University of New England

School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

Second Year
HSNS 265 Nursing Practice: Models of Integrated Care

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	Ballina District Hospital
WARD/UNIT:	General / Rehab
PRECEPTOR/FACILITATOR:	Carmel Purcell
PRECEPTOR CONTACT TELEPHONE:	0411 168 038
PLACEMENT DATES:	FROM 26/8/19 TO 6/9/19

PRIOR TO SUBMISSION PLEASE COMPLETE:	Signature
I have written this document by hand, neatly in biro ensuring no whiteout, highlighter or pencil	MShenn
I have dated the beginning and initialled the end of every entry	MShenn
I am submitting this on completion of placement	MShenn
I have dated and signed the Formative and Summative assessments (as required) with my clinical facilitator or preceptor	MShenn
I have dated and signed the compulsory clinical competencies and procedure achievement summary with my clinical facilitator or preceptor	MShenn
All rostered shifts have been countersigned by supervising RN	MShenn

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 permanent and progressive record of your achievement of the competencies for beginning professional practice. This record will provide you with guidance for your clinical development and will give you an opportunity to set clinical goals and monitor the achievement of these goals. Please refer to pp 71-74 of your Clinical Placement textbook for guidance (Levett-Jones, T and Burgeois, S 2015 'The Clinical Placement: An Essential Guide for Nursing Students" 3rd Edition Elsevier).

You 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.
- Look after it.
- Keep it clear from food and drinks.
- Do not deface your Clinical Record Book in any way.
- Do not remove pages from your Clinical Record Book.
- Do not use whiteout/correction fluid under ANY circumstances
- **Follow carefully the instructions provided in the book to ensure that each document is correctly completed and signed by your designated Clinical Partner/Facilitator prior to leaving the facility.**
- Whilst on Clinical placement if no one is available to complete your clinical placement booklet, contact the Coordinator for Clinical/Field Learning or the Clinical Coordinator (Academic) and they will negotiate with the agency for a report to be completed and forwarded to this university.

This book is to be submitted in the Unit Moodle Site within one week of completion of the placement.

Students who do not submit the Clinical Record Book with the required documentation for each clinical placement may receive delayed or "Fail Incomplete" results for the unit to which the clinical placement relates.

CHECK LIST

DO THIS NOW

- ☑ Write your name, contact telephone number and student number on the front cover of this book.
- ☑ Fill in your *Placement Details* for the forthcoming placement.
- ☑ Complete your goals for this placement online.

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 ***Daily Attendance Time Sheet*** is completed and signed.
- ☐ 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)***.
- ☐ Check that you have achieved the ***Clinical Objectives*** set for this placement (where possible).
- ☐ 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 submission portal in Moodle.**
- ☐ **You MUST keep your original clinical record book as it may be called on for auditing purposes.**
- ☐ **Students are reminded that they will require access to their ORIGINAL books for their portfolio. The Clinical Office will NOT be able to provide access to uploaded versions of their book.**

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.

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)

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?
Improve my skills in IV medication administration	IV therapy is a crucial part of medication administration and I wish to become more confident in this clinical skill.	I will watch an RN practice this skill on placement as much as I can and then have a go myself whilst receiving constructive feedback	I will perform this skill on prac in front of either my RN or facilitator and have them asses me on my clinical practice with IV therapy.
Improve my skills in therapeutic communication	This skill will help me to form relational connections with my patients which will continue to help me throughout my career.	Observing how other RN's communicate with their patients in a therapeutic way will better enable me to improve my skills.	I will take the skills I have learnt and put them into practice on my own patients and have my facilitator asses me on how I went.
participate in a handover of a patient of my own.	I wish to learn + practice the skill of giving an accurate handover + perform one myself based on ways I think are most effective.	giving an accurate handover of clinical information is essential in ensuing correct care + safety for the patient	perform a handover infront of my facilitator or RN and have them asses me on my clinical termionlogy and accuracy.
manage a small patient load	I wish to practice my coordination of care and taking responsibility for a holistic care approach for a patient.	Be allocated a small number of patients at the beginning of my shift. I will then implement nursing care for my patients.	Have my facilitator or RN I am working with provide me with feedback both written + verbal on how I performed this.
continue my nursing education and become familiar with abbreviations + medical terminology.	better developing my knowledge on drugs and medical terminology will allow me to have a greater understanding of what I am administering my patient.	everytime I administer a drug I will look it up in the mims to determine its action, any adverse effects or precautions.	have my facilitator or RN quiz me on some popular medications and their actions to asses how much I have learnt.

CONTACT INFORMATION

The Clinical Office

Clinical Placement Asistants	Rhiannon Morgan-Wright Kellie Lockyer Alisa Gray
Contact details:	Phone: 6773 4388 Email nursingplacements@une.edu.au
Clinical Placement Manager:	Jillian Fitzgerald and Sharon Gallen
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
Postal Address:	The Clinical Office School of Health University of New England Armidale NSW 2351

UNE Student Nurse Clinical Assessment

INSTRUCTIONS FOR CLINICIANS

It is a UNE requirement that students must demonstrate sound clinical performance in order to complete their nursing theory units. Clinical Partners/Facilitators are requested to assess each student on the following:

Individual Nursing Skills

All compulsory assessment/skills assessments for this unit of study are included within this book. They are also outlined on the Procedure Achievement Summary (p9) "Compulsory Skills to be completed this placement".

Additionally you are asked to document (**sign/initial and date**) the development of clinical psychomotor skills on the Procedure Achievement Summary Form.

Any additional skills that are within the student's scope of practice that the student may have an opportunity to be assessed against, may be assessed using the individual skill assessments from the Tollefson text book.

Australian Nursing Standards Assessment Tool (ANSAT)

The ANSAT is a comprehensive validated evaluation tool that provides for a more standardised approach to assessment of nursing knowledge and skills in the clinical environment. This tool is used to assess students against the Registered Nurse Standards for Practice (2016).

This assessment tool is to be completed at the following times:

- At the time any issues are identified
- At the end of each clinical rotation, if in more than one area, to provide students with interim (formative) feedback;
- At the halfway point ***for any placement of 4 weeks duration*** to provide students with interim (formative) feedback;
- At the completion of the clinical placement (final/summative).

Completing the Assessment

Please refer to the ANSAT behavioral cues for assistance in completing this tool. Students are to be assessed regarding their ability to work towards achieving Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards.

It is expected that all Clinical Partners/Facilitators will review student's clinical goals at the beginning of the placement and assist the students to achieve or revise the goals where possible.

It is a requirement of the Nursing and Midwifery Board Australia (NMBA), that where the focus of the student's clinical experience is nursing practice, assessments and documentation relating to the students practice of nursing be completed and signed by a Registered Nurse at all times.

University of New England

HSNS 270 Integrated Nursing Practice 4

Scope of Practice

Students at this level are allowed to perform the skills listed below with Preceptor/Facilitator supervision.

COMPULSORY ASSESSMENT

- Regulatory/Statutory Competencies
- The initial and ongoing nursing assessment of a client/patient
- Managing medication administration
- Monitoring and responding to changes in a client/patients condition
- Participation in basic documentation
- Clinical handover
- Communicates in English

Fundamental assessments

Infection Control

- Standard/additional precautions
- Hand washing and completion of NSW Health Hand Hygiene Certificate
- Aseptic technique/Wound care
  - Dry Dressing
  - Complex wounds – drain, suture or clip removal (including shortening of drains)
  - Complex wounds – wound irrigation
  - Complex wounds – packing a wound
  - Collection of specimens (MSU, CSU and Faeces)
  - Insertion/removal/maintenance of an IDC
  - Removal of IV Cannula

Patient Care

- Effective patient communication
- Assisting patients with nutritional needs (excluding patients with swallowing difficulties)
- Assisting with personal hygiene across the lifespan (mouth care, shaving, hair care and nail care, eye care)
- Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)
- Assisting with elimination needs (toileting, bed pans, urinals, commodes, Stoma care)
- Care and maintenance of indwelling catheter
- Assisting with mobility and use of mobility aids
- Pressure area care
- Range of motion, deep breathing and coughing exercises
- Assisting with lifting and positioning of patients using safe manual handling techniques
- Basic CPR
- Bed making
- Care of the body after death
- Respiratory interventions (Oxygen therapy/Suctioning)
- Management of a person with a tacheostomy

Assessment

- Recording and interpreting of vital signs, blood glucose levels, urinalysis, height and weight across the lifespan, including basic pain assessment
- Admission of the patient across the lifespan and provision of support for next of kin, parent(s) or carer(s)
- Pre-operative and post-operative care
- Pain Assessment
- Collection of a comprehensive health history
- Respiratory assessment
- Cardiac assessment
    - Conduct and interpret an electrocardiogram
- Renal assessment
- Neurological assessment
- Endocrine assessment

Documentation

- Document and interpret a care plan and integrated patient notes
- Recording and monitoring fluid balance charts

Medication Administration (adults and children)

- Calculate and administer doses of oral, topical and PR medications
- Administration of medications via a nebuliser
- Administration and management of oxygen therapy
- Calculation and administration of parenteral (injectable) medications (IMI, S/C,IVI)
- Monitor IV infusions (calculate rates of flow)
- Changing of IV/SC infusions

The University of New England has provided both theoretical and/or practical classes on the skills described in this list.

Students are now prepared to perform these skills with Registered Nurse supervision. ***IMPORTANT NOTE: Students must comply with NSW Health and Institutional guidelines and protocols for the administration of medications and be supervised by an RN at all times when administering medications.***

DAILY ATTENDANCE TIME SHEET 80hrs Required

Day	Date	Time Start	Preceptor/ Facilitator Signature	Time Finish	Printed Name	Designation (RN) – must be RN	Preceptor/ Facilitator Signature	TOTAL HOURS (not including meal breaks)	Printed Name	Designation (RN) - must be RN
Monday	26·8·19	0700		1530	Casmel Pinell	RN		8	Casmel Pinell	RN
Tuesday	27·8·19	[redacted]0700		[redacted]1530	CARL MATHEWS	RN		8	CARL MATHEWS	RN.
Wednesday	28·8·19	1330		2200	Emma Jackson	RN		8	Emma Jackson	RN.
Thursday	29·8·19	1330		2200	LOWENOWSKI	RN.		8	LOWENOWSKI	RN.
Friday	30·8·19	0700		1530	Georgia Shade	RN		8	Georgia Shade	RN
Saturday										
Sunday										
Monday	2·9·19	0700		1530	Casmel Pinell	RN		8	Casmel Pinell	RN
Tuesday	3·9·19	0700		1530	Casmel Pinell	RN.		8	Casmel Pinell	RN
Wednesday	4·9·19	1330		2200	Carina Cook	RN.		8	Carina Cook	RN.
Thursday	5·9·19	[redacted]0700		[redacted]1530		RN		8	Erin Gray	RN
Friday	6·9·19	0700		1530		RN		8	Casmel Pinell	RN
Saturday										
Sunday										
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

SICK DAY/S MUST BE DOCUMENTED ON TIME SHEET – Please include Medical Certificates
All sick days must be 'made up' this clinical placement must reflect a complete 80 hours.

PROCEDURE ACHIEVEMENT SUMMARY

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

Compulsory skills to be completed this placement	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Regulatory/Statutory Competencies (ANSAT)		29/8/19		
The initial and ongoing nursing assessment of a client/patient		29/8/19		
Managing medication administration		29/8/19		
Monitoring and responding to changes in a client/patient's condition		29/8/19		
Participate in basic documentation		29/8/19		
Clinical handover		2/9/19		
Communicates effectively in English		29/8/19		
FUNDAMENTAL ASSESSMENTS				
Infection Control				
Standard/additional precautions		29/8/19		
Hand hygiene		29/8/19		
Aseptic Technique/invasive devices				
Collection of a specimen (MSU, CSU, Faeces)				
Insertion/removal/maintenance of an IDC				
Removal of an IVC				
Wound care				
• Dry Dressing		29/8/19		
• Complex wounds - wound irrigation				
• Complex wounds - wound packing				
Patient Care				
Effective patient communication		28/8/19		
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)		28/8/19		
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, etc)		28/8/19		
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)		28/8/19		
Assisting with elimination needs (toileting, bed pans, urinals, commodes)		28/8/19		
Assisting with mobility and use of mobility aids		28/8/19		
Pressure area care		28/8/19		
Assisting with lifting and positioning of patients using safe manual handling techniques		28/8/19		

Compulsory skills to be completed this placement	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Basic CPR				
Care of body after death				
Respiratory interventions				
• Oxygen therapy (nasal cannula/masks)		29/8/19		
• Suctioning				
Management of a person with a tracheostomy				
Assessment				
Assessing/recording/interpreting of vital signs (BP, HR, RR, SPO2, AVPU, Temp, Pain score)		29/8/19		
Assessing/recording/interpreting of BGL				
Assessing/recording/interpreting of height, weight and waist circumference				
Admission of the patient across the lifespan and provision of support				
Comprehensive pain assessment		29/8/19		
Collection of a comprehensive health history				
Cardiac Assessment				
• Conduct and interpret an ECG				
Respiratory assessment				
• Conduct and interpret spirometry				
Renal assessment				
Neurological assessment				
Documentation				
Document and interpret a basic care plan and integrated patient notes		29/8/19		
Record and monitor fluid balance charts		29/8/19		
Medication admission (adults & children)				
Calculate and administer doses of medications:				
• Oral				
• Sublingual/buccal				
• Topical/transdermal				
• PV/PR				
• Octic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous				
• Intravenous				

ADDITIONAL ACTIVITIES

e.g. Attended In-service Wound care, involved in Simulation, Ground Rounds

→ attended inservice on parkinson's disease
→ attended weekly case study meeting and ward rounds in rehab
→ attended inservice on iron infusions
→ attended an inservice on diabetes

Student Name:	Milly Shennan	**Student ID:**	22016727
Course Name / Code:	HSNS265 → Bachelor of Nursing	**Year Level:**	2nd year
Clinical Setting / Ward:	general / renal ward	**Placement Dates:**	26/8/19 - 6/9/19
Assessment type / date:	**Summative**		

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: 6-9-19

NAME: Ammel Louise Purcell

SIGNATURE: Ammel Purcell RN

*complete this section ONLY if this is a summative assessment

Passed: YES NO

ANSAT – Australian Nursing Standards Assessment Tool

SUMMATIVE ASSESSOR FEEDBACK:

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

Communication is very good, along w her natural ability to be a part of a team.

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

Assert yourself a little more. That will come w time and experience.

3. Any further comments?

I wish Milly all the best in her future. Milly is a pt centred caring student. Pleasure to work with. Carina Goode (RN)

SUPERVISOR COMMENTS:

Milly has outstanding attributes to becoming an assert to the Nursing profession. She will do well. Good Luck.

Signature: L A Powell Date: 4-9-19

STUDENT COMMENTS:

I have thoroughly enjoyed my placement at Balina hospital. I was able to experience a week on the general ward and a week on the rehab ward which were both very educational. I was given the opportunity to work on my clinical skills and put them into practice with the support of the lovely RN's.

Signature: Date: 6.9.19

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

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.

ANSAT Behavioural Cues

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

Students 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	end of hallway walls
	Fire Extinguishers and what fires they are used for?	along ward hallway / near nurses station
	Fire Blanket	along ward hallway
	Fire Hose	along ward hallway
2.	Emergency Arrest Buzzer	next to patient bed
	Emergency Trolley - Adult	nurses station
	Emergency Trolley - Paediatric	—
3.	Defibrillator	treatment room
4.	ECG Machine	treatment room
5.	Procedure & Policy Manual	Nurses station
6.	Infection Control Manual	nurses station
	Drug Cupboards	Drug room
	D.Ds	
	Antibiotics	
	Trolley	
	Creams, lotions	
	Ventolin etc.	
	Water for irrigation	
	Oral medications	Drug room
7.	Syringes/needles etc.	Storage room
8.	Patient charts X-Rays	on computer
	Old notes	on computer
	Notes for filing	Nurses station
	Stationery	nurses station
9.	Sterile supplies	Storage room
10.	Infusion devices	treatment room
11.	Computer - for patient data	nurses station
12.	Scrub sinks & gloves	along the ward
13.	Bed unit - how do you elevate/work the bed?	with bed control

14.	How does the patient call system and TV unit work?	buzzer
	Guedels airway	emergency trolley
	Resuscitation masks	emergency trolley
	Thermometers	emergency trolley / obs machine
	Suction equipment - How does it work?	emergency trolley
	Oxygen masks & tubing	emergency trolley
15.	Locate patients/staff toilets	along the ward
16.	Linen Trolley	along hallways
17.	Pan/Utility Room	on ward next to treatment room
18.	Sphygmomanometer/Glucometers	treatment room
19.	Stethoscopes	on obs machine
20.	Visitors Lounge	near nurses station
Questions to ask your Preceptor/Facilitator		
21	Where does staff have handover?	bedside/ nurses station
22.	What is the ward's phone number if you are sick?	6686 2111
23.	Where do you leave your bag/belongings?	in locuer rooms
	Where can you obtain meals?	in the break room
24.	What is the ward routine for am shift, pm shift, and night shift?	am shift 7am → 3.30pm pm shift 1.30pm → 10pm night shift
25.	How do the phones work?	at nurses station and at patient beaside. calls can be transferred to patient.