University of New England

School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

HSNS 376/576
Transitioning to Practice 2

STUDENT NAME:	Milly Shennan
STUDENT CONTACT TELEPHONE:	0468 672 689
STUDENT ID NUMBER:	220167227
HOSPITAL/HEALTH AGENCY:	Coffs Harbour Hospital
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	Kerrie Cutler
PRECEPTOR CONTACT TELEPHONE:	0401 410 560
LOCATION (eg: town name):	Coffs Harbour
WARD/UNIT:	emergency
PLACEMENT DATES:	FROM 10 / 8 / 20 TO 4 / 9 / 20

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

YOUR CLINICAL RECORD BOOK

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

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

CHECK LIST

DO THIS NOW

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

DO THIS EVERY DAY

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

DO THIS BEFORE YOU LEAVE THE PLACEMENT

- ❑ Make sure your Clinical Partner/Facilitator has signed your ***Procedures Check List*** for procedures performed during this placement.
- ❑ Ensure your Clinical Partner/Facilitator has completed and signed your final assessment (***ANSAT)*** and the **Final Assessment of Clinical Procedures**.
- ❑ 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.**

CLINICAL PLACEMENT ATTENDANCE RECORD

Day	Date	Time Start	Time Finish	Total Hours	Facilitator/ preceptor Name, Signature, and Designation
Week 1					
Monday	10/8	0830	1700	8	Cuttle CF.
Tuesday	11/8	1330	2200	8	Haworth HF.
Wednesday	12/8	1330	2200	8	[illegible] (RN)
Thursday	13/8	0700	1530	8	Cuttle CF
Friday	14/8	0700	1530	8	CBecker (RN)
Saturday					
Sunday					
Week 2					
Monday	17/8	1330	2200	8	CBecker (RN)
Tuesday	18/8	1330	2200	8	K-A Mammatheans [illegible] RN
Wednesday	19/8	0700	1530	8	CBecker (RN)
Thursday	20/8	0700	1530	8	Cuttle CF
Friday	21/8	0700	1530	8	[illegible] (RN)
Saturday					
Sunday					
Week 3					
Monday	24/8	0700	1530	8	CBecker (RN)
Tuesday	25/8	0700	1530	8	CBecker (RN)
Wednesday	26/8	1330	2200	8	[illegible] (RN)
Thursday	27/8	1330	2200	8	[illegible] (RN)
Friday	28/8	0700	1530	8	Cuttle CT
Saturday					
Sunday					
Week 4					
Monday	31/8	0700	1530	8	[illegible] (RN)
Tuesday	1/9	1330	2200	8	[illegible] RN.
Wednesday	2/9	0700	1530	8	[illegible] RN
Thursday	3/9	0700	1530	8	Cuttle RN CF.
Friday	4/9	0700	1530	8	Cuttle 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

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?
Assess, record and interpret continual cardiac monitoring	it allows the detection of changes in heart rate, rhythm and conduction. It is essential in the detection of life-threatening arrythmia's.	Practice interpretting as many patient's as I can's continual cardiac monitoring to gain knowledge + confidence.	explain cardiac monitoring and my interpretation of one to my facilitator or RN and recieve feedback to reflect on what I've learnt
Become confident in the management of intravenous fluids	It is a vital skill of nursing that must be conducted correctly + something that many pt's are on.	Involve myself in priming a line and managing fluids as much as I can until I become confident.	Explain to my RN/facilitor what IV fluids I have running, how I set the rate and what the importance of it is.
conduct and interpret a 12-lead ECG	It is an important tool in clinical desicion-making and provides alot of information such as identifying potentially life-threatening arrythmia's.	Conduct an ecg myself and interpret the results. Aim to determain the rate and rhythm of the ecg.	demonstrate my knowleage + findings of the ecg to my RN/ facilitator. Recieve feedback and apply it to my furner practice.
Accurately respond to changes in a patients condition and recognise deterioration.	Failure to identify deterioration in patients can result in increased illness, worsening morbidity and higher mortality.	I will learn this skill by implementing an A-G assesment 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 my facilitator + recieve feedback.
Effectively manage a patient load.	I wish to furner my skills in managing a patient load + becoming effecient in time management as it is a crucial part of nursing.	Ensure that whilst I'm on placement I practice having a pt load which will help me to become more confident. I will utilise a shift planner.	Successfully completing a shift after caring for multiple patients and getting all required tasks completed for them. Recieve feedback + advice.

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. There are no compulsory skills listed, rather this section should document/summarise the skills the student was able to complete safely during their placement.

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

General Assessment	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
The initial and ongoing nursing assessment of a client/patient	[illegible]	12/8		
Assessing/recording/interpreting of vital signs (BP, HR, RR, SPO2, AVPU, Temp, Pain score)	[illegible]	18/8		
Assessing/recording/interpreting of BGL	CBecker	25/8		
Assessing/recording/interpreting of GCS	[illegible]	12/8		
Assessing/recording/interpreting of height, weight and waist circumference				
Assessing/recording/interpreting of continual cardiac monitoring	CBecker RN	25/8		
Admission of the patient across the lifespan and provision of support	CBecker RN	25/8		
Responding to changes in a patient's condition (recognition of the deteriorating patient)	[illegible]	12/8		
Bladder scanning	CBecker RN	25/8		
Comprehensive pain assessment				
Pressure area assessment				
Falls risk assessment				
Pre/Post-operative assessment				
Conduct and interpret a 12 lead ECG	[illegible]	21/8/20		
Systems focussed Assessments				
Collection of health history	CBecker RN	25/8		
Respiratory assessment				
Cardiac assessment	[illegible]	3/9		
Abdominal assessment	[illegible]	3/9		
Musculoskeletal assessment				
Neurological assessment	CBecker RN	25/8		
Mental health assessment				
Infection Control				
Standard/additional precautions (including PPE)	[illegible]	25/8		
Hand hygiene	[illegible]	19/8		
Disposal of sharps	CBecker RN	25/8		
Managing blood and body fluid spills	[illegible]	19/8		

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Aseptic Technique/invasive devices				
Aseptic Non Touch Technique	Cutler	2/9		
Collection of a specimen (MSU, CSU, Faeces, wound swab)	Cutler	3/9.		
Removal of an IVC	Cutler	20/8		
Removal of sutures/staples/clips				
Wound care (including appropriate assessments)				
• Dry Dressing	Cutler	3/9.		
• Complex wounds (including irrigation, packing, etc)				
Insertion/removal/maintenance of an IDC	Cutler	27/8		
Insertion/removal/management of a feeding tube (NGT/PEG)				
Management of a Central Line (PICC, CVL)				
Patient Care				
Managing the care of a client/patient	CBecker RN	25/8		
Managing an appropriate patient load 4+ patient load	Cutler	3/9		
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)				
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, etc)				
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)				
Assisting with general elimination needs (toileting, bed pans, urinals, commodes)	CBecker RN	25/8		
Assisting with elimination needs related to stoma care				
Assisting with mobility and use of mobility aids	Cutler.	13/8		
Assisting with pressure area care	CBecker RN	25/8		
Assisting with lifting and positioning of patients using safe manual handling techniques	CBecker RN	25/8		
Care of the immunocompromised person				
Care of the person under palliative care				
Basic life support				
Care of body after death				
Nasopharyngeal suctioning				
Culturally competent/culturally safe care	Cutler	3/9.		

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Communication and Documentation				
Effective patient communication	Checker (RN)	25/8		
Patient education	~~Cuttle~~	3/9		
Clinical handover	~~Cuttle~~	24/8/20 Excellent		
Document and interpret a basic care plan and integrated patient notes	Checker (RN)	25/8		
Medication administration (adults & children)				
Initiation and ongoing management of oxygen therapy (Face mask/Nasal Prongs)	~~Cuttle~~	3/9		
Initiation and ongoing management of intravenous fluids	~~Cuttle~~	3/9		
Initiation and ongoing management of Patient Controlled Analgesia (PCA)				
Calculate and administer doses of medications:				
• Oral	Checker RN	25/8		
• Sublingual/buccal				
• Topical/transdermal				
• PV/PR				
• Octic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous	~~Cuttle~~	3/9		
• Intravenous (bolus or infusion)	~~Cuttle~~	3/9		

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	Caring for elderly people (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 learnt that elderly people have a reduced skeletal muscle mass. Very elderly people fall in the age bracket of above 85. Learnt that falls from a standing height are the leading cause of death in very elderly people.

Outcomes
How can you apply this learning to your work and integrate the knowledge and findings into your practice?

I can use this information in my nursing practice & intergrate it into the way in which I care for very elderly people. It is important to know their abnormal vital signs and if they have a sudden decline in function.

Further learning
What further learning could you undertake?

Reading and researching thoroughly on the importance of caring for very elderly people. Utilising the knowledge I have acquired and then applying it to my nursing practice. Reading up on current policies & procedures.

Name/Details of activity	
Attachments (eg. Attendance certificate)	

Summary of learning
What have you learnt? How the CPD activity contributes to your body of knowledge and skills?

Outcomes
How can you apply this learning to your work and integrate the knowledge and findings into your practice?

Further learning
What further learning could you undertake?

Student Name:	Milly Shennan	**Student ID:**	220167227
Course Name / Code:	HSNS376	**Year Level:**	3rd
Clinical Setting / Ward:	emergency department	**Placement Dates:**	10/8/20 - 4/9/20
Assessment type / date:	(Formative/Interim) 21.8.20.		

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: 21.8.20

NAME: Kerrie Curtis

SIGNATURE: Curtis.

*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?

Milly is keen to learn the role of the nurse in ED + to develop her skills in this area. She asks relevant questions to develop her skills in areas she knows needs to develop like ECG, A-G assessments. Milly is enjoying her placement + experiences but I don't think she likes the fast pace ED setting.. Milly has a lovely quiet nature & patients.

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

Milly has a quiet nature but willing to ask questions when unsure. I think that when Milly is comfort + orientated with the ward + staff, she will grow even more.

3. Any further comments?

Milly has done well with understanding + completing the complex documentation system + feeling confident as she gains more experience with assessments eg A-G. She has achieved some of her goals she set herself.

SUPERVISOR COMMENTS:

I look forward to Milly's further growth over the next 2 weeks.

Signature: [signature] Date: 21.8.20

STUDENT COMMENTS:

My first 2 weeks in ED have been very fast-paced + full on but also very enjoyable. I have further developed my knowledge in conducting an A-G assesment, performing ECG's and administering pain medications. I have also been practicing my handover's and taking a patient load which has been very useful to my learning.

Signature: [signature] Date: 21-8-20

Scoring rules:

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

Student Name:	Milly Shennan	**Student ID:**	220167227
Course Name / Code:	HSNS376	**Year Level:**	3rd
Clinical Setting / Ward:	emergency department	**Placement Dates:**	10/8/20 - 4/9/20
Assessment type / date:	(Final/Summative) 4.9.20		

Code: 1 = Expected behaviours and practices not performed
2 = Expected behaviours and practices performed below the acceptable/satisfactory standard
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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
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4. Comprehensively conducts assessments						
• Completes comprehensive and systematic assessments using appropriate and available sources	1	2	3	4	(5)	N/A
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• 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: 4.9.20

NAME: Kerrie Cuttle

SIGNATURE: KCuttle.

*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?

The feedback from staff is - Milly has been a great team player - attending to full assessments, notes, documentation, consulting with her team + asking lots of questions. Milly has a very calm and reassuring nature with the patients.

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

To continue to adapt the new learning environment, learning different policies + procedures for each facility + taking on different nurses experiences + learning from it.

3. Any further comments?

Milly has been able to achieve her goals + more.
Milly's handovers from ED to ward, have been excellent - thorough, to the point + constructive approach.

SUPERVISOR COMMENTS:

I have thoroughly enjoyed supporting Milly during this placement. I wish her all the best for her new grad. year + her chosen nursing path.

Signature: [signature] Date: 4.9.20.

STUDENT COMMENTS:

Throughout this placement my confidence as a nurse has grown as I have been working within my scope of practice and demonstrating safe nursing skills. I am able to think critically, conduct assesments and always ask for guideance and assistance when needed. I believe I have conducted assesments + provided safe and quality nursing practice during this placement.

Signature: [signature] Date: 4.9.20

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

This is a compulsory assessment summary of student performance to enable the student to be eligible for completion of the Bachelor of Nursing/Master of Nursing Practice and registration.

Milly

FINAL ASSESSMENT OF CLINICAL PROCEDURES (Compulsory for completion of degree)					
PERFORMANCE CRITERIA	**Yes**	**No**	**RN Signature**	**Date**	**Comments**
Demonstrates the ability to consistently perform at the level expected of a new graduate nurse	✓			31/8	
Demonstrates a sound knowledge base for practice	✓			31/8	
Carries out thorough patient assessments as necessary	✓			31/8	
Demonstrates the ability to think critically and reflectively about patient care	✓			31/8	
Initiates and implements patient care as appropriate	✓			31/8	
Regularly evaluates the care provided	✓			31/8	
Recognises when assistance/advice is required and seeks such support from more experienced colleagues	✓			31/8	
Demonstrates the ability to time manage and prioritise patient care appropriately	✓			31/8	
Functions effectively in the health care team and values the roles of other team members	✓			31/8	
Practices at all times within established legal and ethical boundaries	✓			31/8	
At the conclusion of this placement the student is able to demonstrate satisfactory management of required care for patients, in correlation to clinical area and relevant staff to patient ratios.	✓		KC	4/9.	

PRECEPTOR/FACILITATOR SIGNATURE: _____ **STUDENT SIGNATURE:** _____

PRECEPTOR/FACILITATOR NAME: Kerrie Cutter. **DATE:** 4/9/20

NB ALL sections of this form are required to be completed for assessment to be entered as satisfactory.

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.