JÖNKÖPING UNIVERSITY
School of Health and Welfare

Supervisor and Student Memorandum – Clinical placement

Course

Gerontological and geriatric nursing, 9 credits

Semester 4

2026-10-25

Table of contents

Implementation of clinical placement **3**
Authorisation for access to computer systems .....
Weekly planning during clinical placement **3**
Design of clinical placement **4**
Required models of the course **4**
Learning plan for clinical placement **4**
Activities during clinical placement **4**
Reflection seminar **4**
Assessment during clinical placement **5**
Activities during clinical placement **5**
Appendix 1 - Medication management matrix **8**

Implementation of clinical practice

This memorandum provides support for supervisors and students. The course has 4-week clinical placement. The placement period (VFU) spans four weeks, during which the student pair is at their placement site four days a week, totalling128 hours. Any weekday can be used, except Friday, as other course components take place then. However, the VFU period should not be compressed; it should remain approximately four days per week. The Working Hours Act must be followed regarding rest between shifts and breaks during each work session. The students have a clinical placement in the health care function in municipalities in Jönköping County.

The weekly planning is a structure for implementing Peer Learning in concrete supervision. Allow the students to prepare, read, watch, learn and try for themselves. Reflect on a regular basis during the day with the students. As a supervisor, you are responsible for leading and implementing nursing together with the student pair. Schedule times for individual discussions and feedback during the first week and final assessment during the second week.

The students work together while providing nursing care. The work assigned to the students is always divided within the student pair, with one implementing and one observing. Students exchange roles in the next assignment. The students take a person-centred approach. Learning occurs incrementally, with students caring for a smaller number of patients initially and a larger number as their training progresses. Consideration is naturally given to patients' needs for care and the complexity of the case.

Nothing may be done to or administered to a patient without the approval of the responsible supervisor.

Authorisation for access to various computer systems

All students need to have a login to the computer systems being used.

Weekly planning during clinical placement

Weekly planning is to be established by the students in consultation with the supervisor regarding what they are expected to be able to perform. The student participates in the nursing of the patients handled by the work team, but they should focus on a few patients at the beginning and increase the number during the four weeks. Focused content is described under the heading *Design of clinical placement*.

During the course's clinical placement, students are to translate their theoretical knowledge into practical knowledge and gain experience of geriatric nursing. Assessments are to be based on standardised methods studied in previous courses and tools such as *(L) -ABCDE, Vital Parameters (NEWS), SBAR, Senior Alert Preventive Care, pain estimations* and *the VIPS documentation tool*. The students are to participate in the documentation of nursing together with the supervisor in a relevant way and according to the applicable regulations.

The following areas are examples of previously studied subjects that the student is now expected to know and develop: verifying identity, interacting with patients and communication, confidentiality, basic hygienic routines, basic nursing, ethics, documentation, describing nursing care in connection with failing health, administering medication according to applicable regulations under supervision. In addition, the students have reflected on their own values and attitudes and the care environment in the meeting with patients with failing health and those close to them.

The students carry out activities designed for the intended learning outcomes of the course. Activities during clinical placement are designed to meet the student's expected level of knowledge, in this case semester 4. The activities are designed to correspond with some of the course's intended learning outcomes, and the student relates to the course's intended learning outcomes when activities are carried out. Activities are specified in this document on page 4.

Design of clinical placement

During the clinical placement (four weeks), the students concentrate on the daily nursing for geriatric patients. Like the methodological module, nursing is provided based on the theoretical knowledge studied in current and previous courses.

The student is to:

- Practise interacting with and communicating with patients and relatives. In each module, practise thinking about how attitudes and values affect the way we interact with patients.
- Identify nursing needs; formulate nursing actions based on needs and goals. Implement and evaluate.
- Identify nursing needs based on cognitive impairment and multimorbidity.
- In addition to previously practiced areas (see students learning plan) also practice dressing wounds and compression treatment.
- Document different areas in the medical record, such as nursing status (data collection), nursing diagnosis, nursing goals, nursing actions, evaluation
- Use quality registers and risk assessments, such as: Senior Alert (DFRI, MNA, Norton, ROAG), Swedish Palliative Register, Swedish BPSD Register.
- Conduct medication management – preparation, identity verification when administering and medical documentation. What laws are there regarding medications and delegation?

Required modules of the course

During the course the student completes a number of required modules. They include drawing up a learning plan prior to the on-site training, carrying out activities and actively participating in a reflection seminar during the on-site training.

Keeping a list of thoughts to follow developments is also recommended but not required. A diary or journal includes the student's individual thoughts related to clinical placement.

Learning plan for clinical placement

Students have a learning plan with them prior to the clinical placement with the supervisor at the training site. The supervisor is to take note of the learning plan to better understand the student's past experiences, goals, expectations and learning strategies. Students have great leeway to express wishes about what they want to be trained in and focus on during the on-site training if given the opportunity. Students then submit their learning plan again through Canvas. It is to be made available to the supervisor about three days before the beginning of clinical placement.

Activities during clinical placement

All activities that have been developed for the course need to be completed during the specified clinical placement period. Activities for ther clinical placement period are specified in this document on pages 5-7. If any activity cannot be performed, then the supervisor is to guide the student pair in reflecting on the relevant activity during one of the students' last days of the clinical placement period. This should be based on risks/benefits in the given situation, what material may be needed, what in particular needs to be considered and so on.

Reflection seminar

A clinical lecturer (CL) and/or assistant clinical lecturer (ACL) participate in these seminars. The students are summoned to the reflection seminar by the clinical lecturer. The student pair may be separated during these sessions. If necessary, alternative solutions for reflection seminars can be used, such as Skype meetings. This may depend on accessibility and distance.

The reflection seminar takes place on the middle of the clinical placement period.

The student pair prepares for the reflection seminar by completing activity 2 and 4 together. At the reflection seminar, students openly share experiences from clinical placement with each other. These experiences are considered in light of the intended learning outcomes below, focusing on promoting health and prevent suffering for the older person.

Intended learning objectives being covered:
- describe geriatric nursing where health is failing and for health promotion

The reflection seminar is a required meeting. In case of absence, an additional reflection seminar during the semester will be provided. The clinical lecturer makes note of the absence in the learning platform used at the school and notifies the course coordinator.

Assessment during clinical placement
Assessment of the student during the on-site training is done with the help of the AssCE assessment tool discussion material. Fifteen factors are to be highlighted during the on-site training period. Continuous communication and feedback between supervisor and student are important. In the end of week two a mid assessment is made based on the AssCe assessment tool. In the forth week the final discussion takes place based on AssCe.

Final assessment discussions are conducted by the supervisor and the student. The CL and ACL will not be included in the final assessment discussion. When there is a risk that a student will fail during the on-site training, the CL and ACL or person responsible for on-site training are to be informed so that an individual educational action plan can be drawn up together with the student for the intended learning outcomes that have been assessed as *Insufficient goal attainment*.

Activities during clinical placement
The purpose of the activities is to structure the student's learning during clinical placement and to help the student achieve the course's intended learning outcomes. All activities are connected in different ways to the nurse's core competencies. As a student, you are responsible for doing the activities during your clinical placement. Carrying out all activities during the clinical placement period is required; you and your student partner choose the order in which they are done.

Activity 1 - Conversation and understanding

The purpose of the conversation is to use questions to help you understand how residents perceive themselves and their lives, those closest to them and their surroundings and sources of joy in everyday life. Together with the supervisor, you select a patient with whom you want to talk. Ask the patient if you may have a conversation in which you ask questions that touch on the patient's life situation.

Examples of questions:

- Tell me what your day is like.
- What can you do yourself/what do you need help with?
- What is a really good/bad day like?
- Tell me how you think your living situation works.
- Talk a little about the people closest to you/relatives – children, siblings, friends and so on.
- Talk a little about what you have worked with, where you have lived and what experiences you have had in your life.
- How would you describe yourself? How well do you feel that your body is working properly?
- What does health mean to you?
- What makes you happy? What do you think about the future?

The conversation is primarily an exercise in listening to and sharing another person's story to see the person in his or her entire context. That means you do not make any value judgements at all during the conversation. Immediately after the conversation, write down everything you remember about how the person answered the questions, how the person seemed to perceive the conversation. Also write down your perception of the conversation. Reflect with the supervisor and student partner.

Intended learning objectives being covered:

- Describe and demonstrate an understanding of ageing and the individual from a life cycle perspective.
- Demonstrate the ability to see the individual from a holistic and life cycle perspective to promote health in connection with co-production in nursing of the elderly.
- Reflect on how attitudes and values affect the way older people are interacted with.

Activity 2 - Identifying nursing needs in cases of cognitive impairment

Together with your supervisor, select a patient who has been diagnosed with cognitive impairment. Make an updated status report on one or several keywords through conversations with the patient, observations, conversations with staff/relatives. Based on the data you receive during the conversation, go back to the patient's medical record and see if you found anything that had not been previously observed or if something needs updating.

Intended learning objectives being covered:

- Describe nursing in cases of failing health and nursing to promote health among the elderly.
- Identify needs and apply co-production in nursing that promotes health and relieves suffering in the elderly and those close to them.

Activity 3 - Medication management

The assignment at the training site is to select a person, together with your supervisor, who has at least three medications on her or his medication list. To do this, you need to use www.fass.se. Review the following and make notes in the table (Annex 1).

- For each of the medications in the attached table, fill in the medication's brand name, the generic substance and the class of medications to which it belongs, such as antidepressants or diuretics.
- Why is the person being treated with this medication? This should be stated on the person's medication list.
- On the FASS website, study the indication for treatment with the medication.
- Determine how each medication is to be administered, and check in the FASS website to see if there are ways to administer the medication other than the way prescribed for the person.
- Note what dosage is to be administered to the person and when.
- Calculate how much of each medication the person takes per day, such as mg, g, ml and so on.
- What is the maximum dosage for the medication according to FASS?
- What are the three most common side effects?
- If there is any interaction risk with the medications, note an interaction risk with the particular medications.
- Speak with the person whose medication list you have reviewed. Ask which medications the person is being treated with and if the person knows the reason why she or he is taking the medication. Write a few short sentences about whether or not you got the impression that the person was informed/had knowledge of her or his medication treatments.

Intended learning objectives being covered:

- Under supervision, administer medications and evaluate, report and record medication effects and side effects according to current regulations.

- Demonstrate understanding of medication treatment and polypharmacy among the elderly.

Activity 4 - Risk diagnoses

The assignment is to choose a person who is suitable for the assignment together with your supervisor. To do the assignment, you need to use all the assessment instruments included in Senior Alert (ROAG, MNA, DFRI, Norton).

Speak with the person to collect data about the relevant areas within the respective assessment instruments in Senior Alert. Use secondary sources to supplement the information (medical record entries, medication list, relatives, other professions). Formulate risk diagnoses based on the information obtained. Use the PES structure but exclude symptoms. Prepare nursing actions based on suggestions from the assessment instruments. This is done in consultation with the patient. Document nursing actions and nursing goals in the medical record. Inform affected personnel about measures you do not perform yourself (delegated measures). Reflect together with the supervisor and student partner.

Intended learning objectives being covered:

- Identify and assess the resources and nursing need of the person receiving nursing care from a holistic perspective and propose, plan, carry out and follow up nursing actions to achieve a healthy outcome.
- Communicate and interact with the person receiving care, relatives and employees – see activity team collaboration based on a person-centred approach.
- Keep nursing medical records based on accepted documentation models.
- Apply the reflection process in different nursing processes.

	Medicine I	**Medicine II**	**Medicine III**
Sales name			
Generic substance			
Group affiliation			
Cause for treatment			
FASS indication			
Method of administration			
Methods of administration according to FASS			
Ordination			
The person's total intake / day			
Max dose			
Side affects according to FASS			
Interaction risk			
Results of discussions about how informed / what knowledge the person has about their own medications			