University of New England

School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

THIRD YEAR
HSNS 364 Professional Practice: Application of Integrated Care

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	St George Hospital
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	Sue Watson
PRECEPTOR CONTACT TELEPHONE:	0400 400 951
LOCATION (eg: town name):	Kogarah
WARD/UNIT:	Renab ward
PLACEMENT DATES:	FROM 27/7/20 TO 31/7/20

For more information, additional copies of documents or questions related to your Clinical Record Book please contact the Clinical School staff.

YOUR CLINICAL RECORD BOOK

Your Clinical Record Books have been designed to provide a record of your clinical placement experience. This record will provide you with guidance for your clinical development. ou are personally responsible for your Clinical Record Book and you are required to follow the following instructions

- Show your clinical book to your Clinical Partner/Facilitator when you commence your clinical placement to discuss your requirements for the placements.
- Keep this Clinical Record Book with you at all times during your clinical placements.
- Keep it clear from food and drinks.
- Do not use white out/ correction fluid or tape under ANY circumstances
- *Whilst on Clinical placement if no one is available to complete your clinical placement booklet, contact the Clinical Coordinator and they will negotiate with the agency for a report to be completed and forwarded to this university.*

CHECK LIST

DO THIS NOW

- ❑ Write your name, contact telephone number and student number on the front cover of this book.
- ❑ Complete your goals for this placement in your Clinical Record Book

DO THIS EVERY DAY

- ❑ Complete your ***Daily Attendance Time Sheet*** and have your Clinical Partner/Facilitator sign it.

DO THIS BEFORE YOU LEAVE THE PLACEMENT

- ❑ Make sure your Clinical Partner/Facilitator has signed your ***Procedures Check List*** for procedures performed during this placement.
- ❑ Ensure your Clinical Partner/Facilitator has completed and signed your ***Australian Nursing Standards Assessment Tool (ANSAT)***.
- ❑ Review your *Personal Goals* set for this placement; date those you have achieved. Ask your Clinical Partner/Facilitator to help you identify goals for your next placement (if applicable).

AT THE CONCLUSION OF THIS PLACEMENT

- ❑ **Submit your completed clinical record book into the Moodle site.**
- ❑ **You MUST keep your original clinical record book as it may be called on for auditing purposes.**

CONTACT INFORMATION

The Clinical Office

Clinical Placement Asistants	Tania Robb Kellie Lockyer Alisa Kennedy
Contact details:	Phone: 6773 4388 Email nursingplacements@une.edu.au
Clinical Placement Manager:	Jillian Fitzgerald
Contact details:	Phone: 6773 4388 Email fcpwil_coord@une.edu.au

Students are reminded to contact the Clinical Office Staff via the AskUNE system.

If we are unable to answer your call please leave your name, brief description of message, contact details and time you called and we will return your call as soon as possible.

Clinical Coordinator - Academic:	Zach Byfield
Contact details:	Email: fcpnursing_academic@une.edu.au Mobile: 0407 414 577

CLINICAL LEARNING GOALS

Clinical goals can be viewed as a well thought out itinerary for your learning. They can give you guidance through clinical experience, keep you focused on the most important areas and can be used to communicate to others, such as your preceptor or Clinical Facilitator RN. They can offer information such as what you hope to achieve during your clinical experience and where your interests lie.

Clinical goals may be prescribed (such as the competencies you need to achieve in your clinical placement book and you may also develop your own. In any sense the goals should be SMART (Fowler, 1998, cited in Levett-Jones & Bourgeois, 2011 2nd Edition).

S Specific

M Measurable

A Achievable

R Realistic

T Timely

Learning goals help you become a safe, effective, competent and confident registered nurse. Your goals will become progressively more sophisticated as you proceed through the program and each semester they will build upon and consolidate what you have already learnt (Levett-Jones & Bourgeois, 2011, p77-78, 2nd Edition).

When developing clinical goals you should consider the following

What do I want to learn? (goal)

Why do I want to learn it? (rational)

How are you going to learn it? (strategy)

How are you going to prove that you have achieved your goal? (evidence)

Refer to the Text - Levett-Jones & Bourgeois, 2011, 2nd Edition, The Clinical Placement; an essential guide for students, p77-78 it has a good example of how to set out your clinical goals.

CLINICAL PLACEMENT ATTENDANCE RECORD

Day	Date	Time Start	Time Finish	Total Hours	Facilitator/ preceptor Name, Signature, and Designation
Week 1					
Monday	27/7	1300	2130	8	S. WATSON RN
Tuesday	28/7	1330	2200	8	[illegible] (RN)
Wednesday	29/7	1330	2200	8	S. WATSON RN
Thursday	30/7	1330	2200	8	S. WATSON RN
Friday	31/7	1330	2200	8	S. WATSON RN
Saturday					
Sunday					
Week 2					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
Week 3					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
Week 4					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

No crediting of sick days/missed days/public holidays must be 'made up' either on this or on future placements, before the completion of the degree

Goal What do I want to learn?	Rational Why do I want to learn it?	Strategy How am I going to learn it?	Evidence How am I going to prove that I have achieved my objective?
Collect a health history on a patient I am caring for	I wish to perform this skill as it allows the healthcare team to create an accurate Careplan.	Introduce myself to the pt, gain consent and ask about medical, social and family history.	Collect a health history on one of my patients and have my facilitator asses me and provide me with feedback.
Manage the care of a patient with a chronic or complex health history.	I wish to further my skills in caring for a complex patient as it is a critical part of nursing.	Work alongside an RN caring for a complex patient and fully invave myself in their care.	Create a care plan for a complex patient [redacted] have my RN review it for feedback + advice.
Effectively manage a patient load	I wish to further my skills in managing a patient load + becoming efficient in time management.	ensure that whilst I'm on placement I practice having a patient load which will help me to become more confident.	Successfully completing a shift after caring for multiple patients and getting all required tasks done for them.
Accurately respond to changes in a patients condition + recognise deterioration.	Failure to identify deterioration in a patients can result in increased illness, worsening morbidity and mortality.	I will learn this skill by implementing an A-G assesment on my pt's to determine any signs of deterioration.	Find a deterioration in a patient and express what actions I would take to a senior RN and get feedback.
Perform a clinical ISBAR handover on a patient I have been caring for all shift.	I wish to perfect this skill as good communication improves patient safety and reduces risk of error.	Practice writing out a handover using the ISBAR tool before communicating it to fellow staff members. Practice as often as I can.	Perform a succint, clear and concise ISBAR handover to a senior RN or my facilitator and recieve feedback + advice.

S. WATSON

PROCEDURE ACHIEVEMENT SUMMARY

The following lists the skills that the student nurse has received theoretical and/or practical education (i.e. their scope of practice)

A Registered Nurse is requested to sign and date the procedures in the appropriate column.

Students are expected to comply with local healthcare policy in the practice of any skill

Skills for consolidation this placement	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Collection of health history				
The initial and ongoing nursing assessment of a client/patient				
Managing the care of a client/patient with a chronic or complex condition	S. WATSON	31/7/20		
Managing an appropriate patient load	S. WATSON	31/7/20		
Document and interpret a basic care plan and integrated patient notes	A. KAUR	29/07/20		
Effective patient communication	A. KAUR	29/07/20		
General Assessment				
Assessing/recording/interpreting of vital signs (BP, HR, RR, SPO2, AVPU, Temp, Pain score)	A. KAUR	29/7/20		
Assessing/recording/interpreting of BGL	A. KAUR	29/7/20		
Assessing/recording/interpreting of GCS				
Assessing/recording/interpreting of height, weight and waist circumference				
Assessing/recording/interpreting of continual cardiac monitoring				
Admission of the patient across the lifespan and provision of support				
Responding to changes in a patient's condition (recognition of the deteriorating patient)				
Bladder scanning				
Comprehensive pain assessment				
Pressure area assessment				
Falls risk assessment				
Pre/Post-operative assessment				
Conduct and interpret a 12 lead ECG				
Respiratory assessment				
Cardiac assessment				
Abdominal assessment				
Musculoskeletal assessment				
Neurological assessment				
Mental health assessment				

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Infection Control				
Standard/additional precautions (including PPE)	A. KAN	29/07/20		
Hand hygiene	A. KAN	29/07/20		
Disposal of sharps	A. KAN	29/07/20		
Managing blood and body fluid spills				
Aseptic Technique/invasive devices				
Aseptic Non Touch Technique				
Collection of a specimen (MSU, CSU, Faeces, wound swab)				
Removal of an IVC				
Removal of sutures/staples/clips				
Wound care (including appropriate assessments)				
• Dry Dressing				
• Complex wounds (including irrigation, packing, etc)				
Insertion/removal/maintenance of an IDC				
Insertion/removal/management of a feeding tube (NGT/PEG)				
Management of a Central Line (PICC, CVL)				
Patient Care				
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)	A. KAN	29/07/20		
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, etc)				
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)				
Assisting with general elimination needs (toileting, bed pans, urinals, commodes)	A. KAN	29/07/20		
Assisting with elimination needs related to stoma care				
Assisting with mobility and use of mobility aids	A. KAN	29/07/20		
Assisting with pressure area care	A. KAN	29/07/20		
Assisting with lifting and positioning of patients using safe manual handling techniques	A. KAN	29/07/20		
Care of the immunocompromised person				
Care of the person under palliative care				
Basic life support				
Care of body after death				
Nasopharyngeal suctioning				
Culturally competent/culturally safe care				

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Communication and Documentation				
Patient education				
Clinical handover	S. Watson	3/7/20		
Medication administration (adults & children)				
Initiation and ongoing management of oxygen therapy (Face mask/Nasal Prongs)				
Initiation and ongoing management of intravenous fluids				
Initiation and ongoing management of Patient Controlled Analgesia (PCA)				
Calculate and administer doses of medications:				
• Oral	S. Watson	3/7/20		
• Sublingual/buccal				
• Topical/transdermal				
• PV/PR				
• Octic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous	A. Kang	3/07/20		
• Intravenous (bolus or infusion)				

ADDITIONAL ACTIVITIES

Record details of any additional activities such as in services or learning opportunities. Further pages can be copied/printed and added as required.

Name/Details of activity	Infection control in-service
Attachments (eg. Attendance certificate)	
Summary of learning What have you learnt? How the CPD activity contributes to your body of knowledge and skills?	
~~Learnt~~ consolidated learning in correct donning/doffing in PPE. Revised + become more knowledgeable in different contact precautions (droplet, airborn, contact)	
Outcomes How can you apply this learning to your work and integrate the knowledge and findings into your practice?	
I will apply this within my nursing practice when caring for all patients in my care and particularly those on contact precautions.	
Further learning What further learning could you undertake?	
Continuing to educate myself on the importance of infection control + wearing PPE. It is important I keep up up to date with latest policies + guidelines regarding infection-control.	

Name/Details of activity	
Attachments (eg. Attendance certificate)	
Summary of learning What have you learnt? How the CPD activity contributes to your body of knowledge and skills?	
Outcomes How can you apply this learning to your work and integrate the knowledge and findings into your practice?	
Further learning What further learning could you undertake?	

SUMMATIVE ASSESSOR FEEDBACK:

1. What has the student done well throughout this placement?

Millie has been actively engaged in this placement, competently carrying out all skills that fall within her scope of practice. She demonstrated good knowledge of the patients condition, plan of care and medications. Millie used a shift planner well to prioritize care and manage a patient load in a coordinated, organised and timely manner. Her handovers + progress notes were clear, concise and relevant.

2. What strategies can the student use to advance their learning in future placements?

To continue to build on your skills and knowledge (as you have been doing) in coordinating and managing the care of a group of patients, having good knowledge of all aspects of their care and their goals of care.

3. Any further comments?

Millie also demonstrated she was thinking critically + able to problem solve, and anticipate patient care needs. Her interactions were at all times respectful and dignified with both patients and staff. I also observed that Millie was safe in practice at adhered to infection control measures without prompting, adhered to the checks + rights of medication administration, and reported to, ~~the RN~~ and consulted with the RN appropriately.

SUPERVISOR COMMENTS:

Signature: _____ Date: 31.7.2020

STUDENT COMMENTS:

I thoroughly enjoyed my placement on the renab ward. I feel as though I have consolidated my clinical skills and achieved as many goals as possible. I felt as though I have become confident in managing a patient load and participating in the ongoing assesment of a patient

Signature: _____ Date: 31/7/20

Scoring rules:

- Circle N/A (not assessed) ONLY if the student has not had an opportunity to demonstrate the behaviour
- If an item is not assessed it is not scored and the total ANSAT score is adjusted for the missed item
- Circle ONLY ONE number for each item
- If a score falls between numbers on the scale the higher number will be used to calculate a total
- Evaluate the student's performance against the MINIMUM practice level expected for their level of education

Student Name:	Milly Shennan	**Student ID:**	220167227
Course Name / Code:	HSNS376	**Year Level:**	3rd
Clinical Setting / Ward:	Rehab Ward	**Placement Dates:**	27/7 → 31/7
Assessment type / date:	SUMMATIVE 31.7.2020		

Code: 1 = Expected behaviours and practices not performed
2 = Expected behaviours and practices performed below the acceptable/satisfactory standard
3 = Expected behaviours and practices performed at a satisfactory/pass standard
4 = Expected behaviours and practices performed at a proficient standard
5 = Expected behaviours and practices performed at an excellent standard
N/A = not assessed
****Note**: a rating 1 &/or 2 indicates that the STANDARD has **NOT** been achieved

Assessment item	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
• Recognise 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 - In your opinion as an assessor of student performance, *relative to their stage of practice*, the overall performance of this student in the clinical unit was:
Unsatisfactory ☐ **Limited** ☐ **Satisfactory** ☐ **Good** ☑ **Excellent** ☐

DISCUSSED: (YES) NO **ADDITIONAL PAPERWORK:** YES (NO)
DATE: 31.7.2020
NAME: SUSAN WATSON
SIGNATURE: S Watson

*complete this section ONLY if this is a summative assessment
Passed: (YES) NO

Information on the following pages are provided as a guide for students and facilitators in the completion of this record book. This page and the following do not need to be submitted into the Moodle site.

1. THINKS CRITICALLY AND ANALYSES NURSING PRACTICE

➢ *Complies and practices according to relevant legislation and local policy*

- Follows policies and procedures of the facility/organisation (e.g. workplace health and safety / infection control policies)
- Maintains patient/client confidentiality
- Arrives fit to work
- Arrives punctually and leaves at agreed time
- Calls appropriate personnel to report intended absence
- Wears an identification badge and identifies self
- Observes uniform/dress code
- Maintains appropriate professional boundaries with patients/clients and carers

➢ *Uses an ethical framework to guide their decision making and practice*

- Understands and respects patients'/clients' rights
- Allows sufficient time to discuss care provision with patient/clients
- Refers patients/clients to a more senior staff member for consent when appropriate
- Seeks assistance to resolve situations involving moral/ethical conflict
- Applies ethical principles and reasoning in all health care activities

➢ *Demonstrates respect for individual and cultural (including Aboriginal & Torres Strait Islander) preference and differences*

- Practices sensitively in the cultural context
- Understands and respects individual and cultural diversity
- Involves family/others appropriately to ensure cultural/spiritual needs are met

➢ *Sources and critically evaluates relevant literature and research evidence to deliver quality practice*

- Locates relevant current evidence (e.g. clinical practice guidelines and systematic reviews, databases, texts)
- Clarifies understanding and application of evidence with peers or other relevant staff
- Applies evidence to clinical practice appropriately
- Participates in quality activities when possible (e.g. assists with clinical audit, journal club)
- Shares evidence with others

➢ *Maintains the use of clear and accurate documentation*

- Uses suitable language and avoids jargon
- Writes legibly and accurately (e.g. correct spelling, approved abbreviations)
- Records information according to organisational guidelines and local policy

2. ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS

➢ *Communicates effectively to maintain personal and professional boundaries*

- Introduces self to patient/client and other health care team members,
- Greets others appropriately
- Listens carefully and is sensitive to patient/client and carer views
- Provides clear instructions in all activities
- Uses a range of communication strategies to optimise patient/client rapport and understanding (e.g. hearing impairment, non-English speaking, cognitive impairment, consideration of non-verbal communication)
- Communication with patient/client is conducted in a manner and environment that demonstrates consideration of confidentiality, privacy and patient's/client's sensitivities

➢ *Collaborates with health care team and others to share knowledge that promotes person-centred care*

- Demonstrates positive and productive working relationships with colleagues
- Uses knowledge of other health care team roles to develop collegial networks
- Demonstrates a collaborative approach to practice
- Identifies appropriate educational resources (including other health professionals)
- Prioritises safety problems

➢ *Participates as an active member of the healthcare team to achieve optimum health outcomes*

- Collaborates with the health care team and patient/client to achieve optimal outcomes
- Contributes appropriately in team meetings
- Maintains effective communication with clinical supervisors and peers
- Works collaboratively and respectfully with support staff

➢ *Demonstrates respect for a person's rights and wishes and advocates on their behalf*

- Advocates for the patient/client when dealing with other health care teams
- Identifies and explains practices which conflict with the rights/wishes of individuals/groups
- Uses available resources in a reasonable manner
- Ensures privacy and confidentiality in the provision of care

3. MAINTAINS THE CAPABILITY FOR PRACTICE

➢ *Demonstrates commitment to lifelong learning of self and others*

- Links course learning outcomes to own identified learning needs
- Seeks support from others in identifying learning needs
- Seeks and engages a diverse range of experiences to develop professional skills and knowledge
- Supports and encourages the learning of others

➢ *Reflects on practice and responds to feedback for continuing professional development*

- Reflects on activities completed to inform practice
- Plans professional development based on reflection of own practice
- Keeps written record of professional development activities
- Incorporates formal and informal feedback from colleagues into practice

➢ *Demonstrates skills in health education to enable people to make decisions and take action about their health*

- Assists patients/clients and carers to identify reliable and accurate health information
- Patient/client care is based on knowledge and clinical reasoning
- Refers concerns to relevant health professionals to facilitate health care decisions/delivery
- Provides information using a range of strategies that demonstrate consideration of patient/client needs
- Prepares environment for patient/client education including necessary equipment

- Demonstrates skill in patient/client education (e.g. modifies approach to suit patient/client age group, uses principles of adult learning)
- Educates the patient/client in self-evaluation

➢ *Recognises and takes appropriate action when capability for own practice is impaired*

- Identifies when own/other's health/well-being affect safe practice
- Advises appropriate staff of circumstances that may impair adequate work performance
- Demonstrates appropriate self-care and other support strategies (e.g. stress management)

➢ *Demonstrates accountability for decisions and actions appropriate to their role*

- Provides care that ensures patient/client safety
- Provides rationales for care delivery and/or omissions
- Sources information to perform within role in a safe and skilled manner
- Complies with recognised standards of practice

4. COMPREHENSIVELY CONDUCTS ASSESSMENTS

➢ *Completes comprehensive and systematic assessments using appropriate and available sources*

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

➢ *Accurately analyses and interprets assessment data to inform practice*

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

5. DEVELOPS A PLAN FOR NURSING PRACTICE

➢ *Collaboratively constructs a plan informed by the patient/client assessment*

- Uses assessment data and best available evidence to construct a plan
- Completes relevant documentation to the required standard (e.g. patient/client record, care planner and assessment, statistical information)
- Considers organisation of planned care in relation to other procedures (e.g. pain medication, wound care, allied health therapies, other interventions)

➢ *Plans care in partnership with individuals/significant others/health care team to achieve expected outcomes*

- Collaborates with the patient/client to prioritise and formulate short and long term goals
- Formulates goals that are specific, measurable, achievable and relevant, with specified timeframe
- Advises patient/client about the effects of health care

6. PROVIDES SAFE, APPROPRIATE AND RESPONSIVE QUALITY NURSING PRACTICE

➢ *Delivers safe and effective care within their scope of practice to meet outcomes*

- Performs health care interventions at appropriate and safe standard
- Complies with workplace guidelines on patient/client handling
- Monitors patient/client safety during assessment and care provision
- Uses resources effectively and efficiently
- Responds effectively to rapidly changing patient/client situations

➢ *Provides effective supervision and delegates safely within their role and scope of practice*

- Accepts and delegates care according to own or other's scope of practice
- Seeks clarification when directions/decisions are unclear
- Identifies areas of own or other's practice that require direct/indirect supervision
- Recognises unexpected outcomes and responds appropriately

➢ *Recognise and responds to practice that may be below expected organisational, legal or regulatory standards*

- Identifies and responds to incidents of unsafe or unprofessional practice
- Clarifies care delivery which may appear inappropriate

7. EVALUATES OUTCOMES TO INFORM NURSING PRACTICE

➢ *Monitors progress towards expected goals and health outcomes*

- Refers patient/client on to other professional/s
- Begins discharge planning in collaboration with the health care team at the time of the initial episode of care
- Monitors patient/client safety and outcomes during health care delivery
- Records and communicates patient/client outcomes where appropriate

➢ *Modifies plan according to evaluation of goals and outcomes in consultation with relevant health care team and others*

- Questions patient/client or caregiver to confirm level of understanding
- Updates care plans/documentation to reflect changes in care
- Uses appropriate resources to evaluate effectiveness of planned care/treatment

Search and Find

To assist you to familiarize yourself with each individual clinical area please locate the following equipment and supplies in the ward you have been placed in and write where they are found in the column provided.

	EQUIPMENT	LOCATION
1.	Fire Exits	Door left of the nurses station
	Fire Extinguishers and what fires they are used for.	Nurses Station
	Fire Blanket	Nurses station - hanging on the walls.
	Fire Hose	
2.	Emergency Arrest Buzzer	Beside (on the wall)
	Emergency Trolley - Adult	Nurses Station
	Emergency Trolley - Paediatric	
3.	Defibrillator	On the resus trolley
4.	ECG Machine	Utility room
5.	Procedure & Policy Manual	on the computer
6.	Infection Control Manual	Nurses Station
	Drug Cupboards -	
	D.Ds	Medication room
	Antibiotics	" "
	Trolley	Utility room
	Creams, lotions	Utility room
	Ventolin etc.	Resus trolley / medication room
	Water for irrigation	medication room / med trolley
	Oral medications	
7.	Syringes/needles etc.	Medication trolley in utility room
8.	Patient charts X-Rays	} Nurses Station
	Old notes	
	Notes for filing	
	Stationery	
9.	Sterile supplies	Utility room / medication trolley
10.	Infusion devices	
11.	Computer - for patient data	Nurses Station
12.	Scrub sinks & gloves	Utility room / patient room
13.	Bed unit - how do you elevate/work the bed?	Remote Control

14. How does the patient call system and TV unit work?	Nurse call buzzer Remote control
15 Airway Management Guedels airway- Resuscitation masks Suction equipment - How does it work? Oxygen masks & tubing	In the resusitation trolley in the nurses station
15. Locate patients/staff toilets	Pts room / hallway of ward
16. Linen Trolley	In the hallway of the ward
17. Pan/Utility Room	In the hallway of the ward
18. Locate Sphygmomanometer Glucometers Thermometers	Utility room
19. Stethoscopes	Utility room
20. Visitors Lounge	At the entrance to the ward
Questions to ask your Preceptor!	
21 Where do staff have handover?	Bedside/ Nurses Station
22. What is the ward's phone number if you are sick?	
23. Where do you leave your bag/belongings? Where can you obtain meals?	In the locker In the tea room
24. What is the ward routine for am shift, pm shift, night shift?	am shift 7-3.30 pm shift 1.30-10 night shift 2130 - 0700
25. How do the phones work?	at nurses station

Have a great placement!