University of New England

School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

FIRST YEAR
HSNS 162 Foundations of Nursing: Application to Practice

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	Maitland Hospital
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	Joy Edwards
PRECEPTOR CONTACT TELEPHONE:	0422027745
LOCATION (eg: town name):	Maitland
WARD/UNIT:	Medical
PLACEMENT DATES:	FROM 14/5/18 TO 1/6/18

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

DAILY ATTENDANCE TIME SHEET 120hrs Required

Day	Date	Time Start	Preceptor/Facilitator Signature	Time Finish	Preceptor/Facilitator Signature	TOTAL HOURS (not including meal breaks)	Printed Name	Designation (RN) - must be RN -
Monday	14.5.18	0700		1530		8	J.EDWARDS	RN/Facilitator
Tuesday	15.5.18	0700		1530		8	C.Urwin	RN / EDWARDS RN
Wednesday	16.5.18	0700		1530		8	C.Urwin	RN
Thursday	17.5.18	0700		1530		8	Boakye	RN
Friday	18.5.18	0700		1530		8	TJackson	RN.
Saturday								
Sunday								
Monday	21.5.18	1300		2130		8	A.Vaughan	RN
Tuesday	22.5.18	1300		2130		8	R Sadler	RN
Wednesday	23.5.18	1300		2130		8	M. Cummings	RN.
Thursday	24.5.18	1300		2130		8	J.KLUCK	RN
Friday	25.5.18	1330		2200		8	M. Cummings	RN
Saturday								
Sunday								
Monday	28.5.18	1330		2200		8	EDWARDS	RN
Tuesday	29.5.18	1300		2130		8	P. Damodaran	RN
Wednesday	30.5.18	0700		1530		8	mPherson	RN
Thursday	30.5.18	0700		1530		8	TJackson	RN
Friday	1.6.18	0700		1530	EDWARDS	8	C.Urwin	RN
Saturday								
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								

STUDENT DECLARATION: I declare that the hours documented are a true reflection of the hours worked. (Student Signature).....

SICK DAY/S MUST BE DOCUMENTED ON TIME SHEET – Please include Medical Certificates

NB: Medical Certificates **must** be from a medical doctor. Pharmacy Certificates or invoices are not acceptable.

PROCEDURE ACHIEVEMENT SUMMARY

A Registered Nurse is requested to sign and date the procedures in the appropriate column.				
	Safe Practice Demonstrated		Needs more Supervised Practice	
COMPULSORY SKILLS TO BE COMLETED EACH PLACEMENT	**RN Signature**	**Date**	**RN Signature**	**Date**
Regulatory/Statutory Competencies (NCAS) pp12-13	Edwards RN	1.6.18		
The initial and ongoing nursing assessment of a client/patient (NCAS) pp23-26	Edwards RN	1.6.18		
Participation in basic documentation/charting (Tollefson text) p27	Edwards	28.5.18	Edwards RN	24.5.18
Clinical handover (Tollefson text) p28	Edwards RN	28.5.18	Edwards RN	24.5.18
Communicates effectively in English	Edwards RN	28.5.18		
Communication with others	Edwards RN	28.5.18		
FUNDAMENTAL ASSESSMENTS*(copy competency from Tollefson text and upload completed assessment with your Clinical Record Book)*				
Infection Control				
Standard precautions		31.5.18		
Hand washing and completion of NSW Hand Hygiene Certificate(Tollefson text p12)		31.5.18		
Patient Care				
Effective patient communication	Edwards RN	25.5.18		
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)				
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, eye care) (Tollefson text p282)		31.5.18		
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower) (Tollefson text p276)		31.5.18		
Assisting with elimination needs (toileting, bed pans, urinals, commodes) (Tollefson text p127)	Edwards RN	25.5.18		
Assisting with mobility and use of mobility aids (Tollefson text p292)		31.5.18		
Pressure area care (Tollefson text p297)		31.5.18		
Positioning a dependent patient (Tollefson text p288)				
Range of motion, deep breathing and coughing exercises				
Assisting with lifting and positioning of patients using safe manual handling techniques				
Basic CPR				
Bed making	Edwards RN	17.5.18		
Care of body after death				

	Safe Practice Demonstrated		Needs more Supervised Practice	
Assessment	**RN Signature**	**Date**	**RN Signature**	**Date**
Recording and interpreting of blood pressure; temperature, pulse and respiration (TPR) measurements (Tollefson text pp204, 209)	EDWARDS RN Edwards	9.4.5.18	Edwards RN	16.5.18
Recording and interpreting of height, weight and waist circumference measurement (Tollefson text p197)				
Admission of the patient across the lifespan ~~and provision of support for next of kin, parent(s) or carer(s)~~	Edwards		Edwards RN	1.6.118
Documentation				
Document and interpret a basic care plan and integrated patient notes				

ADDITIONAL ACTIVITIES

e.g. Attended Inservice; Woundcare, Simulation
Woundcare → witnessed washing, cleaning and re-dressing of wound areas and Skin tears.
→watching close observation bay / Ancov ward for high dependent care
→Witnessed an ECG

UNIVERSITY OF WOLLONGONG CDNM HealthWorkforce

Nursing Competency Assessment Schedule-NCAS

Registered Nurse Standards for Practice (NMBA 2016)

INTERIM	FINAL
	AL

Please insert your initials

TRIMESTER___/ YEAR___

Standard 1 to 7 (RN assessor- Please place your **initials** in the appropriate column)	Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)	Not Assessed
Standard 1 (RN Please place your ***initials*** in the appropriate column)						
Thinks critically and analyses nursing practice		AL				
Standard 2 (RN Please place your ***initials*** in the appropriate column)						
Engages in therapeutic and professional relationships		AL				
Standard 3 (RN Please place your ***initials*** in the appropriate column)						
Maintains the capability for practice		AL				
Standard 4 (RN Please place your ***initials*** in the appropriate column)						
Comprehensively conducts assessments			AL			
Standard 5 (RN Please place your ***initials*** in the appropriate column)						
Develops a plan for nursing practice			AL			
Standard 6 (RN Please place your ***initials*** in the appropriate column)						
Provides safe, appropriate and responsive quality nursing practice		AL				
Standard 7 (RN Please place your ***initials*** in the appropriate column)						
Evaluates outcomes to inform nursing practice		AL				

How would you rate the overall performance of this student during this clinical practicum ***(please initial)*** :

Unsatisfactory ☐ Satisfactory ☐ Good ☑ AL Excellent ☐

Nursing and Midwifery Board of Australia (NMBA) 2016, *Registered Nurse Standards for Practice*.
Modified from: Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', *Journal of Nursing Education*, vol. 22(9), pp. 376-381.

Independent: (I)	Refers to being safe & knowledgeable; proficient & coordinated and appropriately confident and timely. Does not require supporting cues
Supervised: (S)	Refers to being safe & knowledgeable; efficient & coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues.
Assisted: (A)	Refers to being safe and knowledgeable most of the time; skillful in parts however is inefficient with some skill areas; takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues
Marginal: (M)	Refers to being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues.
Dependent: (D)	Refers to concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/interventions necessary.

Scoring guide:

- ONLY ***initial*** (not assessed) if the student has not had an opportunity to be exposed to and therefore demonstrate the standard.
- Any item not assessed should not be scored.
- You should only ***initial*** one column for each of the one to seven descriptors
- Evaluate the student's performance against the ***minimum*** standard level expected for a beginning/entry level registered nurse.

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection)

Throughout this placement I have gained an extensive amount of knowledge about safe quality practices and how to effectively communicate with team members and patients. I have developed skills that assist me to conduct assessments and complete them to my best ability. My confidence has grown in my capabilities of critical assessments and evaluating outcomes during this placement.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical placement? ***(please initial)***

Unsatisfactory ☐ Satisfactory ☐ Good ☒ Excellent ☐

Comments by RN: (please ***initial***) INTERIM | FINAL JE

Milly has worked well within her scope of practice. She has shown initiative as the placement has progressed. She accomplished her goals for the 1st year placement. Milly can confidently do a set of observations on a patient and report back to her RN. She is kind and caring towards her patients. She has earned praise from her RN Mentors in the Medical Ward. Edwards (EDWARDS) RN

Continue on a separate sheet if necessary

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 1·6·18

Clinical facilitator: *(please print)* J. EDWARDS **Sign:** Edwards **Date:** 1·6·18

Initial and Ongoing Nursing Assessment of a Client-Patient Employer Competencies (Skills Areas)

Clinical Competency Area	
Competency exemplar:	The initial and ongoing nursing assessment of a client/patient (should include first contact)
Demonstration of:	The ability to effectively and safely assess the needs of a single client/patient.

	Performance Criteria (RN Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
PREPARATION FOR INITIAL CONTACT WITH THE CLIENT/PATIENT	1. Identifies specific indications for contact / communication / action with the client/patient (i.e. what initial information is available, if any?).	1.2, 1.3, 1.5, 4.5, 6.1, 6.5.		R				
	2. Verifies the validity of any written information concerning this client/patient.	1.6, 4.5, 5.1, 6.5			R			
	3. Reviews the patient documentation / history / information / medication chart / communication(s) from members of the healthcare team and others (family/friends etc).	1.4, 4.1, 4.5, 5.1, 6.5				R		
	4. Effectively and in a timely manner performs hand hygiene.	1.1, 1.2, 2.2, 3.1, 6.5		R				
	5. Gathers the necessary equipment for assessment (if appropriate) includes assessment documentation.	1.6, 4.1			R			
	6. Locates & greets the client/patient & "*takes in*"/assesses a range of cues (visual, auditory and olfactory) at the point of contact.	1.1-6, 2.1-3, 3.1, 4.1, 4.2, 4.3, 5.1, 6.5, 7.1		R				
	7. Effectively carries out an initial client/patient assessment analyzing and critically evaluating those initial findings.	4.1, 4.4, 5.2, 6.5			R			
	8. Responds promptly and appropriately should the outcome of the initial assessment require immediate escalation.	5.2, 7.1, 7.2			N	IA		
	9. Makes the client/patient 'feel at ease, and identifies the client/patient's ability to engage visually / verbally / cognitively and physically (i.e. their motor response).	2.1, 2.2		R				
CARRYING OUT THE INITIAL NURSING ASSESSMENT OF THE CLIENT/PATIENT	10. Effectively carries out a comprehensive and systematic assessment with / of the client/patient;	4.1-4, 5.1, 6.5, 7.2						
	i. Notes/'senses' impression;		i.		R			
	ii. Gathers a range of evidence from patient and 'family';		ii.		R			
	iii. Utilises appropriate assessment equipment and		iii.	R				
	iv. Appropriate assessment tools;		iv.		R			
	v. Acts with appropriate urgency should the need be evident during the nursing assessment;		v.		N	A		
	vi. Other: Please specify:	*May not be necessary*	vi.					
	11. Clear evidence of a developing rapport and a therapeutic relationship in the interaction with the client/patient.	1.1-7, 2.1, 2.2		R				
	12. Uses a range of questioning styles and demonstrates appropriate listening skills.	1.2, 2.1, 2.2, 2.3,5.1, 7.1			R			
	13. Demonstrates a communication style that is purposeful & professional in demeanour illustrating a sense of caring.	1.2, 2.1, 2.3		R				

	Performance Criteria (RN Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
CARRYING OUT THE INITIAL NURSING ASSESSMENT OF THE CLIENT/PATIENT	14. Explores, through the use of an appropriate framework, dimensions for gathering a health history; a. Social; b. Emotional; c. Physical and developmental; d. Intellectual e. Spiritual and f. Considers Health education and Health promotion opportunities.	1.1-7, 4.1-4, 5,1, 5.3, 7.1	a.		R			
			b.		R			
			c.		R			
			d.		R			
			e.		R			
			f.		R			
	15. Acknowledges and values data from a variety of sources bringing 'meaning' to the findings of the nursing assessment.	4.1, 4.2, .5.1, 5.3			R			
	16. Documents a plan of care in agreement with the client/patient and significant others that uses the framework utilised above (e.g. Activities of Living).	1.3, 1.4, 4.1, 6.5, 7.3			.	R		
	17. Evidence of a developing therapeutic relationship with the client/patient; e.g. gives client/patient a clear explanations regarding the nursing assessment.	2.1, 2.3, 3.1, 5.2,			R			
	18. Maintains dignity at all times, provides privacy and comfort measures – displays problem solving abilities particularly related to; i. the maintenance of appropriate personal space; ii. the management of boundary issues and iii. any other; Specifically:_____	1.3, 1.4, 2.1 4.3, 4.4 *May not be necessary*	i.	R				
			ii.	R				
			iii.					
	19. Monitors the patient according to local policy / procedure / best evidence.	4.4, 5.1, 6.5, 7.1		R				
	20. Ensure patient is positioned appropriately and comfortably & prepared for any intervention in this period (paying particular attention to DRABCD). *(e.g. airway, breathing, circulation, etc)*	1.2, 2.1, 2.2, 5.3, 6.1, 6.2, 7.1		R				
	21. Prepares any intervention/medication and completes them appropriately and in a timely, safe and effective manner.	6.1, 6.5, 7.1			N/A			
	22. If necessary uses safe medicine administration and employs safe practices during any interventions with the client/patient during the assessment period.	1.1, 1.2, 1.3, 2.1, 2.5, 3.2, 4.2, 5.1, 5.2			N/A			
	23. If necessary assists the patient to take the medication or deal with the intervention.	1.2, 7.1			N/A			
	24. Implements appropriate beginning discharge planning, health education and promotion and teaching to client/patient and carer(s).	1.3, 1.4, 1.6, 3.3, 4.3, 4.4, 5.2, 6.5, 7.1, 7.2, 7.3			R			
CLOSING THE ACTIVITY	25. Concludes the nursing assessment period with the client/patient by considerately concluding the therapeutic relationship.	2.1-5		R				
	26. Facilitates client/patient repositioning to maintain privacy dignity, ensures comfort as far as possible at that point.	1.1, 1.4, 2.1, 3.1, 5.4, 7.2		R				
	27. Cleans/tidies area; disposes of any waste appropriately and as soon as is practicable; removes gloves & other PPE (as necessary); performs hand hygiene appropriately.	6.5			R			
	28. Replaces, cleans and/or disposes of equipment appropriately.	6.5		R				

	Performance Criteria (RN Please place your ***initials*** in the appropriate column)	The coding below indicates the NMBA Registered Nurse Standards for Practice (NMBA 2016)		Independent: (I)	Supervised: (S)	Assisted: (A)	Marginal: (M)	Dependent: (D)
DOCUMENTATION & COMMUNICATION	29. Reporting and Recording of relevant information: i. Findings from assessment and possible nursing diagnoses; ii. Nursing Care; iii. Medication chart; iv. Other if appropriate (e.g. particular assessment chart) Specify i.e. plan FRAMP, WATERLOW	3.4, 5.4, 6.5, 7.1, 7.2, 7.3 *May not be necessary*	i.			A		
			ii.			A		
			iii.		N/A			
			iv.			A		
EDUCATIONAL OPPORTUNITY	30. Demonstrates ability to reflect on the activity and to link theory to practice i. Relates to decisions made, ii. Evidence utilised and iii. Implications for assessing & planning of client/patient care.	1.1, 1.2, 1.6, 3.2, 5.1	i.		A			
			ii		A			
			iii.		A			

Berman, A et al 2014 ***Kozier & Erb's Fundamentals of Nursing***, 3rd Ed (Aust), Pearson, Australia
Bondy, K, M, 1983, 'Criterion–referenced definitions for rating scales in clinical evaluation', ***Journal of Nursing Education***, vol. 22(9), pp. 376-381
Crisp, J & Taylor, C 2013 ***Potter and Perry's Fundamentals of Nursing***, 4th Ed, Elsevier, Australia
Tollefson, J 2015, Clinical psychomotor skills: assessment tools for nursing students, 4th Ed., South Melbourne, Vic. Cengage Learning, Australia.

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Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection).

This placement has helped me to become confident in gathering information, communicating with patients and comprehensive assessments. I now feel more informed about the required responsibilities to effectively implement ongoing nursing skills and assessments.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? *(please initial)*

Unsatisfactory ☐ **Satisfactory** ☐ **Good** ☒ **Excellent** ☐

Comments by RN:

Milly needed assistance and guidance to complete the patients admission history / waterlow / FRAMP / Ontario forms. She was able to attend the observations confidently and document on the SAGO chart. As this was Milly's 1st placement she is generally unfamiliar with some of the admission forms and questions, but completed the admission process with the patient Edwards (EDWARDS) RN

Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? *(please initial)*

Unsatisfactory ☐ **Satisfactory** ☒ **Good** ☐ **Excellent** ☐

Student Name: *(please print)* Milly Shennan **Sign:** Mshennan **Date:** 1.6.18

Clinical Facilitator/Educator: *(please print)* J. EDWARDS **Sign:** Edwards **Date:** 1.6.18

Clinical skills competency

COMPETENCY: Documentation	CRITERIA:
DEMONSTRATES: The ability to accurately record information about a patient in a timely manner RN Please place your initials in the appropriate column	C=Competent S=Requires Supervision D=Requires Development

PERFORMANCE CRITERIA (numbers indicate *NMBA Registered Nurse Standards for Practice*, 2016)	C	S	D
1. Identifies indications for documentation in the persons chart/record (1.1, 3.3, 3.4)	M		
2. Uses appropriate medical terminology and approved abbreviation and acronyms (1.1. 1.4, 1.6, 2.7, 3.3, 3.4, 3.6, 3.7, 6.1)		M	
3. Provides relevant and accurate content (1.4, 1.5)	M		
4. Adheres to legal requirements (1.4, 1.5)	M		
5. Demonstrates the ability to effectively use the facilities' standard forms (1.4, 1.5, 6.5)	M		
6. Demonstrates the ability to link theory to practice (1.1, 3.3, 3.4, 3.5)	M		

*Source - Tollefson, J, & Hillman, E. 2016 "Clinical Pyschomotor Skills: Assessment Tools for Nurses" Revised 6th Edition - CENGAGE Learning (pp88-91).

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp85-92 – model for reflection)

To practice starting to write patient notes I would read over past notes that had been written about the patient. I followed the guideline of ensuring I included all relevent and important information about the patient. Every shift on placement I aimed to document 1-2 patient notes and would write a draft copy up first, have my RN check it off and then transcribe them into the patients notes.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? (Please initial)

Unsatisfactory ☐ Satisfactory ☐ Good ☒ Excellent ☐

Comments by RN:

Milly can document fairly well, needs occasional M cues to confirm with RN. Familiar with SAGO chart and can use this chart efficiently. Milly is learning the medical terminology that is necessary in medical/Nursing documentation. She understands M the importance of good documentation.

Edwards RN *Continue on a separate sheet if necessary* (EDWARDS)

How would you rate the overall performance of this student during this clinical activity? (Please initial) :

Unsatisfactory ☐ Satisfactory ☐ Very Good ☒ Excellent ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShenn **Date:** 1·6·18

Clinical facilitator (RN): *(please print)* J. EDWARDS **Sign:** Edwards **Date:** 28·5·18

NB Completion of this competency is required to satisfactorily complete this placement.

Clinical skills competency

COMPETENCY: Clinical handover	**CRITERIA:** C=Competent S=Requires Supervision D=Requires Development
DEMONSTRATES: The ability to clearly and concisely report the condition of a patient or group of patients to another health care professional **RN please place your initials in the appropriate column**	

PERFORMANCE CRITERIA (numbers indicate *NMBA Registered Nurse Standards for Practice*, **2016**)	C	S	D
1. Identifies indication (1.1, 3.3, 3.4)	M		
2. Conducts the handover in private surroundings (1.2, 2.1, 2.7, 6.1)	M		
3. Uses a template (1.1, 1.2 1.6, 3.4, 6.1)	M		
4. Provides information that is accurate, concise and complete (1.1, 1.5, 1.6, 2.7, 3.4 6.1)	M		
5. Uses medical terminology appropriately (1.1, 1.4, 1.6, 2.7, 3.4, 6.1)		M	
6. Delivers information in a timely manner (1.4, 1.6, 2.7, 3.4, 3.6, 3.7, 4.3, 6.1))	M		
7. Demonstrates ability to link theory to practice. (1.1, 3.3, 3.4, 3.5)	M		

*Source - Tollefson, J, & Hillman, E. 2016 "Clinical Pyschomotor Skills: Assessment Tools for Nurses" 6th Edition - CENGAGE (pp84-87).

Compulsory Reflection by Student: (Please refer to Levett-Jones and Burgeois text *The Clinical Placement* pp95-102 – model for reflection)

At the beginning of my placement I did not participate in handover and simply observed. Throughout the week I began to make notes on my handover sheet on some medical terms and extra notes about how the patient was throughout my shift. For the last 2 weeks of my placement I gave handover on a patient at the end of every shift and each time became more + more confident.

Continue on a separate sheet if necessary

How would you rate your overall performance whilst undertaking this clinical activity? (Please initial)

Unsatisfactory ☐ Satisfactory ☐ Good ☒ Excellent ☐

Comments by RN:

Milly is fairly confident giving nursing handover. She is improving with her use of medical terminology. She can deliver the handover concisely and in a timely manner. She uses ISBAR template well and asks the RN for assistance when needed. Edwards (EDWARDS) RN

Continue on a separate sheet if necessary

How would you rate the overall performance of this student during this clinical activity? (Please initial):

Unsatisfactory ☐ Satisfactory ☐ Very Good ☒ Excellent ☐

Student Name: *(please print)* Milly Shennan **Sign:** MShennan **Date:** 1·6·18

Clinical facilitator (RN): *(please print)* J. EDWARDS **Sign:** Edwards **Date:** 28-5-18

NB Completion of this competency is required to satisfactorily complete this placement.

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?
Charting and documenting	I would like to learn how to chart correctly and effitiently as it is a vital part of nursing	Reading and observing an RN's notes and understanding their terminology. Also practising patient progress notes	Gaining feedback and advice from an RN who has assessed my notes and charts that I have practiced.
Effective communication with patients and staff	It will allow me to provide my collegues with thorough patient information and develop my skills	Practice what I want to say to a patient and participate in handover to gain as much info as possible.	performing handover on my own while my facilitator assess me and provides me with feedback.
effectively assist with personal hygeine care	It is important to ensure hygeine needs are met to prevent spread of infection and promote dignity + respect for patients	involving myself in patient hygeine. [redacted] Practicing bathing, cleaning and assisted showering	Having an RN watch and provide feedback and assess me while performing patient hygeine.
Manual blood pressure and vital observations	important aspect of nursing. I want to perfect my skills and develop confidence to work independently	Ask for extra practice time if I'm not feeling confident. Practising within my scope each shift.	Being assessed by an RN on shift to supervise me and provide feedback.
Develop skills for patient care.	To learn to effectively care for my patients and thoroughly provide correct procedures	put the theory I have learnt into practice and correctly follow guidelines and standards of practice ^safe	Recieve feedback from patients and a supervising RN.