

**University of New England
School of Health**

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

**HSNS373
Transitioning to Practice 1**

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	John Hunter Hospital
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	Cherina Jee
PRECEPTOR CONTACT TELEPHONE:	0414 862 447
LOCATION (eg: town name):	Newcastle
WARD/UNIT:	J1
PLACEMENT DATES:	FROM 25/5/20 TO 19/6/20

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. 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.
- 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 final assessment (***NCAS***).
- 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.

Goal	Rational	Strategy	Evidence
What do I want to learn?	Why do I want to learn it?	How am I going to learn it?	How am I going to prove that I have achieved my objective?
Effectively manage a patient load	I wish to further my skills in managing a patient load + become efficient in time management as it is a critical part of nursing.	Ensure that whilst I am on prac that 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 patient's condition + recognise deterioration.	Failure to identify deterioration in patients can result in increased illness, worsening morbidity + higher mortality.	I will learn this skill by implementing an A-G assessment on my patients to determine any signs of deterioration.	Find a deterioration in a patient and express what actions I would take to a senior RN or facilitator + get feedback.
Perform a full A-G assessment on a patient.	I wish to continue practicing this skill as it helps break complex situations down into manageable parts.	Conduct as many A-G assessments as I can on a variety of patients with varying medical conditions.	Perform an A-G and then discuss my findings with a senior RN or my facilitator and receive feedback.
Become confident in assessing, reading + interpreting ECG's.	I wish to become confident in this skill as it is important to be able to identify if a rhythm is normal, abnormal & complex.	By practicing ECG's lead placement on patients + reading/interpreting ECG leads as often as I can.	Interpret an ECG strip and explain to a senior RN or my facilitator what I believe it is and receive feedback on my response.
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 + reduces risk of error.	Practice writing out a handover using the ISBAR tool before communicating to a senior RN or my facilitator + receive feedback.	Perform a succinct, clear and informative ISBAR handover to a senior RN or my facilitator + receive feedback.

Practice as often as I can.

CLINICAL PLACEMENT ATTENDANCE RECORD



Day	Date	Time Start	Time Finish	Total Hours	Facilitator/ preceptor Name, Signature, and Designation
Week 1					
Monday	25/5	0700	1530	8	C. Joe RN
Tuesday	26/5	1330	2200	8	Thelma RN
Wednesday	27/5	1330	2200	8	Thelma RN
Thursday	28/5	1330	2200	8	Karen RN
Friday	29/5	0700	1530	8	Stuart (SMARCH) RN
Saturday					
Sunday					
Week 2					
Monday	01/6	1330	2200	8	AT I. TUSEK. RN
Tuesday	02/6	1330	2200	8	AT I. TUSEK. RN
Wednesday	03/6	0800	1630	8	an Donald
Thursday	04/6	0700	1630	8	C. Joe RN
Friday	05/6	0700	1530	8	C. Joe RN
Saturday					
Sunday					
Week 3					
Monday	08/6	0700	1530	8	Gems CT.
Tuesday	09/6	0700	1530	8	Cherie Joe RN
Wednesday	10/6	1330	2200	8	R FERRIS RN
Thursday	11/6	1330	2200	8	S. Sothern RN
Friday	12/6	0700	1530	8	N. Owen RN
Saturday					
Sunday					
Week 4					
Monday	15/6	0700	1530	8	R FERRIS RN
Tuesday	16/6	0700	1530	8	C. Joe RN
Wednesday	17/6	0800	1630	8	C. Joe RN
Thursday	18/6	0700	1530	8	C. Joe RN
Friday	19/6	1330	2200	8	C. Joe RN
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					

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 RN Signature	Date	Needs more supervised practice RN Signature	Date
The initial and ongoing nursing assessment of a client/patient	✓ TUSEK	5/6		
Assessing/recording/interpreting of continual cardiac monitoring	✓ TUSEK	3/6		
Responding to changes in a patient's condition (recognition of the deteriorating patient)	✓ TUSEK	3/6		
Management of a Central Line (PICC, CVL)	✓ TUSEK	3/6		
Managing the care of a client/patient	✓ TUSEK	3/6		
Managing an appropriate patient load	✓ TUSEK	3/6		
Clinical handover	✓ TUSEK	3/6		
General Assessment				
Collection of health history	✓ TUSEK	3/6		
Respiratory assessment				
Cardiac assessment				
Abdominal assessment				
Musculoskeletal assessment	✓ TUSEK	3/6		
Neurological assessment	✓ TUSEK	3/6		
Mental health assessment	✓ TUSEK	3/6		
Assessing/recording/interpreting of BGL	✓ TUSEK	3/6		
Assessing/recording/interpreting of GCS	✓ TUSEK	3/6		
Assessing/recording/interpreting of height, weight and waist circumference				
Admission of the patient across the lifespan and provision of support	✓ TUSEK	3/6		
Bladder scanning				
Comprehensive pain assessment	✓ TUSEK	3/6		
Pressure area assessment	✓ TUSEK	3/6		
Falls risk assessment	✓ TUSEK	3/6		
Pre/Post-operative assessment	✓ TUSEK	3/6		
Conduct and interpret a 12 lead ECG				

	Safe practice demonstrated	Needs more supervised practice
	RN Signature	Date
Infection Control		
Standard/additional precautions (including PPE)	☒ TUSEL	S/6
Hand hygiene	☒ TUSEL	S/6
Disposal of sharps	☒ TUSEL	S/6
Managing blood and body fluid spills	☒ TUSEL	S/6
Aseptic technique/invasive devices		
Aseptic Non Touch Technique	☒ TUSEL	S/6
Collection of a specimen (MSU, CSU, Faeces, wound swab)	☒ TUSEL	S/6
Removal of an IVC	☒ TUSEL	S/6
Removal of sutures/staples/clips	☒ TUSEL	S/6
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)	☒ TUSEL	S/6
Patient Care		
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)	☒ TUSEL	S/6
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, etc)	☒ TUSEL	S/6
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)	☒ TUSEL	S/6
Assisting with general elimination needs (toileting, bed pans, urinals, commodes)	☒ TUSEL	S/6
Assisting with elimination needs related to stoma care		
Assisting with mobility and use of mobility aids		
Assisting with pressure area care		
Assisting with lifting and positioning of patients using safe manual handling techniques	☒ TUSEL	S/6
Care of the immunocompromised person	☒ TUSEL	S/6
Care of the person under palliative care		
Basic life support		
Care of body after death		
Nasopharyngeal suctioning		
Culturally competent/culturally safe care	☒ TUSEL	S/6

	Safe practice demonstrated RN Signature	Needs more supervised practice RN Signature
Communication and Documentation		
Effective patient communication	☒ TUSELL Sjb	
Patient education	☒ TUSELL Sjb	
Document and interpret a basic care plan and integrated patient notes	☒ TUSELL Sjb	
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)	☒ TUSELL Sjb	
Calculate and administer doses of medications:		
• Oral	☒ TUSELL Sjb	
• Sublingual/buccal	☒ TUSELL Sjb	
• Topical/transdermal	☒ TUSELL Sjb	
• PV/PR		
• Otic/Ocular		
• Intranasal		
• Intramuscular/subcutaneous		
• Intravenous (bolus or infusion)	☒ TUSELL Sjb	

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	Carbapenemase-producing Enterobacteriaceae (CPE) 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?		
I have learnt that it is a bacteria that is likely to be resistant to most antibiotics. It needs to be on Contact Precautions and the correct PPE is required for staff.		
Outcomes How can you apply this learning to your work and integrate the knowledge and findings into your practice?		
Wearing appropriate PPE when interacting with the pt with CPE. I was able to apply my learning + knowledge on CPE as there was a pt on my Ward I was caring for who had CPE.		
Further learning What further learning could you undertake?		
reading through the policies associated with CPE + becoming familiar with how to care appropriately for a pt with CPE.		

Name/Details of activity	Inservice - height + weight on a child	
Attachments (eg. Attendance certificate)		
Summary of learning What have you learnt? How the CPD activity contributes to your body of knowledge and skills?		
How to correctly measure a child's height + weight and compare BMI's to what is normal. Able to bring up the topic of obesity in an appropriate way.		
Outcomes How can you apply this learning to your work and integrate the knowledge and findings into your practice?		
Effectively measure a child's height + weight and then determine a BMI.		
Further learning What further learning could you undertake?		
Read policies and further educate on how to bring up the topic of obesity.		

Student Name:	Milly Shennan	Student ID:	220167227
Course Name / Code:	HSNS373	Year Level:	3rd Year
Clinical Setting / Ward:	J1	Placement Dates:	25th May - 19th June
Assessment type / date:			

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	1	2	3	4	5	N/A
• 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	1	2	3	4	5	N/A
• 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	1	2	3	4	5	N/A
• 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	1	2	3	4	5	N/A
• 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	1	2	3	4	5	N/A
• 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	1	2	3	4	5	N/A
• 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	1	2	3	4	5	N/A
• 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:

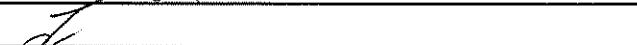
Unsatisfactory Limited Satisfactory Good Excellent

DISCUSSED: YES NO

ADDITIONAL PAPERWORK: YES NO

DATE: 6.5.2020

NAME: Cheriee Jee

SIGNATURE: 

*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?

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

3. Any further comments?

SUPERVISOR COMMENTS:

Signature: _____ Date: _____

STUDENT COMMENTS:

Signature: _____ Date: _____

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:	HSNS 373	Year Level:	3rd Year
Clinical Setting / Ward:	J1 - Childrens Surgical	Placement Dates:	25/5 → 19/6
Assessment type / date:			

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: 10.6.20

NAME: Cherina Jee

SIGNATURE: Cherina Jee

*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?

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

3. Any further comments?

SUPERVISOR COMMENTS:

Signature: _____ Date: _____

STUDENT COMMENTS:

Signature: _____ Date: _____

Scoring rules:

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- 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



ANSAT – Australian Nursing Standards Assessment Tool

SUMMATIVE ASSESSOR FEEDBACK:

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

Milly is eager to learn and build on her knowledge base. She works very well with nursing staff and demonstrates excellent interpersonal skills. She is proactive student and good at making nursing care plan.

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

- * Reflecting on her performance
- * Close observation of other staff practice.
- * Review of each days learning.

3. Any further comments?

No.

SUPERVISOR COMMENTS:

Milly is putting her theory into practice and is asking questions when needed. She is most agreeable and a willing worker. She has received excellent feedback from ward staff.

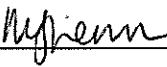
Signature: 

Cherina Jee

Date: 05/06/2020

STUDENT COMMENTS:

I am really enjoying my current placement. I have gained an extensive amount of knowledge and am enjoying practicing a range of clinical skills, communication skills + providing safe and appropriate nursing practice.

Signature: 

Date: 18-6-20

Scoring rules:

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- 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



ANSAT – Australian Nursing Standards Assessment Tool

SUMMATIVE ASSESSOR FEEDBACK:

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

Milly is putting her theory into practice and is asking questions when needed. She works very well with nursing staff and they have praised her attitudes and caring nature. Ward staff praised her for excellent time management.

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

- * Reflecting on her performance
- * Close observation of other staff practice.
- * Review of each days learning.

3. Any further comments?

No.

SUPERVISOR COMMENTS:

Milly is very keen to learn and is making steady progress with her skills. She has a pleasant personality and has been most cooperative.

Signature:  , Cherina Jee Date: 18/06/2020

STUDENT COMMENTS:

I have thoroughly enjoyed my placement in a paediatric ward. When reflecting on my learning + skills I am proud of the way I have been able to put my theory into practice and really consolidate my skills.

Signature:  Date: 18.6.20

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

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?	near nurses station
Fire Blanket	along ward hallway
Fire Hose	along ward hallway
2. Emergency Arrest Buzzer	next to patient bed
Emergency Trolley - Adult	/
Emergency Trolley - Paediatric	adjacent to nurses station
3. Defibrillator	treatment room
4. ECG Machine	storage room
5. Procedure & Policy Manual	Nurses Station
6. Infection Control Manual	Nurses Station
Drug Cupboards	
D.Ds	
Antibiotics	
Trolley	Drug room
Creams, lotions	
Ventolin etc.	
Water for irrigation	
Oral medications	
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

ANSAT Behavioural Cues

- 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

• Structures systematic, safe and goal oriented health care accommodating any limitations imposed by patient's/client's health status

➤ *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

• Evaluates patient/client and self-care skills and abilities to determine if further support is required

- Confirms effectiveness of care plans and interventions
- Confirms outcomes the assessment is able to relevant information
- Integrates assessment to important patient/client issues
- Completes assessment in acceptable time
- Describes the care plan and appropriate treatment for patient/client during the assessment process
- Integrates assessment results to provide complete information to patient/client, family members or health care team
- Describes the care plan and appropriate treatment for patient/client during the assessment process

• Presents relevant assessment findings

- Communicates application of knowledge to delivery of health care strategies (e.g. compares findings to normal)
- Communicates to relevant health care professionals, including other information, medical records, test results as appropriate)

8. COMMUNICATES INFORMATION

8.1 COMMUNICATES WITH PATIENT/CLIENT

• Confirms safety and effectiveness of care plans and interventions

- Performs health care treatments at acceptable and safe standard
- Consults with workplace guidelines on patient/client handling
- Monitors patient/client safety during assessment and care provision
- Lays patient out effectively and efficiently
- Monitors effectiveness of rapidly changing patient/client situations

8.2 COMMUNICATES WITH CARE TEAM

- Communicates information and determines outcomes that take into account of practical
- Accepts and adapts care according to patient or other's version of practice
- Monitors outcomes when descriptions/decisions are unclear
- Identifies areas of their or other's practice that require direct/indirect input/advice
- Monitors unanticipated outcomes and responds appropriately

14. How does the patient call system and TV unit work?	buzzer + remote control
Guedels airway	emergency trolley
Resuscitation masks	emergency trolley
Thermometers	emergency trolley / obs machine
Suction equipment - How does it work?	emergency trolley + behind bed
Oxygen masks & tubing	emergency trolley + behind bed
15. Locate patients/staff toilets	entrance to ward
16. Linen Trolley	along the hallways of ward
17. Pan/Utility Room	on ward next to kitchen room
18. Sphygmomanometer/Glucometers	treatment room
19. Stethoscopes	on obs machine / storage room
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?	13311
23. Where do you leave your bag/belongings?	In break room
Where can you obtain meals?	break / tea room
24. What is the ward routine for am shift, pm shift, and night shift?	<p>am shift 0700 - 1530</p> <p>pm shift 1330 - 2200</p> <p>night shift /</p>
25. How do the phones work?	at Nurses station + at pt bedside. calls can be transferred to a patient.