Student Nurses

Kenepuru Hospital Orientation Booklet

Listen Learn Care Respect

Let's Get This Right

WARD'S

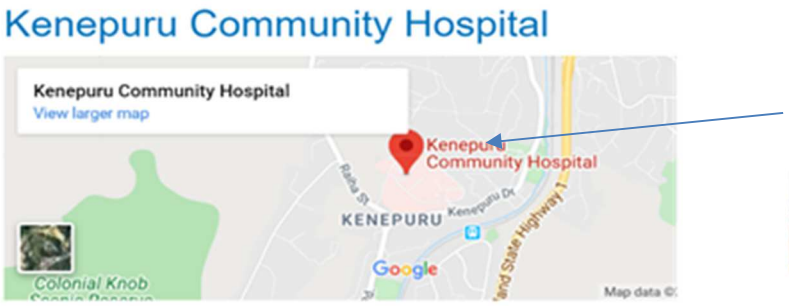
FOUR, FIVE & SIX

2023

Student Name:

Main campus

Parking free both sides from Pedestrian crossing back down hospital drive towards Raiha Street. More parking information given on orientation.



Te Whatu Ora
Health New Zealand

CONTENTS

Welcome!

The Clinical Area

Kia ora tātou, Malo lelei, Talofa lava, Namaste, Kia orana, Fakalofa lahi atu, Bula vinaka, Nǐ hǎo, Selamat pagi, hola, kon'nichiwa, Hello, Welcome to Kenepuru Community Hospital !

We are a Health of the Older Persons Service (HOP) and Older Rehabilitation & Allied Health (ORA) service who specialise in the assessment, treatment and rehabilitation of older patients.

This placement will provide a unique learning opportunity, expect us to encourage you to step forward and out of your comfort zone in a supported manner.

We invite you to seek out more knowledge and understanding within our multidisciplinary team that may consist of Doctors, Nurses, Pharmacists, Physiotherapists, Occupational Therapists, Allied Health support workers or Health Care Assistants, Dietitians, Speech Language Therapists and many others such as the AWHI team exploring how their roles effect nursing to broaden your nursing knowledge, clinical skill set, knowledge and understanding.

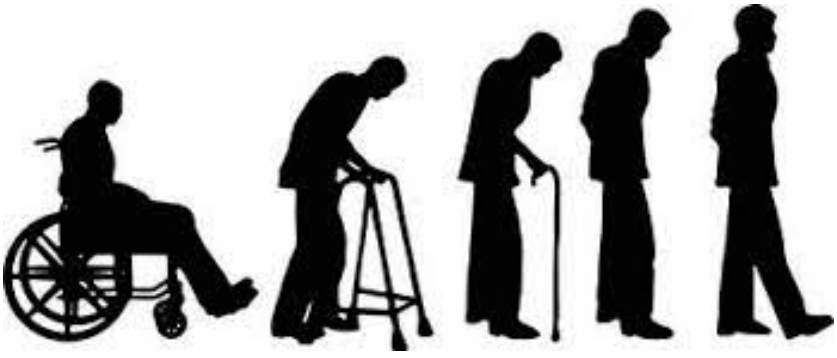
Please note: We have a different Early Warning Score system so pay attention to observations and find out why this is. We also recommend gaining a base knowledge into delirium verses dementia, and pain management in the older patient before coming on the wards.

We are looking forward to working with you

Philosophy

Within the HOP/ORA service, we collaborate with patients, their families and the MDT members in a caring whānau and patient centred manner. We utilise a varying array of assessments and treatments to optimise a patient's independence and functional ability so their pre admission lifestyle is maintained to the best of their ability. We aim to discharge patents to the safest environment that suits their individual needs with or without a package of care which may be to their own home or an aged care facility.

Central to this approach is the philosophy of advocating for patients needs ensuring that our practices are provided with dignity and respect, hoping to improve their quality of life and well-being for their future. Our expectation is that dignity and respect are also given to each multidisciplinary team member which includes you and your practice.



What is Rehabilitation Nursing?

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment that is committed to restoring and maintaining baseline function of the patient alongside their family/whanau to enable them to achieve their life goals. Patient goals are set in consultation with the patient and their family and supported by the multidisciplinary team.

Rehabilitation nurses play many roles, they are collaborators, educators, care coordinators, advocates, and change agents that base their practice on rehabilitative and restorative principles this may include: Managing complex patients with specialists to create comprehensive care plans based on patient goals and maximising potential or, Encouraging active engagement and support to reduce the chance of readmission.

The Associate Charge Nurse Manager, Clinical Nurse Educator, Your preceptor and class colleagues will support you during your orientation and placement to ensure that you have access to all relevant information. Ask questions, seek information, practice and learn so that you can support positive patient outcomes and build on clinical tools. We encourage you to talk to patients and their families and reflect their stories, goals and visions during MDT meetings.

Patient type on the ward

Kenepuru Hospital has a surgical unit, maternity unit, child health services, dental service, outpatient clinics, dialysis unit and specialist rehabilitation services for the elderly.

Predominately the inpatient wards cater to the health of the older person (HOP) and their complex rehabilitation health needs however, Ward Six is a speciality ward that provides neurological / stroke rehabilitation and Ward Seven is a surgical ward.

WARD'S Four & Five Provide care and rehabilitation to patients generally above sixty years of age. Our patients have an extensive range of complex health needs comorbidities or multimorbidities that they have developed over their lifetimes, these may include but are not limited to: cardiovascular issues, orthopaedic problems, complex social backgrounds, fractures, strokes, heart attacks, joint injuries, cancer, respiratory ailments, diabetes, sensory impairment, and mental health problems.

We encourage patient's independence and active mobilisation as much as possible, promoting their wellbeing and enhancing their likelihood of returning home. Rehabilitation may span many different timeframes depending on the issues at hand, our patients may stay from one week to six months. Through Collaboration we may address communication issues, memory problems, fine motor skill enhancement, mobility deficits, pain management and energy conservation. Every patient has different rehabilitation needs to address.

Dedicated Educational Unit

The DEU is based on an Australian model and offers an alternative to the Preceptorship model to focus on student learning and curriculum integration. Te Whatu Ora Capital, Coast & Hutt valley aims to work in partnership with the education providers Victoria University, Massey University (Massey), Whitireia New Zealand (Whitireia).

The unit believes in a commitment to shared responsibility and collaboration that promotes a learning partnership between education and practice allowing practice areas to provide a more supportive clinical learning and teaching environment for students. DEU's are dedicated to supporting nursing students on clinical placement by encouraging incidental and intentional learning modes, with peer teaching.

Clinical Liaison Nurse (CLN)

Wards four: Senia and Hayden Ward five: Ana and Smiler Ward Six: Malia, are your Clinical liaison nurse's (CLN) for and **your main clinical contacts**. We will provide you with some structured clinical learning during your clinical placement. We have an excellent understanding of your programme and academic study and will work alongside your academic tutors and yourself to support your learning needs and complete formative and summative assessments during your placement. In addition the CLN will compete all assessments and references relating to ACE for third year students. **If you have any concerns or questions do not hesitate to contact us through the contact list provided**.

Student Roles & Responsibilities in the DEU

If in doubt ask, if unsure ask, if worried ask, if you have never done it before ask, if you have a question ask, if you want to do it ask, we are here to help you pass! not fail you because we need you as a nurse. **Please ask heaps of questions – there are no such things as dumb questions.** Alongside your CLN and ALN you will:

- ✓ Take responsibility for your learning
- ✓ If students are unable to attend any scheduled shifts (prior to shift commencement), they are responsible for contacting the DEU practice area, and the ALN. Additional make up time for clinical absences is to be arranged as applicable with tertiary education provider and the DEU nurse educator.
- ✓ Establish a working relationship with the clinical team.
- ✓ Self-monitor progress toward achievement of the competencies for Registered/ Enrolled Nursing scope of practice
- ✓ Obtain feedback from CLN, ALN and DEU staff.
- ✓ Maintain communication with DEU staff regarding the patients'/clients health status.
- ✓ Provide care consistent with the learning outcomes as outlined in the respective course requirements.
- ✓ Be accountable to the RN preceptor for the care provided.
- ✓ Immediately contact CLN/ALN In the event of a 'critical incident' occurring.
- ✓ Participate in the evaluation of the overall effectiveness of the DEU practice area with respect to student learning outcomes.
- ✓ Be involved in collaborative research and quality activities as appropriate.
- ✓ Participate in peer teaching/learning through discussion, skill practice and reflection. There is no onus on either student to teach; instead the relationship is collegial where learning occurs opportunistically.
- ✓ Practice the skills of direction and delegation as appropriate.

Student Goals

The minimum goal of students on this placement is the accurate completion of PADP plans each shift and ability to provide basic nursing cares. Other objectives will depend on the your individual goals or those set by education providers. These will be met with the support and supervision from the preceptor as long as they are communicated at the start of shift, here are some questions and objectives to get you started:

- The provision of appropriate care to the patient and whanau
  - What defines appropriate care
- Accurate follow up assessment post vital observations
  - what happens once you have taken observations
- Competent implementation of care
  - Plan care for your patients for your shift
- Documentation
  - Digital notes verses written notes
- Referrals
  - District nurse/ dietitian/ speech language and…….
- Gain an understanding of the multidisciplinary team
  - Who makes up your patients team?
- Practice good infection control measures
  - Covid / MRSA /ESBL
  - What are these infection control measures referred to as?
- Pain management
  - Following injury / pre or post mobilisation?/ what other reasons
- Fluid management/Fluid balance
  - Strict? What is the reason?
- Wound management
-
  - How often? and will it require DN referral?

- Mobility assessment
  - New admission verses discharge

DEU Expectations of staff

The DEU practice area staff facilitates students' learning by:

- ✓ Actively involving students in the assessment, planning, provision, evaluation documentation and reporting of nursing care.
- ✓ Providing them with opportunities to take on increasing responsibility for patient/client care once they have demonstrated appropriate safe practice.
- ✓ Providing a climate of positive support and mentoring for students where student presence is valued and their contribution recognised.
- ✓ Providing a cooperative and collegial team spirit which supports the nursing council principles of direction and delegation.
- ✓ Encouraging peer teaching/learning between each other.
- ✓ Actively participating in decision making regarding the model of student education/supervision used within the DEU/clinical placement.
- ✓ Demonstrating to students a high standard of professional and evidence-based nursing practice.
- ✓ Demonstrating a commitment to own professional development e.g. PDRP, post graduate study.
- ✓ Working with education provider to ensure congruence between what Massey/Whitireia teaches and what is practised as safe, effective nursing care.
- ✓ Participating in the evaluation of the overall effectiveness of the DEU practice area with respect to students learning outcomes.
- ✓ Being involved in collaborative research and quality activities as appropriate.
- ✓ Providing feedback to CLN, ALN and students' on their progress and performance for the student clinical assessment.

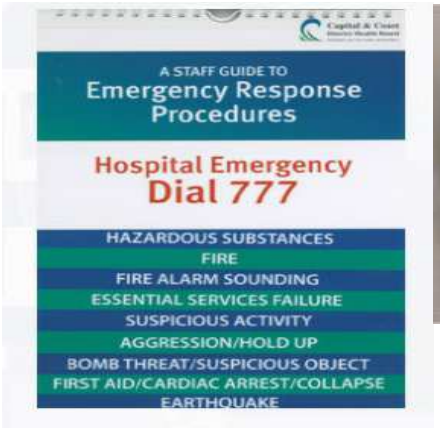
Nurse Preceptor Role in the DEU:

Your Preceptor will work alongside you to support your practice and learning during your placement. We are unable to provide the same preceptor for your entire placement but we endeavour to keep continuity. You will work with your preceptor in a shared care model for your placement period, this means you will be allocated patients from your preceptors workload for your shift. It is **your** responsibility to ensure the nurse you are working with is aware of your objectives for the day/week. You must provide evaluations and/or other paperwork to your preceptor in a timely fashion (i.e. not on the due date!!). You preceptor will not complete any evaluations if you give it to them on your last days in the unit.

- ✓ Hold a current practicing certificate without conditions that could impact on their ability to perform
- ✓ Has attended the Preceptor workshop to gain skills regarding learning styles and adult teaching and learning principles
- ✓ Knowledge of learning objectives and NCNZ competences
- ✓ Provides direction and delegation to the student on a daily basis
- ✓ Assists the student to recognise learning opportunities to meet learning objectives
- ✓ Role models professionalism
- ✓ Facilitates the development of nursing knowledge and clinical practice.
- ✓ Provides daily constructive written and oral feed back to the student to assist with setting short and long term learning objectives.
- ✓ Provide weekly feed back to the CLN and ALN if required
- ✓ If concerned with a student's progress, promptly discuss with the CLN for further support/interventions.
- ✓ Objectives

Emergency Management

This placement, you are highly likely to be involved in an emergency event which may include: a fall, an emergency bell, smell of smoke, cardiac arrest, stroke, seizure, earthquake, collapse, fire or anything deemed as a risk to safety or harm to you, your patient or others !



Emergency bell

We welcome and support you to push the emergency bell situated at the bedside or on bathroom wall if you have any emergency. Please respond to others who have called emergency bells and offer help. If in doubt call the emergency. It is better to have help and not need it than to not have help and need it. In the event of an emergency situation:

- **Don't Panic!**
- **Stay by your patient !**
- **Practice your DR's ABCD's !**
- **If someone else raises an alarm see what you can do to help!**
- **Locate your allocated leader for that shift and be directed by them!**

CALL 777

IN ANY EMERGENCY SITUATION AND ASK FOR HELP (OFFSITE 048061777)

Sickness & Important Contacts

Please email the Clinical Liaison Nurse as first point of contact.

SICKNESS: **after notifying your ALN please call the hospital switchboard and *TALK WITH BOTH* the DUTY MANAGER AND THE WARD.**

To contact staff from outside of the hospital ring the hospital switchboard **04 385-5999** and ask for the extension number. For inside calls dial the extension number only.

	Main contact	Email for main contact	Phone number for ward/Unit
Hospital Switchboard		**04 385-5999 then ask for below extensions**	
Clinical Liaison Nurse's	**Senia Francois Ward 4** **Hayden Wallace Ward 4** **Ana Paongo Ward 5** **Ali Calderon Ward 5** **Malia Bond Ward 6**	**DEU LEAD BOTH WARDS** **Senia.Francois@ccdhb.org.nz** **SCHEDULING ALL WARDS** **Hayden.wallace@ccdhb.org.nz** **WARD FIVE PLACEMENT CONCERNS** **Ana.Paongo@ccdhb.org.nz** **WARD SIX PLACEMENT CONCERNS** **Maria.Bond@ccdhb.org.nz**	**Ward 4 Ext 7006** **Ward 5 Ext 7005** **Ward 6 Ext 7330**
Clinical Nurse Educators	**Emilyn Torio-Roales (Eia)** **Fiona Martin**	**Emilyn.Torio@ccdhb.org.nz**	**Ext: 2964**
Clinical Nurse Manager	**Lisa MacDonald**	**Please email the Clinical Liaison Nurse as first point of contact**	
Associate Clinical Nurse Manager	**Elizabeth Forward Ward 4** **Radhika Patel Ward 5** **Helen Harrison Ward 6**	**Please email the Clinical Liaison Nurse as first point of contact** **Please email the Clinical Liaison Nurse as first point of contact** **Please email the Clinical Liaison Nurse as first point of contact**	**– Ext 7022** **– Ext 7210** **– Ext 7326**

Shift Hours

If sick do not come to placement, please notify your ALN, CLN, the duty manager and the ward from the contact details page.

You are required to do the following shift times while on placement (unless prearranged) be in the nursing station ready for handover at the following times **Morning (Am) 0650 hrs to 1530hrs, Afternoon (pm) 1420 hrs to 2315hrs, Night 2230hrs to 0715hrs.** You must not leave early. Absent, late, or sickness hours may be required to be made up as per education facility requirements.

Uniform Requirements

You must be in full nursing uniform for your entire clinical placement. If you uniform is soiled during placement a set of hospital scrubs can be lent to you for the remainder of the shift and will need to be returned. Infection control is important and we ask that you do not use your own observation equipment on the ward. Due to infection control a clean uniform must be worn, long hair must be tied back and cardigans or long sleeves must not be worn when working in the floor.

Care Plans

All patients admitted to Kenepuru Hospital require a **PDAP** to be completed within the first 24 hours of their admission. Patient admission to discharge plans must be updated daily and more frequently if required when patient care changes. **Completed PDAP plans are the minimum requirement of every student on Placement.**

Assessment

Keep in mind that comprehensive assessments support long-term management. The class taught assessment skills you have practiced will play an important part in your decision making and care.

You will practice the assessment skills you currently have and incorporate those found in the Patient Admission To Discharge Plan (PDAP) linking them to appropriate goals for each patient under your care and their individual circumstances will contribute to favourable patient outcome-focused plans for treatment, rehabilitation and education.

Mobility

While on the ward you are encouraged to mobilise all patients safely using determined mobility aids. Patient safety is paramount and if in doubt get assistance. Mobilising patient's early leads to reduced length of hospital stay, improved mobility, increased strength, overall physical function and better-quality mental health for our patients.

Handover

Please use the handover tool that is given to you at the beginning of the Placement. It is important that you take notes and plan your care using the handover template, by listening to the handover and taking notes, reading the patients notes and by rounding your patients at shift change over

You are responsible for the handover of your patient. You handover should include but is not limited to:-

- Patients General condition
- Observations including EWS and noted changes in same
- Medication given and what time. Changes in medication orders
- Fluid Status (input and output) including nutrition, FBC charts and Bowel motions (BM) Observe wounds/line dressings; e.g. PICC or IVC
- Mobility –aids required physiotherapist- instructions / Falls risk
- Doctors Plan for the next 24hrs.

MULTI-DISCIPLINARY TEAM MEETINGS (MDT)

As the Student Nurse you will attend a minimum of one of your patients MDT meetings with your preceptor, you are expected to add information. Meetings are run by consultant group order. This means that not all of your patients will be discussed at all of the meetings.

Documentation and Daily log sheet

In addition to your education provider/ placement work all DEU students must complete a daily shift log sheet prior to the end of every shift which acts as evidence of completed work and highlights areas of improvement for your entire placement.

Patient Progress Notes

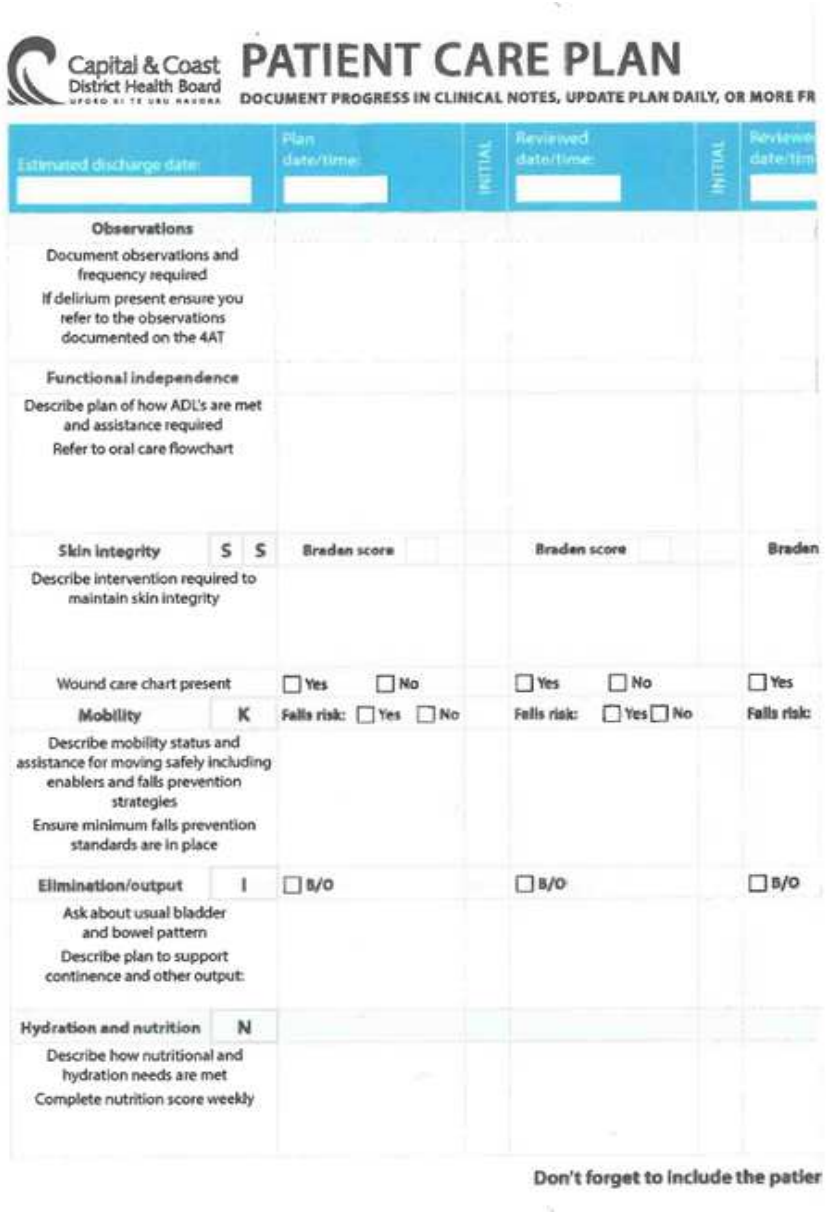
Students must write their patient progress notes they can be done throughout the shift. Patient notes are a legal document and should reflect professionalism and health literacy. Kenepuru ward four is also currently trialling digital patient progress notes (e-notes).

- **All notes must use headers *Remember if it is not written down it did not happen***
- **All notes must start with date time shift and "Nursing Notes".**
- **All Notes must be completed with your name education provider and "student nurse", they must also be countersigned by your preceptor.**

SOME SUGGESTED HEADERS:

▪Observations	▪Output/continence (urine/ bowels)	▪Nutrition
▪LOC & General mood/cognition	▪discharge planning	▪Medications
▪Mobility	▪Additional plans.	▪Family discussions
▪Patient priorities (goals)	▪ADL's	▪cultural/spiritual
▪Pain	▪Skin integrity/ wounds	

Please seek approval before taking documents off wards and if using dairies or note pads do not use identifiable personal information, when in doubt ask.



Capital & Coast District Health Board

PATIENT CARE PLAN

DOCUMENT PROGRESS IN CLINICAL NOTES, UPDATE PLAN DAILY, OR MORE FR

Estimated discharge date:	Plan date/time:	INITIAL	Reviewed date/time:	INITIAL	Reviewed date/tim
Observations					
Document observations and frequency required If delirium present ensure you refer to the observations documented on the 4AT					
Functional independence					
Describe plan of how ADL's are met and assistance required Refer to oral care flowchart					
Skin integrity S S	**Braden score**		**Braden score**		**Braden**
Describe intervention required to maintain skin integrity					
Wound care chart present	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes
Mobility K	**Falls risk:** ☐ Yes ☐ No		**Falls risk:** ☐ Yes ☐ No		**Falls risk:**
Describe mobility status and assistance for moving safely including enablers and falls prevention strategies Ensure minimum falls prevention standards are in place					
Elimination/output I	☐ B/O		☐ B/O		☐ B/O
Ask about usual bladder and bowel pattern Describe plan to support continence and other output:					
Hydration and nutrition N					
Describe how nutritional and hydration needs are met Complete nutrition score weekly					

Don't forget to include the patier

Capital & Coast District Health Board

PATIENT

DOCUMENT PROGRESS

NHI: ... NAMES: ... DATE OF BIRTH: ... / ... / ... SEX: ...
PLACE PATIENT ID HERE

Estimated discharge date:	Plan date/time:	INITIAL	Reviewed date/time:	INITIAL
IV access	**Phlebitis scorere**		**Phlebitis score**	
Intravenous (IV) access device Describe ongoing care required				
Communication				
Describe aids required				
MDT				
Actions from MDT meetings Specify				
Discharge planning				
Describe actions required				
Infection risk				
Precautions, patient education				
Environment				
Environment required by patient e.g. isolation, low stimulus				
Cultural/ mental/ spiritual / psychological / social				
Specify				

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Nursing NOTES and Enotes

Documentation is important for patient care and accountability. ward four is currently trailing Enotes (digital notes through the computer). All other wards continue to use written notes. Students are responsible for their own documentation which must be sighted and counter signed by preceptors every shift and as mentioned, students are to Ensure PADP Care Plans are up to date and detailed.

Regardless of method of documentation:

Headers are to be used for all notes but only use headings applicable to patient

Patient priorities (goals), discharge planning/family discussions
How is patient feeling today, family concerns, any problem solving around home situation.
Cultural/spiritual
Any new needs identified, any actions eg Chaplain, cultural, support service
LOC / General Mood/Cognition
Orientation and any concerns, Need for high vis/POE- *Refer to POE forms*
Observations
EWS Score and intervention done (i.e. Low BP- contacted doctor, IVF started etc etc.)
Refer to OBs chart for individual score
MET Call- document notes in enotes
MET Call sticker in progress notes
Pain : Location of Pain- new or old?, PQRST, Pain medications and effects
Mobility: Independent/ supervision/assist
Mobility aids/ hoist
Turning regimen
Can they move themselves in bed? Can they get themselves in and out of chair/ bed? Type of chair used.
Refer to PADP for plan and falls risk
Continence (Urine/ Bowels)
Has the pt HPU/ BNO/BO/BNO- *Refer to fluid/ bowel chart*
IDC/ SPC or type of pad used, pads in the community or new?
HNPU- bladder scan?
BNO- laxatives?
Able to mobilise to the toilet? Can they get themselves in and out of the toilet?
Can they wipe/ clean themselves
Skin Integrity/ Wounds
Refer to PADP for braden score and care plan
Refer to wound chart for wound assessment and care
Cannulas/ SC ports/ PICC and other drains
Pressure injury new or old?
Nutrition
Independent/ assist with feeding/ needs set up but eat and drink on their own?
Amount of intake- food and fluid- *Refer to food and fluid chart, Refer to weight chart*
Is the patient on a food and fluid chart?
ADLs
How much assistance do they need in the shower?
Can they get themselves dressed?
Can they brush teeth/ dentures? Do they have teeth or dentures?
Can they get their hearing aids in and out?
Medications
Regular meds/ PRN meds administered
New medications charted- see drug chart
Additional Plans*EDD, Destination, ORA Started,Handover provided,Community Referrals,*
Future investigations- dental/CT/Xray, etc?

AROC Functional Independence Measure (FIM)

Functional change is a key outcome measure of rehabilitation episodes, and as such it is essential that FIM items are scored accurately. The functional ability of a patient changes during rehabilitation and the FIM instrument is used to track those changes. FIM measures the 'burden of care', or need for assistance required by a patient to effectively perform basic activities of daily living. It is important that clinicians accurately document the need for assistance and the type of assistance required by the patient. Adding FIM to documentation contributes to FIM scoring overall and assists the multidisciplinary team in developing a rehabilitation plan with the patient. However, often documentation does not completely reflect the patient's actual need for assistance and therefore cannot be used accurately to contribute to FIM scoring.

The AROC FIM Audit Tool was initially developed by the Australasian FIM Master Trainers based on their collective experience of FIM scoring and auditing FIM scoring.

The FIM Scoring Scale
NO HELPER
Score 7: Complete Independence (no help, no devices, safely and timely) **Score 6: Modified Independence** (assistive device, safety or timeliness issues)
HELPER
Modified Dependence **Score 5: Supervision, Setup or Standby Prompting** **Score 4: Minimal Contact Assistance or Prompting** (patient does 75% or more of effort) **Score 3: Moderate Contact Assistance or Prompting** (patient does 50% - 74% or more of effort) Complete Dependence **Score 2: Maximal Contact Assistance or Prompting** (patient does 25% - 49% of effort) **Score 1: Total Assistance** (patient does less than 25% of effort)

DOCUMENTATION EXAMPLES FOR FIM

Bladder

⊘ "Mary PU'd x2 overnight."	This documentation only indicates that Mary's sphincter opened and closed twice overnight. It does not describe anything else.
✓ "Mary rang for a bedpan to PU X2 overnight. She needed x 2 to assist with clothing and positioning, x1 to wipe. No incontinence."	This documentation describes that Mary remembered to ring for assistance (Memory - can remember at a basic level), was aware she needed help (Problem Solving - she solved a problem at a basic level), used a pan with x2 to assist (Score = 1 for Bladder Management, 2 helpers to assist), did not do a toilet transfer, used a pan (Toilet Transfer Score = 1) and was unable to adjust clothing and perform perineal hygiene (Toileting = Score 1). Although the actual length of the documentation of this example is relatively short it is very informative.

Bladder Management — Problem Solving

⊘ "Some incontinence this shift."	This documentation indicates that the patient was incontinent. It does not describe the level of assistance received or the frequency of accidents.
✓ "Patient says she had 1 urine accident this shift. Used incontinence pad independently."	This documentation describes the equipment required (incontinence product), the level of assistance required (none) and how often the patient had an accident. Bladder Management - Part 1 Level of Assistance = 6 Problem solving - Patient is using incontinence products independently. Use this knowledge in conjunction with other knowledge in regard to problem solving.

Eating

⊘ "Max is tolerating food and fluids."	This documentation only tells you that the patient was eating and drinking but does not provide enough information to score the FIM accurately. FIM score may be a "7" based on this comment.
✓ "Patient ate a normal diet independently once his meal was cut up by staff. Patient needed encouragement to drink adequate amounts throughout the shift."	Further documented information about the same patient enables the FIM scorer to feel confident with a "5" score for set up and prompting.

Locomotion — Walk/Wheelchair

⊘ "Mobilised with standby assist x 1."	This documentation does not describe mode of locomotion or distance travelled – unable to score Locomotion.
✓ "Mobilised 17m with steadying assistance of x 1 helper"	This documentation describes the distance the patient mobilised and how much assistance was given. Locomotion Walk/Wheelchair, FIM score = 2

Transfers for bath or shower — Bathing — Grooming

⊘ "Showered with setup."	This documentation says that the patient was showered. Although it may describe setup, (Bathing FIM score = 5) these words are often used by staff to indicate that the patient had a shower and was given a towel.
✓ "Transferred to the shower on a commode (staff pushed). Patient washed her face, arms, chest, abdomen and front perineal area. Assistance given to wash, rinse or dry other areas."	This documentation describes how the patient was transferred and what parts of her body she washed, rinsed and dried. Transfers – Bath or Shower, FIM score = 1 Bathing FIM score = 3 Grooming - Patient is able to wash their face. Use this knowledge in conjunction with other knowledge for grooming.

Dressing Upper/Lower Body

⊘ "Mr Smith dressed independently with some minimal assistance."	This documentation is confusing. He cannot be independent and receive help - unable to score FIM.
✓ "Mr Smith dressed in in a T shirt, underpants, track pants, socks and slippers. He required assistance with his left sleeve and socks. He managed the rest."	This documentation describes what was worn and how much help was required. Dressing upper score = 4. Help with left sleeve – he managed 3 out of 4 parts to the task =75%. Dressing Lower score = 4. Help with socks – he managed 8 out of 10 parts to the task = 80%.

Bowel

⊘ "Bob went to the toilet on the commode x1 overnight. His bowels opened – soft, formed."	This documentation does not describe whether Bob required any assistance or not.
✓ "Bob rang for assistance to toilet overnight. He required supervision to transfer onto and off the commode from his bed. He was pushed over the toilet. Bob managed his own clothing and wiping. His bowels opened – soft, formed. He asked to wash his hands (no assist. required) and be taken back to his bed."	This documentation describes the use of basic memory and problem solving. He transfers bed to chair with supervision only (Score = 5 for Bed to Chair Transfer). Toilet Transfer is scored as 1 as he was pushed on the commode. He can wash his hands – part of the Grooming task.

Multiple FIM Items

⊘ "Marjorie needed moderate assist with ADLs."	It's very difficult to know from this documentation whether the helper is referring to all ADLs or just showering/dressing/toileting.
✓ "Marjorie was independent with eating and grooming, but required moderate assistance with showering, upper and lower body dressing and toileting"	Here the documentation is clear, so that it is easy to score eating and grooming as "7" but the other self-care items as "3". This documentation would be further enhanced with reference to any equipment used by Marjorie for these self-care tasks.

Multiple FIM Items

⊘ "Mrs Smith was yelling loudly overnight waking others."	This documentation provides very little information.
✓ "Mrs Smith was unsettled from 0100-0230 yelling loudly waking others. She was unable to say what was wrong when asked. She walked to the toilet using her walking frame and steadying assistance. She managed her own toileting tasks with prompting. Large void – no incontinence. Returned to bed. Regular pain relief given with a glass of water which she manged independently. Settled back to sleep for rest of night."	This documentation describes poor problem solving and poor social interaction skills. 'Comprehension' and 'Expression' ability for that period was poor. Locomotion score would be 4 (steadying assist only). Prompting only was needed for 'Toileting' task (Score = 5). Mrs Smith can drink from a glass independently (part of Eating Item score).

Multiple FIM Items

⊘ "Bill was confused and agitated overnight."	This documentation does not describe any assistance from the staff member to assist or prompt Bill through his confusion and agitation during the evening shift.
✓ "Bill was unable to follow and remember instructions overnight after a broken sleep. He needed multiple prompts and encouragement from staff throughout the shift to enable him to safely attend to his toileting needs and to resume his sleep."	This documentation advises that multiple prompts were instrumental in assisting Bill to toilet safely and to settle back to sleep.

MDT Hospital Roles.

Clinical Nurse Manager (CNM):
The Manager reports directly to the Service Directorate, Mental Health and Addiction Services and has an overall responsibility for the administration, service delivery and the quality of the services delivered.

Associate Clinical Nurse Manager (ACNM):
The ACNM reports to the CNM and is responsible for the day to day running of the ward. They oversee the intake of admission through to discharge, and are responsible for the liaison between all staff and services, utilisation of resources, and facilitation of multidisciplinary meetings.

House officer-Registrar- Consultant
These are doctors who look after the medical needs of client's on the ward.

Administration Staff:
Administration staff are essential for the establishment and maintenance of client information and data. They provide secretarial support, process client-related information and facilitate the smooth transfer of this information throughout the services. Administration staff include the receptionists who attend the telephone enquires and client appointments.

Registered Nurses & Enrolled Nurses:
The nurse's role includes administration of medication, client education and supporting clients to understand their diagnosis and assisting clients to develop strategies to minimise the impact of illness in their quality of life. RNs & ENS also provide care coordination and monitoring of client symptoms and risks.

Clinical Nurse Specialist (CNS):
This position offers clinical and professional support for nurses. The CNS functions as a role model for nursing practice and acts as a resource for nurses and for others about nursing. The focus of the role includes improved consumer outcomes and enhanced professional practice for nurses. The Intensive CNS supports and works to support RNs in their clinical development and practice.

Occupational Therapist (OT):
Occupational therapy is assessment and treatment through the specific use of selective activity. Functional assessments and group work are also key in assessing day-to-day skills of our client group.

Social Worker (SW):
The role of the Social Worker includes: personal counselling and family therapy, working with consumers to resolve particular stresses, supporting consumers to obtain services, accommodation or practical support they may need and providing liaison with community agencies e.g. WINZ. Social Workers work within a strengths-based framework.

Advancing Wellness at Home Initiative (AWHI)
Provides a link between the ward and home. Oversees clients on leave from the ward. Monitors patient mobility and medication compliance and reports to the Responsible Clinician (RC) any concerns in regards to the client. A key role within MDT meetings of client's progress in the community.

Physiotherapist:
Physiotherapists help patients with physical difficulties caused by illness, injury, disability or ageing. They also facilitate independence and the recovery of body function when people have a disability or problem caused by physical, neurological (related to the brain and nervous system) or other disorders.

Allied heath assistant:
work under direction and delegation of allied health care team members, they may be responsible for providing patient support and care, managing appointments, organising equipment, completing reports or assessments and assisting in achieving rehabilitation goals set by patients and the allied health team members such as increase in mobility or balance.

OBSERVATIONS

BLOOD PRESSURE

□□Use the sphygmomanometer and stethoscope until you are competent, you cannot use the digital machines.
□□Report any abnormally **high or low** reading to your buddy. Consider the patients normal baseline and current medication.
□□Note that the BP recording in some instances may mean withholding certain drugs e.g. Captoprill. Discuss this with your buddy.

PULSE

□□Take radial pulse reading.
□□Take pulse for 60 seconds.
□□Report anything abnormal e.g. slow, fast, irregular

TEMPERATURE

□□Use the tympanic thermometer for routine temp taking.
□□Report any temperature above 37.5 degrees and temperatures below 35.8

RESPIRATIONS

□□Monitor all patients on narcotic analgesia e.g. PCA, or Epidural
□□Short of breath, observe rate and depth
□□Post op patients

O2 SATS

□□Monitor all patients, and on narcotic analgesia
□□Immediate post op patients
□□At risk of DVT or PE
□□Patients receiving oxygen therapy

LEVEL OF CONSCIOUSNESS / NEUROVASCULAR OBS

➢Alert, Voice/ Pain. Unresponsive/ seizure
□□Colour (pink, pale, dusty)
□□Warmth (warm, cool, hot)
□□Movement (Nil, moving fingers and toes)
□□Sensation (Nil, tingling, pins & needles, dull)
□□Capillary refill

WORK OUT EWS, LOC, <u>REPORT ANYTHING THAT IS OUT OF NORMAL RANGE</u> AND ANY EWS 1 AND ABOVE

Vital Signs	Date / Time (24 hour)													EWS													Date / Time (24 hour)
Respiratory Rate (breaths/min) *write value in box*	> 35													MET													> 35
	25-35													3													25-35
	21-24													2													21-24
	12-20													0													12-20
	9-11													1													9-11
	5-8													3													5-8
	< 5													MET													< 5
Supplemental O_2	*write value L/min*													2													L/min
O_2 Saturation (%) *write value in box*	≥ 96													0													≥ 96
	94-95													1													94-95
	92-93													2													92-93
	≤ 91													3													≤ 91
Temperature (°C) *mark with X write value if off scale*	≥ 39s													2													≥ 39s
	38s													1													38s
	37s													0													37s
	36s																										36s
	35s													1													35s
	≤ 34s													2													≤ 34s
Blood Pressure (mmHg) *score systolic value only*	Write ≥ 220													3													Write ≥ 220
	210s																										210s
	200s																										200s
	190s																										190s
	180s																										180s
	170s																										170s
	160s													0													160s
	150s																										150s
	140s																										140s
	130s																										130s
	120s																										120s
	110s																										110s
	100s													1													100s
	90s													2													90s
	80s													3													80s
	70s																										70s
	60s													MET													60s
	50s																										50s
Heart Rate (bpm) *mark with X*	Write ≥ 140													MET													Write ≥ 140
	130s													3													130s
	120s													2													120s
	110s																										110s
	100s													1													100s
	90s																										90s
	80s																										80s
	70s													0													70s
	60s																										60s
	50s																										50s
	40s													2													40s
	30s													MET													30s
Level of Consciousness ✓	Alert													0													Alert
	Voice / Pain													3													Voice / Pain
	Unresponsive													MET													Unresponsive
EARLY WARNING SCORE TOTAL																											**EWS TOTAL**
Pain *write score (0-10)*	Move / Rest																										Move / Rest
Urine Output ✓ Catheter	> 100mls / 4h																										> 100mls / 4h
	< 100mls / 4h																										< 100mls / 4h
No catheter	PU last 8h																										PU last 8h
	Not PU last 8h																										Not PU last 8h

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Capital & Coast District Health Board

Surname: ..... NHI: .....
First Names: .....
Date of Birth: ...../...../..... Sex: .....
PLACE PATIENT ID HERE

Kenepuru Adult Vital Signs Chart

Medical Staff Modification to Early Warning Score (EWS) Triggers

The EWS can be changed to prevent chronic disease incorrectly triggering escalation. This can only be authorised by a Consultant or Registrar and should be regularly reviewed by the primary team. **Ignore any modification that is not signed & dated.**

Vital Sign	Accepted Values & Modified EWS	Date & time	Doctors name, designation & contact details
		/ / :	
		/ / :	
		/ / :	
		/ / :	
NOT FOR CPR ☐	NOT FOR MET ☐	/ / :	

All limitations must be documented in the patient's clinical record.

Mandatory Early Warning Score Escalation Pathway

Total Early Warning Score	Mandatory Action
EWS 1-5 *or* any vital sign in yellow zone	**EWS 1-2:** ▪ Manage pain, fever or distress. ▪ Increase frequency of vital sign monitoring. ▪ Discuss with nurse in charge. **EWS 3-5:** ▪ As above & house officer review within 60 minutes. ▪ Advise duty nurse manager.
EWS 6-7 *or* any vital sign in orange zone Acute illness or unstable chronic disease	Registrar review within 20 minutes ▪ Inform nurse in charge ▪ Increase frequency of vital sign monitoring ▪ Document plan including intervention, escalation & review timeframe ▪ Contact Patient At Risk (PAR) nurse #6785 if advice needed
EWS 8-9 *or* any vital sign in pink zone Likely to deteriorate rapidly **EWS 10+** *or* any vital sign in blue zone Immediately life threatening critical illness	▪ **Dial 777** ▪ **State *'Medical Emergency'* and your location** ▪ **Support Airway, Breathing & Circulation** ▪ **Consider transfer to Wellington Regional Hospital**

CALL 777 FOR ANY PATIENT YOU ARE WORRIED ABOUT REGARDLESS OF VITAL SIGNS OR EWS

If there is no timely response to your request for review, escalate to the next coloured zone. A full set of vital signs with corresponding EWS must be taken & calculated each time at the frequency stated in the 'Essential Vital Sign Measurement - Adult Inpatients' protocol.

Each vital sign is scored according to the coloured zone it falls within (see key below)
Any patient receiving supplemental oxygen *automatically scores 2*, regardless of rate

Early Warning Score Colour Key				
0	1	2	3	MET: MEDICAL EMERGENCY TEAM

Medications:

All medications must be double checked by Registered Nurses. Please be very particular to use the 5 rights of medication administration when checking and dispensing medications. Students are not permitted to administer controlled medications in any form.

IV Therapy:

Second year nursing students may only reconstitute and draw iv medications under direct supervision. Third year student nurses may practice the administration of intravenous medication under full supervision in transition only. In accordance with CCDHB policy All IV therapy must be checked and given under the direct supervision of an IV certified Nurse.

Common Medications

Name of Medication	What is it for?	common adverse reactions/side effects
Allopurinol		
Amlodipine		
Aspirin		
Atorvastatin		
Baclofen		
Carbamazepine		
Cilazapril		
Citalopram		
Clopidogrel		
Dabigatran		
Digoxin		
Escitalopram		
Fentanyl		
Fluoxetine		
Furosemide		
Gabapentin		

Levetiracetam		
Melatonin		
Metoclopramide		
Metoprolol		
Mirtazapine		
Nimodipine		
Omeprazole		
Ondansetron		
Paracetamol		
Quinapril		
Sevredol		
Simvastatin		
Thyroxine		
Warfarin		

Useful Information to seek

- PADP policy
- Early Warning Score Assessment Tool (CCDHB policy CCP AST-01)
- Pressure Risk Assessment Tool (CCDHB policy CPP SAF-07)
- Falls Risk Assessment Tool (CCDHB policy CPP SAF-02)
- Ward resources folders
- Drug measurements' and calculations
- Acute Pain Management—PCA (CCDHB policy CPP APM-02)
- Medicines—Administration (CCDHB policy CPP MED-06)
- Hand Hygiene (CCDHB policy CPP PAT-02)

Common abbreviations

1:1	Staff member constantly with the patient. Constant – right by their side, Specials – within eyesight at all times
ADL	Activities of daily living – e.g. washing, dressing, cooking
ARC	Aged residential care (i.e. resthome or private hospital
BGL	Blood glucose levels referring to tests, checks or results. Eg BGL OD would be blood glucose test once a day.
BPSD	behavioural and psychological symptoms of dementia, e.g. wandering, calling out, hallucinations
ESBL	extended-spectrum beta-lactamases enzymes live in GI tract, but result in infections that reduce effectiveness of antibiotics resulting in worsening infections.
EDD	Estimated date of discharge
EPOA	Enduring power of attorney – "welfare guardian" person appointed either by the patient (when well) or by the courts to make decisions for a patient deemed mentally incompetent.
FC/FBC	Food chart and fluid balance chart
FIM	Functional independence measure – assessment of ability in a variety of tasks from motor to social to cognitive – less in depth than the AMPS

GOC	Goals of care is the four tier (level) replacement for not-for-resuscitation orders. The aim is to improve decision making and documentation relating to limitations of medical treatment. Level A is for resuscitation. Level B & C are not for resuscitation and will stipulate additional ceilings of care such as antibiotics, met calls or for transfer to wellington. D is not for Resuscitation, not for met calls and will stipulate ceiling of care favoured towards comfort and palliation with the goal of making a patient feel more comfortable and improving their quality of life, but will not cure.
HTN	Hypertension
L/S BP	Lying standing blood pressures.
MDT	Multidisciplinary team
MRSA	Methicillin-resistant Staphylococcus aureus infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections. Normally hospital acquired.
PG	Psychogeriatric
Phmx/ HX	Previous medical history or medical history.
T2DM/T1DM	Diabetes mellitus refers to a group of diseases that affect how the body uses blood sugar (glucose). Type one type two
WBAT	Weight bearing as tolerated.
WF/ GF/ WS / Sling / Steady	Mobility device's used to move patients around bed space or ward. will also indicate whether a patient needs assistance.

Transfer of Accountability Summary at Whiteboard

For each of your patients the handover summary will include only the information below. Some information will not need to be included If it has not changed / not required. All other information must be documented in patient notes which will be read following bedside handover

Name/ Age/Bed Space		
Diagnosis / reason for admission		
EWS score		
Key Information / to do list **Tests / Investigations**	• • •	•
ADL's		
Mobility / Aids/ Falls Risk		
Braden Score **PA care** **Wound care**		
Input **Food / Fluid chart extras**	• • • •	• • • •
Output **Bristol stool** **Bladder diary**	• • •	• • •
Medication **Times**		
PRN		
Notes Completed		
Care plan		

RUNNING FEEDBACK RECORD EXAMPLE

Student Name: _____ Course: _____

Clinical Area: _____Placement period: _____

ALN/ CTA: _____ CLN ____ _____

Clinical Practice: Running Record		
Date	**Observations made / RN feedback provided /student reflection**	**CTA/RN**
	List one goal /Area for development for next shift:	
	List one goal /Area for development for next shift:	
	List one goal /Area for development for next shift:	
	List one goal /Area for development for next shift:	

Hints for helping your Nursing students learn

Produced in collaboration by, Hutt Valley District Health Board, Capital and Coast District Health Board, Massey University and Whitireia New Zealand.

	Year 1	Year 2	Year 3
Nursing care, knowledge & skills	• Take and record vital signs • Making beds • Assisting patients with their ADL • Helping patients at meal times • Spending time learning the basics about patients conditions in that setting and observation of how the conditions are managed • Taking responsibility (under supervision) for a patient with less complex needs	• Understanding the pathology of conditions which are seen in that setting • Talk to students about the management of basic conditions and ask them to make suggestions about care (e.g. pain management) • Make suggestions re health promotion for patients in that area • Get the students involved in writing care plans • Encouraging the students to start to make decisions based on their clinical judgement • Sitting in and starting to participate in the ward round / MDT Meeting • Managing the care of an acute patient.	• The student should get involved in more complex skills such as wound care, catheterisation & bowel care, advanced monitoring • Further developing clinical judgement and making decisions around care – ask the students about what action they will take next etc. • Helping patient make informed choices around their care • Involving patients in decisions • Writing care plans • Have a caseload of acute patients and being responsible day to day for their needs – becoming more complex towards the end of the placement
Relationships & communication	• Spending time talking with patients to develop confidence in communication • In more complex situations – allow student to observe the RN or other people in the team • Being a role model for the student	• Students can be speaking to other professionals and agencies regarding their group of patients • Starting to manage more challenging communication scenarios • Delivering the Handover / Report to the team	• Talking to patients and families about care. • Dealing with more challenging communication, contacting members of the team Drs, CNS etc. • Learning how to access support (e.g. aids and adaptations or interpreting services / deaf line) to assist with communication and making referrals
Assessment & the patient journey	• Observing the RN deliver care to the patient • Observing an admission and discharge • Sitting in on the MDT Meeting • Ask students about their observations	• Being involved in more specific assessments – pressure care, mental state examination, early warning signs, carrying out risk assessments • Giving the student the chance to recognise and report on abnormal observations • Observation and participation in admission and discharge processes • Completing and admission and discharge	• Being able to carry out assessment as needed and feedback abnormalities, make suggestions about care and referrals • Understanding the referral process and why people come into that service. • Knowing the care pathway and being able to follow it • Be able to critically reflect on the care being delivered
Medication	• Learning about medications in the setting. • Observing and participation of a medication round • Pick out 1- 2 common medications in the setting and ask the student to learn about it	• Injections • Improving knowledge of medication • Medication rounds and IVs (when workbook complete) under supervision • Pick out common medications specific to the setting and ask the student to learn about it	• Injections • Understand the use/ effect and side effects of all medications they are administering • Medication rounds and IVs (when workbook complete) under supervision
Team work	• Talking to the student about team work • Allowing student to support other people in the team if they notice they're busy	• Being aware if others in the team need help and support	• Students should be managing a case load and there be an increase in acuity of the patients as they move through the placement. • Give them feedback on making clinical priorities • Should be writing all care plans for the patients under their care
The MDT	• Explaining the roles of the MDT • Spending time with other members of the MDT e.g. a visit to a clinic linked to ward	• Understanding when to make referrals outside of the setting and starting to make those referrals • Students can start to make links and share information with the MDT • Participation in the MDT meeting (presenting a patient) and helping with some of the follow up work • Helping the student understand how agencies work together • Visits to relevant community settings	• Understanding how the roles of the wider MDT / external health and social care landscape support their patients. • Considering how patients' needs are met in line with this available support • Work with the people in the patient's life to ensure on-going support • Presenting their group of patients at MDT and following up on MDT outcomes
Profession & professionalism	• Demonstrating respect for client and for team members • Tell students it's OK to ask for help – starting to understand scope of practice	• Encourage the student to challenge and question clinical decisions • Students should support junior students and / or peers • Teaching students that it's OK to ask for help	• Critically reflecting on own practice and being able to identify own learning needs • Support junior colleagues • Talk to students about transitioning to the role of an RN
Safety	• Students should understand the health and safety issues • Ask them to explain differences in working in different settings (e.g. MH or in a patient's own home)	• Demonstrating an increased awareness of self and others when in setting	• Demonstrating an increased awareness of self and others when in setting
Legislation / policy	• Talk to student about policies in that area e.g. Infection control, cultural safety and Mental Health Act. • Ask students to read relevant policies	• Understanding how policies and procedures might impact on care of their patients. • Ask students to identify, find and read policies which may be relevant to that area	• Being able to show how legislation might be important in that area e.g. how the MHA is applied • Able to access and utilise policies and procedure to guide practice

SELF-CARE

If you are currently experiencing any stress, distress, life concerns, or know of someone who is It can seem whakamataku/scary or whakamā/shameful to ask someone you don't know to kōrero about how you're feeling. Seeking help is looking after you so you can look after others.

Here are some ideas when you are unsure about who to reach out to or when you feel stuck:

1. Consider talking with your ACNM, CNM, or an HR person if it is work-related.

2. Use the Raise service which aims to raise staff up when needing support for mental health and wellbeing. The service is strictly confidential, completely independent of management and unions, and is provided by experienced and qualified personnel and better yet it's free: What sort of things CAN raise assist with?

- Mentoring/coaching
- Stress – personal or work
- Drug and alcohol issues
- Career planning
- Help with your CV
- Budgeting assistance
- Depression/anxiety
- Time management
- Workplace changes
- Work issues
- Anger/conflict issues
- Relationship/family issues
- Life transition/direction
- Health and wellbeing
- Grief and loss
- Bullying/harassment
- Team building

3. Consider utilizing a helpline like 1737 which you can text/call at any time to speak with a trained counsellor. Lifeline 0800543354 if you are feeling distressed & need support straight away. Call 0800 POUNAMU (768 626) for a Māori-led approach to your korero, Phone Asian Family Services on 0800 862 342 if you would like to speak with someone from an Asian culture, Call Vaka Tautua on 0800 825 282 to have a phone talanoa /conversation about what you're going through from a Pasifika perspective.

4. Visit the mental health foundation online: https://mentalhealth.org.nz for practical advice and assistance.

5. Talk with a friend or family member to simply share what is happening & ask them to keep checking in on how things are resolving.

6. Have a look on the internet and remember, when something challenging is happening, we need to increase our self-care to match the challenge. Have a think about ways you can commit to looking after yourself through this time.

Treasure Hunt

This list is designed to help you become familiar with the environment, but is by no means exhaustive of all the things you will be required to locate.

☐	Pyxsis Medication Machine	☐	Discharge information
☐	Controlled Drug cupboard	☐	Clinical policies & procedures
☐	Steady Sara	☐	"Notes on Injectable Drugs"
☐	Linen supplies	☐	Roster
☐	Clinical Nurse Manager Office	☐	Manual BP machine
☐	ACNM Office	☐	Suction Equipment
☐	Learning hub/ te whare tahi	☐	Scales
☐	Intravenous Fluids and equipment	☐	Bio-hazard bags
☐	Store room	☐	Tympanic thermometer & covers
☐	Staff tea room	☐	Emergency response flip chart
☐	Resuscitation trolley	☐	Photocopier
☐	Dirty utility room	☐	Patient charts
☐	Clean utility room	☐	Laboratory forms
☐	Dressing trolley and Materials	☐	Hoists / Raizer chair
☐	Isolation Equipment	☐	Incident Reporting
☐	ECG machine	☐	Staff Bathroom
☐	Blood glucose trolley	☐	Sterile Gloves
☐	District Nurse Referral	☐	Emergency cabinet
☐	Where to store your bags	☐	Drug Fridge
☐	OT kitchen	☐	Oxygen tanks
☐	X-ray facilities	☐	Gym
☐	Cleaners room	☐	Dressing Materials
☐	Parking	☐	Café's
☐	outpatients	☐	Dialysis unit
☐	Emergency water supply	☐	Helipad

Evaluation of Clinical Experience

Attendee: _____ Date of placement_____

Date of Evaluation_____Facilitators:_____

This evaluation is intended to offer feedback to the clinical area.

Clinical Learning	1 Strongly Agree	2 Agree	3 Neither agree or disagree	4 Disagree	5 Strongly disagree	Comments
The staff were welcoming and learned to know the students by their personal name						
The staff were easy to approach and generally interested in student supervision						
A preceptor(s) was identified/introduced to me on arrival to area						
One preceptor had an overview of my experience and completed my assessment						
An orientation to the clinical area was provided						
My learning objectives were achieved						
I felt integrated into the nursing team						
I formally met with the "named preceptor" at least fortnightly						
There were sufficient meaningful learning situations in the clinical placement						
How was the Preceptor?						
The preceptor assessed and acknowledged my previous skills and knowledge						
The preceptor discussed my prepared learning objectives						
The preceptor assisted with planning learning activities						
The preceptor supported me by observing and supervising my clinical practice						
The preceptor was a good role model for safe and competent clinical practice						
I felt comfortable asking my preceptor questions						
The preceptor provided me with regular constructive feedback on my practice						

Additional comments:

Please return this form to Charge Nurse Manager or Clinical Nurse Educator