavior • Knowledge and vocabulary (keeping in mind that knowledge vocabulary are dependent on culture, education and language spoken) • Memory • Understanding • Sensory and motor assessment				
Records accurately and reports any deviations				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to assess a patient experiencing pain				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Provides patient with privacy and reduces distraction				
Assesses patient's pain using the following guidelines: • History of present pain • Onset and duration • Location • Quality and character • Intensity • Aggravating or relieving factors				
Demonstrates knowledge of pain intervention strategies e.g. • Positioning • Administration of medication • Use of appropriate tools				
Observes and records physiological effects of pain such as tachycardia, change in BP, pallor, diaphoresis and tachypnea				
Documents pain assessment and reports				
Monitors outcome of interventions				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to assess the cardiovascular system				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gives patient a clear explanation of the procedure				
Gathers equipment				
Washes hands				
Provides privacy, comfort measures, position the patient supine or sitting upright				
Obtains a blood pressure reading				
Inspects the anterior chest				
Auscultates the apical pulse, obtains rate and rhythm				
Identifies each of the four auscultation sites, listens at each				
Assists patient to a position of comfort				
Assesses peripheral pulses				
Inspects the patient's extremities for indicators of cardio-pulmonary disorders as: • Cool, cyanotic or mottled digits • Clubbing of the fingernails • Thickened toenails • Skin discoloration on lower legs				
Checks each extremity for capillary refill, edema, over bony areas				
Documents and reports as part of the physical assessment				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖Ability to effectively maintain a sterile field				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gathers equipment				
Confirms the sterility of packages				
Positions patient comfortably				
Gives explanation for the procedure				
Washes hands aseptically				
Uses clean, sterile gloves to comply with universal precautions				
Performs required procedure using principles of aseptic technique				
Cleans, replaces and disposes of equipment appropriately				
Documents and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to care effectively for a patient with a wound				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Recognizes healthy/necrotizing tissue				
Demonstrates understanding of the process of wound healing				
Liaises with and seeks advise from wound care nurse				
Gathers equipment for use during procedure				
Gives a good explanation for the procedure				
Washes hands				
Prepares room to provide privacy for patient and minimize embarrassment				
Positions patient comfortably, administers analgesia if required and ordered				
Applies protective apparel such as plastic apron, mask and gloves				
Removes soiled dressing				
Disinfect hands				
Establishes a sterile field				
Irrigates wound, assess wound				
Applies dry dressing to the wound to ensure optimal absorption				
Secures dressing with selected tape				
Cleans, replaces and disposes of equipment appropriately				

Competency Statement: ❖ Ability to care effectively for a patient with a wound (cont'd)				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Documents and reports relevant information, including appearance of the wound and drainage, • Type of dressing applied • Patient's response to the procedure • Date and time				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖Ability to assess the blood glucose level of the patient				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gives patient a clear explanation of the procedure				
Gathers equipment				
Washes hands (clean gloves are used to comply with universal precautions)				
Encourages patient to wash hands				
Selects and cleans site				
Prepares the glucometer, as per manufacture's instructions				
Obtains peripheral blood				
Cleans, replaces and disposes equipment appropriately				
Washes hands				
Teaches patient about blood sugar levels				
Documents and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖Assists in ambulating patients safely				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gives patient a clear explanation of the procedure				
Identifies safety consideration				
Gathers equipment, assistive devices (walkers, cariers, crutch walking)				
Assists the patient appropriately				
Documents and reports relevant information				
Other				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively and safely assist the patient with their elimination needs				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assesses patient's ability to be independent				
Gives patient a clear explanation of procedure (tact and consideration are needed so the patient's embarrassment about sights, sounds, and odors is minimized)				
Gathers equipment as required.				
Washes hands				
Positions patient appropriately, providing privacy				
Assists patient to use commode, urinal, bedpan				
Perennial care				
Provides equipment for hand washing				
Disposes of excreta				
Obtains urine (if ordered or routine) for urine analysis				
Washes hands				
Documents and reports any abnormalities as outputs				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively maintain a patient's joint mobility or teach patient to do so				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gives patient a clear explanation of the exercise				
Considerations for implementation are understood				
Assesses patient's ability to move each joint				
Gathers and adjusts equipment prior to initiation of procedure				
Washes hands				
Assists patient to move each joint through its entire range of motion.				
Teaches patient to accomplish range of motion exercise with minimal assistance				
Encourages patient to do activities of daily living which increases the range of motion of all joints				
Documents and reports on range of motion exercises, which includes an initial rotation of the joint exercised along with any changes noted.				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to maintain personal hygiene in a dependent patient				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assesses patient for ability to apply self care				
Discusses personal hygiene needs and preferences with patient				
Shows respect for patient cultural preferences				
Ascertains and honors patients preferred items for personal care				
Gathers equipment as determined during assessment				
Washes hands				
Dons' protective apparel (such as gloves, plastic apron).				
Provides privacy, alters bed height, attends to environmental temperature and position patient's to facilitate care.				
Cleans, replaces and disposes of equipment appropriately				
Documents and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Pre-requisite for this statement: New Nurse Graduate to complete and pass the MOH –Mandatory Medication competency.

Competency Statement: ❖ Ability to effectively and safely administer medication by the following routes:				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
1. Oral Medication				
Verifies physician's order prior to administering the medication				
Washes hands				
Abides by rules and regulation set by facility and MOH when administering medication • Legal responsibility • Calculating accurate dosages • Drug names and classification				
Assessment of the physiological function that the drug is expected to effect, e.g.: • Pain assessment prior to administering analgesia • Pulse assessment prior to administering Digoxin • BP assessment prior to administering an antihypertensive				
Documents and reports relevant information				
Uses the five 'rights' to administer the medication and assists patient to take medication				
Documents and reports appropriately				
Cleans, replaces and returns equipment				
Others				

Medication Calculation:

_____
_____
_____
_____
_____
_____

Remedial:

_____
_____
_____
_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively and safely administer medication by the following routes (cont'd):				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
The following are specific to the parenteral route: • Safety • All injections require non-touch technique • Ampoules, empty vials, needle and used syringes are discarded in sharp containers				
2. Intramuscular and subcutaneous				
Locates and assesses appropriate site				
Safely administers medication to maximize effects and minimize discomfort				
Documents and reports relevant information				
Others				
3.Via Burette				
Inserts a burette into a new IV fluid bag				
Injects medication into burette				
Sets rate of IV				
Attaches medication label				
Returns to assess the patient during administration of medication				
Documents and reports relevant information				
4.Via IV Container				
Assesses the patient and IV site				
Selects and checks drug with 2nd nurse				
Calculates medication and IV flow-rate				
Prepares the syringe with medication				
Injects medication into the IV container				

Competency Statement: ❖ Ability to effectively and safely administer medication by the following routes (cont'd):				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
4.Via IV Container (cont'd)				
Prevents distractions whilst preparing medication				
Wears gloves as self protection				
Cleans, replaces and disposes of equipment appropriately				
Washes hands				
Labels IV container as per policy				
Documents and reports relevant information				
Other				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively administer ophthalmic medication				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Verifies written order,				
Identifies eye to be treated				
Gives patient a clear explanation of procedure				
Gathers equipment prior to the procedure				
Provides privacy, comfort measures				
Washes hands and dons gloves				
Prepares equipment in a non-touch technique				
Cleanses the eyes as ordered				
Positions patient				
Pulls lower lid down with non-dominant hand				
Instills drops into conjunctival sac				
If using ointment: squeezes a small amount of ointment out and discards				
• Squeezes a small ribbon of ointment into lower conjunctival sac • Asks patient to roll their eyes behind closed lids				
Cleans, replaces and disposes of equipment appropriately				
Documents and reports relevant information				
Others				

Remedial:

_____
_____
_____
_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively and safely monitor a patient with a blood transfusion				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Demonstrates knowledge of blood groups and cross matching				
Demonstrates knowledge of blood products				
Gathers equipment				
Explains procedure and its benefit to the patient				
Washes hands				
Establishes an IV Infusion with normal saline (IV access is established as per the policy followed by facility)				
Records vital signs				
Identifies the patient and blood product according to policy				
Monitors the patient				
Disposes of the blood unit according to facility policy				
Continues to monitor patient				
Documents and reports relevant information as per facility policy				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to use non-pharmacological interventions for pain relief: provide for dry heat and cool therapy				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assesses patient				
Verifies there are no contraindications				
Gives patient a clear explanation of procedure				
Prepares equipment prior to procedure				
Washes hands				
Provides privacy, comfort measures				
Prepares hot or cold pack as appropriate				
Wraps the hot or cold pack in a protective cover, secures with tape				
Places wrapped pack on the body part				
Times the treatment				
Monitors treatment site				
Completes the treatment as prescribed and assesses for pain				
Documents and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively and safely suction oropharynx / nasopharynx of a patient				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Reviews patient respiratory assessment over the past 24 hours.				
Gives a clear explanation to the patient of the purpose of the procedure and the sensations that will be felt				
Washes hands				
Positions the patient				
Assesses patients vital signs				
Gathers equipment				
Disinfects hand				
Turns suction device on and sets regulator to appropriate setting				
Opens sterile packs using aseptic techniques				
Dons sterile gloves				
Attaches catheter tip to suction tubing and test equipment				
Enters nasal cavity and suction				
Changes suction catheter				
Enters oropharynx and suction				
Cleans, replaces, and disposes of equipment appropriately				
Washes hands				
Document and reports relevant information including patient's breathing status following the procedure				
Others				

Remedial:

_____
_____
_____
_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively and safely suction the patient with an endotracheal tube or tracheostomy				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assesses the patient, respiratory status over the past 24 hours				
Reviews patients baseline vital signs				
Observes for signs and symptoms of lower airway obstruction				
Gives a clear explanation to the patient of the purpose of the procedure and the sensation that will be felt				
Gathers equipment relevant to procedure, prior to actual use on patient				
Washes hands				
Patients who are able, place in a comfortable position				
Turns suction device on and set regulator to appropriate setting				
Disinfects/washes hands				
Opens sterile packs using aseptic technique to establish a sterile field				
Dons sterile gloves to maintain sterility of the suction catheter				
Attaches catheter tip to suction tubing and tests equipment				
Hyper-oxygenates the patient, lubricates and inserts catheter				
Applies suction				
Replaces oxygen therapy and reassesses respiratory status				
Turns suction device on and set regulator to appropriate setting				

Competency Statement: ❖ Ability to effectively and safely suction the patient with an endotracheal tube or tracheostomy (Cont'd)				
Cleans, replaces and disposes of equipment				
Washes hands				
Documents and reports relevant information				
Others				

If required: Change tracheostomy dressing

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to effectively and safely care for a patient with tracheostomy tube				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Reviews patients respiratory status for the past 24 hours				
Gives patient a clear explanation of procedure				
Washes hands				
Collects equipment				
Places oxygen and humidification sources near to the stoma (if required)				
Assesses the patient				
Positions patient				
Prepares the tracheostomy care kit				
Suctions the tracheostomy (refer to tracheostomy suction skills)				
Removes the dressing				
Cleanses and dries the stoma site and dress with dry gauze				
Changes tracheostomy ties and secures				
Provides oral hygiene				
Cleanses, replaces and disposes of equipment appropriately				
Washes hands				
Documents procedure and the patients response to the procedure				
Reports any abnormalities				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖Ability to manage patient with chest drains / underwater seal drainage				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assesses/reviews patient's respiratory status for the past 24 hours				
Gives patient clear explanation of procedure, reassures the patient				
Gathers equipment used in care of patient with a chest drain				
Maintains safety considerations (as per facility policy) at the beside, such as a set of two padded clamps, or petroleum gauze dressing				
Assesses the underwater seal drainage system hourly • Underwater seal chamber is below the level of the chest • Tubing is free of kinks, or other external obstructions to allow for free drainage • Connections are securely taped				
• Monitors each of the following (according to facility/unit policy) • Observes the dressing for drainage intactness • Notes amount and color of drainage • Observes fluctuation of the fluid level • Checks the suction setting to remain as ordered.				
Washes hands				
Assesses patient's respiratory status				
Assesses vital signs				

Competency Statement: ❖Ability to manage patient with chest drains / underwater seal drainage (cont'd)				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assists the patient to change position (as ordered)				
Teaches and encourages patient to do coughing and deep breathing exercises				
Washes hands				
Documents and reports care given to patient with results of assessments				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to provide oxygen therapy via nasal cannula or various masks				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Assesses patient's respiratory status				
Assists patient to relax and become cooperative (if agitated or restless)				
Gathers and prepares equipment				
Washes hands				
Positions patient to breath more easily (positioning depends on the patients condition and level of consciousness)				
Attends to safety precautions				
Applies the appropriate oxygen delivery device				
Monitors patient during therapy				
Regularly inspects equipment				
Documents and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to monitor a patient using pulse oximetry				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Demonstrates the use of this monitoring device for assessment of the effectiveness of oxygen therapy				
Attends to safety precautions, e.g. pulse oximeters should not be applied to a limb that has a pressure dressing or intravenous line or a BP cuff				
Explains procedure and reassures patient				
Gathers equipment				
Washes hands				
Selects and prepares appropriate site				
Attaches sensor probe according to manufacture's instructions				
Connects probe to oximeter monitor, sets alarms at level appropriate for the patient				
Demonstrates ability to care for the equipment				
Monitors patient appropriately				
Cleans, replaces, and disposes of equipment appropriately				
Washes hands				
Documents SpO_2 along with other vital signs				
Document and reports relevant information				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to care for a catheterized (urinary) patient				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gives patient a clear explanation of procedure				
Assesses patient status				
Gathers equipment				
Provides privacy				
Washes hands				
Positions patient, obtains assistance if needed				
Provides perineal care (as per facility policy)				
Provides catheter care (as per facility policy)				
Monitors urine volume				
Demonstrates uses of catheter bags, flushes catheters				
Detects problems which may arise with indwelling catheters				
Washes hands				
Provides appropriate patient education				
Documents and reports nursing care in plan of care				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖ Ability to obtain a recording from a 12 lead ECG				
Performance Criteria	**Self Assessment**	**Validation**	**Comments**	**Initials Ppt./Date**
Gives patient a clear explanation of procedure				
Gathers appropriate equipment				
Washes hands				
Provides comfort measures to patient				
Attaches limb and chest electrodes to the patient				
Prepares ECG machine according to manufacture's instruction				
Ensures that each reading is as accurate as possible				
Records the ECG				
Shows significance of tracing to an experienced Registered Nurse				
Assists patient to a comfortable position				
Cleans, replaces and disposes of equipment appropriately				
Washes hands				
Documents and reports relevant information including actual recording				
Others				

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Patient teaching is considered an integral part of the role of the nurse. The following is a brief description of the process involved.
Please refer to the appropriate resources to further support and develop this role.
Changing values and beliefs and behavior is not easy and requires time, effort and a well-motivated patient.

Competency Statement: ❖ Ability to effectively teach a skill to a patient

Performance Criteria	Self Assessment	Validation	Comments	Initials Ppt./Date
Identifies nursing diagnosis				
Assesses patients knowledge of the health problem(s)				
Assesses readiness, willingness and ability to learn.				
Explains purpose of the teaching session				
Identifies goals of the teaching session				
Identifies teaching methods and instructional aid				
Provides information at the patient's level				
Creates an appropriate learning environment				
Applies identified teaching methods				
Gives feedback throughout the teaching of the patient				
Encourages the patient to use the new skill/information				
Reinforces positive behavior				
Documents and reports teaching provided for continuity of care				
Seeks advise from other health care personnel for further teaching				
Evaluates outcome and ensures appropriate follow-up				
Others				

Remedial:

_____
_____
_____
_____

Signature, Facilitator/Preceptor: _____

Date: _____

Additional Template for Clinical Skills Competency Tool is provided in the following pages.

Competency Statement: ❖

Performance Criteria	Self Assessment	Validation	Comments	Initials Ppt./Date

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖

Performance Criteria	Self Assessment	Validation	Comments	Initials Ppt./Date

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖

Performance Criteria	Self Assessment	Validation	Comments	Initials Ppt./Date

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Competency Statement: ❖

Performance Criteria	Self Assessment	Validation	Comments	Initials Ppt./Date

Remedial:

_____

_____

_____

_____

Signature, Facilitator/Preceptor: _____

Date: _____

Reflective Diary

Framework to Maintain a Reflective Diary

Introduction
The reflective diary is intended to be your own personal record of what you have learnt through your practice/experience and during the period you are enrolled in the program. It is part of your professional development, whereby you will be able to share its contents with your facilitator and preceptor.

The content and structure of your diary is up to you. However, it is a mandatory component of the program. Although your facilitator will not ask to read it, he/she has to sign it to provide evidence that you are maintaining it. Your facilitator will sign it at each set or arranged meeting to monitor your progress.

Purpose
This tool is usefully used in the following:

- To provide you with a baseline for you to track your progress and development
- To help you evaluate what you have learnt
- To provide a context for you to reflect on your practice
- To provide a valuable resource to link to and develop your individual professional development plan.

Format
The diary could be kept in the form of:

- A note book
- A traditional diary

It is difficult to suggest what should go in a reflective diary, but you might consider some or all of the following guidelines, which are intended to support you as you start on this exercise. During the course of your clinical experience you may develop your own reflective style and can adapt the following to meet your own individual needs.
You should start on you reflective diary immediately---so go out and get that notebook.

Throughout the time frame of the program you are expected to provide and discuss with your preceptor/facilitator two (2) reflective diaries.

Guidelines

- What aspect of my nursing practice am I reflecting on
- State name and type of activity
- Make notes answering the following suggested questions:

1. What have I done? (*A description of the activity or what has happened*)
2. How did I behave? (*A description of behavior and role in what has happened*)
3. What have I learnt from this activity?
4. Did my learning contribute to my professional knowledge and competence?
5. What can I apply immediately to my practice and client care? (*Work-based practice outcome*)
6. Has what I have experienced and learned changed my attitude towards (or feeling about) myself/other people/nursing? (*Effects of Learning*)
7. Is there anything I did not understand or need to explore further? (*Clarify learning*)
8. What else do I need to do/know to extend any professional development in this area?
9. What other needs have emerged from this activity that I could relate to my professional development plan (*Learning outcome*)

Formatted: Bullets and Numbering

Suggestion:
Revisit your answers. Did you learn anything new from this practice? What would you do differently next time?
There is no need to consider these every day, but it is important that you can address all or some of these at some point during the period that you keep the diary.

Individual Professional Development Plan

Individual Professional Development Plan

At certain stages throughout the program you will encounter situations and issues in which you can turn these encounters into challenges by developing objectives to overcome them.
The program has developed several objectives and plans to support you. The facility appraisal tool will ask you to set your own objectives.

The Individual Professional Development Plan is a tool to assist you in identifying and documenting encountered issues that relate to your nursing practice, and develop short-term objectives to meet your immediate learning need. Your facilitator and preceptor will support you in structured meetings to guide you through the process.

Guidelines

The following are some suggestions on how you could make the development plan facilitate your learning:

- Write things down in point form.
- The plan is a tool to help you focus on your learning needs, develop skills to meet those needs and support your communication of those needs between yourself, your preceptor/facilitator and Head Nurse.
- Use the reflective diary to help you review your current development needs
- Use a quiet place and free time to complete the plan
- Be realistic in what you want to achieve and consider things you can do within the time frame of the program (6 months)
- Set yourself a small number of targets which are manageable
- Review your progress regularly with your preceptor/ facilitator and Head Nurse (if you feel comfortable to do that)
- Use this plan to set new targets / goals as you progress within practice

There are three plans in this hand book, whereby completing each plan at the set times:

- **One month after starting the program**
- **At four months while in the program (facility appraisal at three months period of employment)**
- **At six months on completing the program (this may assist you with your yearly appraisal)**

Form E

Individual Professional Development Plan

Date: _____ (At one month)

Development Need	Plan to meet Need	Review Date	Recommendation by Facilitator / Preceptor

Outcome of discussion/comments with facilitator/preceptor/others[3]

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of NNG: _____ _____

Signature: _____ **Date:** _____

Name of Facilitator/Preceptor/ others: _____

Signature: _____ **Date:** _____

***Please Note**: If the Facilitator / Preceptor feel the need to set other dates to discuss the progress plan, they may do so in coordination with the New Nurse Graduate.*

Others[3]: Nursing staff such as a Head Nurse, Unit Manager or Senior Charge

Form E

Individual Professional Development Plan

Date: _____ (At four months, to review progress)

Development Need	Plan to meet Need	Review Date	Recommendation by Facilitator / Preceptor

Outcome of discussion/comments with facilitator/preceptor/others

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of NNG: _____ _____

Signature: _____ **Date:** _____

Name of Facilitator/Preceptor/ others: _____

Signature: _____ **Date:** _____

***Please Note**: If the Facilitator / Preceptor feel the need to set other dates to discuss the progress plan, they may do so in coordination with the New Nurse Graduate.*

Form E

Individual Professional Development Plan

Date: _____ (At six months, final discussion and recommendation)

Development Need	Plan to meet Need	Review Date	Recommendation by Facilitator / Preceptor

Outcome of discussion/comments with facilitator/preceptor/others

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of NNG: _____ _____

Signature: _____ **Date:** _____

Name of Facilitator/Preceptor/ others: _____

Signature: _____ **Date:** _____

***Please Note**: If the Facilitator / Preceptor feel the need to set other dates to discuss the progress plan, they may do so in coordination with the New Nurse Graduate.*

Notes:

Notes:

Notes:

Things to remember:

Things to remember:

Medication Calculation Sheet:

Medication Calculation Sheet:

The Journey Continues

Reflecting on your experience gained during the program period, we expect that you have developed new performance skills, attitudes and gained new knowledge which you have found and will find valuable in the future as a nurse.

From now onwards, your development and the speed of your development will be influenced by many factors which includes your attitude towards further experiences, interaction with people, exposure to further learning opportunities.

We wish you a prosperous future in nursing as a career. We believe that you will continue to develop and build on your knowledge and experience, in whichever direction you choose to succeed.

Section Head
Emirati Nurse and New Graduate Development
Federal Department of Nursing


In Support Of
the New Nurse Graduate