Te Whatu Ora
Health New Zealand
Te Pae Hauora o Ruahine o Tararua
MidCentral

DISTRICT NURSING

STUDENT NURSE ORIENTATION

Developed by: Nga Manu Teka: Practice Development
January 2024

Ngā Manu Teka
Practice Development Unit

Contents

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DOCUMENT CONTROL

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1.	November 2019	
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Approved	November 2019	

WELCOME

Welcome to the MidCentral District Nursing Service.

We hope that you enjoy your placement with us and that you find it a worthwhile and interesting learning experience where you are able to apply your theoretical knowledge to practice, expand your knowledge base and advance your nursing skills. Our aim is to give you a supportive environment in which to do this, and where you can learn how to work as part of a wider team in partnership with people and their whānau.

District Nurses as agency staff will guide you while giving you responsibilities. These will involve active participation in planned learning activities within the realm of safe nursing practice. District Nurses will observe and discuss with you your progress and performance and report evaluation outcomes to you as students and to your Clinical Lecturer. Each student will be assigned to a specific District Nurse.

We have developed a planned orientation programme to assist you as students to achieve your learning aims. Your preceptor will primarily be responsible for you however please feel free to contact me or the Charge Nurse with any questions.

Christine Cumming

Nurse Educator

KEY CONTACTS

District Nursing Service	Reception	PHONE: (06) 350 8100 FAX: (06) 350 8102 E: districtnursingreferrals@midcentraldhb.govt.nz
Nurse Educator 3 days a week	Christine Cumming	PHONE: (06) 350 8100 MOBILE: 027 297 7412 E: christine.cumming@midcentraldhb.govt.nz
Nurse Educator 1 day a week		PHONE: (06) 350 8100 E:
Associate Charge Nurses	Theresa Makiwa, Kate Palmer, Kirsty Ward	PHONE: (06) 350 8109 MOBILE: 027 366 0900
Charge Nurse	Mandy Bevan	PHONE: (06) 350 8105

Please contact the Nurse Educator or your Clinical Lecturer to confirm your start dates and times. If you are unable to attend your placement, please ring the service and advise the Associate Charge Nurse and your Clinical Lecturer.

EXPECTATIONS OF THE STUDENT NURSE

- On the first day please complete the Student contact details form (page 15) and give it to the Nurse Educator or Associate Charge Nurse.
- If you are unable to arrive on time for any reason or are unwell and cannot come in please ring and ask to speak to the Associate Charge Nurse.
- All Nurses, at all bases, commence morning duties at 0800. All students will work 0800-1630, Monday to Friday in their first week of the placement unless otherwise discussed and it is expected that they will get to the allocated base at that time.
- District Nurses can be accessed, by phone, from 0700-2300, on either 3508100 or 0800 001 491 (if out of free call area). Messages for all bases, can be left on either number.

- **PALMERSTON NORTH** Ph. 3508100 or 0800-001-491 (if out of free call area)
    - Located at Kowhai House, Community Village, Gate 1, Heretaunga St.
    - Use main door entrance. Usually the Nurse Educator will be there to greet you otherwise the receptionist will direct you to your preceptor.

  PARKING

    - Morning shift, car park at back of village, off Bodell Place.
    - Afternoon shift, car park nearest Kowhai House, Gate 1, off Heretaunga St.
    - Parking fees apply. Students can purchase concession parking cards from the Wilson Parking Office on site to get a discounted parking fee; a $20 bond is required to purchase these cards.
    - If parking on the streets allow enough time for a 10-minute walk.
- **FEILDING** Ph. 3235408
    - Located at Feilding Health Centre, 7 Duke Street (off Derby St) - use main entrance. Go to reception and ask for DN. Car park available.
- **DANNEVIRKE** Ph. 06-3749633
    - Located at Dannevirke Community Hospital, corner Barraud and Waterloo St. The DNs share the room with other MCH Services. Park on road.
- **PAHIATUA** Ph. 06-3767 444 (ext. 3). S
    - Located at corner of Main and Centre Streets; shared with other MCH Services
    - District Nurses' office is first room on right hand side, through reception. Park in Main Street (Centre St is saved for patients) unless otherwise directed.

- **LEVIN** Ph. 06 366 0888
    - Located at Horowhenua Hospital, 62 Liverpool Street.
    - First day go to front reception desk & ask receptionist to phone the DNs and they will come & meet you. Then you will get a guest ID card. Carpark available.
- **OTAKI** Ph. 06-3648223
    - Located in Medical Centre at 2 Aotaki Street. Go to reception and ask for DN. Park on road.
- **FOXTON**
    - Te Waiora Health Centre. 10 Lady's Mile. Go to reception and ask for DN. Carpark available.
- You must complete the full shift that you are allocated to work. If you are unable to do so, please discuss this with your preceptor and inform your Clinical Lecturer.
- The preceptor you are working with should be aware of your learning objectives. Please discuss these at the start of your shift.
- Your preceptor will work with you to help you learn about assessment and management of a variety of conditions relevant to the setting.
- If you are not achieving your objectives, please see your Clinical Lecturer.
- Please review your knowledge of normal temperature, pulse, respiration rate, blood pressure and blood glucose levels; wound healing, continence and palliative care.
- Please ensure that your uniform meets your institution standards and that your uniform is clean, jewellery removed and hair tied back.
- Please complete the Preceptor Evaluation Form (Page 13) and give to the Associate Charge Nurse.

HEALTH AND SAFETY

Every staff member is responsible for their own safety and the safety of others. The Occupational Health and Safety Manual outlines the hazards within the department. Please familiarise yourself with these hazards and their management. All accidents are to be reported to the Charge Nurse and a RiskMan completed.

EMERGENCIES

All students should make themselves familiar with the response requirements for all emergencies during their orientation.

OBJECTIVES

Before you start with the service please consider what you want to achieve on this placement. Bring a list of objectives, remembering that these need to be realistic. Please share with your preceptor/s at the beginning of your placement the documentation that must be completed while on that placement. Use your initiative to make the most of your placement, for example:

- ask lots of questions
- ask to do and see things, e.g. dressings, procedures.

LEARNING AIMS identified by District Nursing Service may include but are not limited to:

- Familiarising self with the District Nursing Service through reading information provided.
- Familiarising self with the District Nursing Standards of Practice (on the DN Portal).
- Demonstrating knowledge of primary nursing in the community, your role and responsibilities.
- Demonstrating knowledge of channels of communication & key personnel.
- Identifying available resources and equipment, and how to access and utilise.
- Demonstrating knowledge of the role and responsibilities of other team members and Community Health Service structure.
- Discussing procedure to follow in an emergency situation in base/community.
- Demonstrating knowledge of home visiting & professional practice, risk management, patient assessment, care planning & documentation, wound management, continence management and palliative care.

DOMAINS OF NURSING PRACTICE (NCNZ)

PROFESSIONAL RESPONSIBILITY; INTERPROFESSIONAL HEALTH CARE AND QUALITY IMPROVEMENT: DOMAINS 1 AND 4	
INTRODUCTION TO DEPARTMENT	**Signature**
Care of personal belongings	
Buildings / Layout / Toilets	
Car Parking	
STRUCTURE AND ROLE OF SERVICE	**Signature**
Role of Charge Nurse/Associate Charge Nurse, Nurse Educator, Referral Nurse, Admin Staff	
Role of Nursing Leadership at MCH • Executive Director of Nursing and Midwifery • Associate DON Primary, Public and Community • Nurse Educators • CNS Tissue Viability • Nurse Practitioner: Respiratory • Nurse Practitioner: Diabetes • Nurse Practitioner: Pain • IV Therapy service • CNS Urology • CNS Colo-rectal Service	
DAILY ROUTINES	**Signature**
Ordering and Collecting Supplies	
Dressing Bag	
Car Box	
Messages	
Display Book	
Sharps and Rubbish Disposal	
COMMUNITY HEALTH & ALLIED STAFF	**Signature**
Hospice Palliative Care Coordinators	
Occupational Therapists	
Physiotherapists – Mobility and Respiratory	
SupportLinks ○ Home Help ○ Meals On Wheels	
Social Workers	
QUALITY	**Signature**
Organisation Policy	
Nursing Philosophy	
DNS Philosophy and Quality Committee	
Policies and Procedures on portal	
Nursing Standards	

INTERPERSONAL RELATIONSHIPS: DOMAIN 3	
HOME VISITING AND PROFESSIONAL PRACTICE Nursing Students will be able to demonstrate knowledge and identify resources/management in the following areas. It is the student's responsibility to ensure Clinical Nursing Lecturer or District Nurse verify the checklist.	**Signature**
• Always wear name badge & be dressed in uniform	
• Demonstrate communication skills	
• Discuss the establishment of a therapeutic relationship	
• Demonstrate appropriate versus inappropriate self-disclosure	
• Observe environment for safety, neighbours/support, cleanliness	
• Take care in house i.e. do not put bags on tables, be careful not to cause any damage	

PROFESSIONAL RESPONSIBILITY: DOMAIN 1	
RISK MANAGEMENT	**Signature**
• Emergency procedures, rooms / community	
• RiskMan (accidents/incidents)	
• Safe Moving and Handling	
• Student responsibility in relation to drug administration	
• Students not to drive company cars	
• Patient Rights and Responsibilities	
• Cultural safety	
• Standard precautions	
• Multi-drug Resistant Organisms	
• Hazard identification	

MANAGEMENT OF NURSING CARE: DOMAIN 2	
ASSESSMENT, CARE PLANNING & PATIENT DOCUMENTATION	**Signature**
• Patient confidentiality is maintained	
• Care plan reflects adherence to policy, e.g. manual handling	
• Care plan and documentation is done in patient's presence	
• Care plan is legible and updated as required	
• Assessment and care plan reflects holistic view and patient participation	
• Clinical notes are written containing essential information only and countersigned by District Nurse/Nursing Lecturer	
• Identify service contracts	
• Identify Community Health Information Processing System (CHIPS)	
• Identify management of ACC patients	
• Referrals to other agencies	

WOUND CARE	Signature
• Identify the factors affecting healing	
• Identify the aetiology of the wound	
• Discuss the stages of wound healing	
• Can identify tissue type of wounds	
• Demonstrate knowledge of generic wound dressings and when to use each product	
• Demonstrate knowledge of differences between arterial & venous ulcers and management of same	
• Demonstrate appropriate dressing technique	
• Demonstrate knowledge of wound healing and rationale for care plan	
• Know how to contact resource personnel and where to find resource material	
• Identify Braden Tool and grades of pressure injuries	
CONTINENCE MANAGEMENT	**Signature**
• Demonstrate knowledge of principles of continence assessment	
• Can discuss options for continence management	
• Demonstrate knowledge of catheter management including catheterisation	
• Know how to contact resource personnel and where to locate resource material	
PALLIATIVE CARE	**Signature**
• Discuss principles of symptom management e.g. • nausea and vomiting • constipation • weight loss • pain	
• Demonstrate knowledge of drug administration, use and side effect of drugs used for above symptoms	
• Can discuss principles of preventive intervention e.g. bowel management, pressure relief	
• Can discuss how to contact resource personnel and the role of Hospice	

Venous Leg Ulcers

- Usually on the gaiter area
- Large and shallow
- Ruddy granulation
- Irregular edge
- Produce heavy quantities of exudate
- Oedema
- Brown staining on the skin due to breakdown of red blood cells (haemosiderin)
- Varicosities
- Palpable pedal pulse – unless too oedematous
- Often sensitive to touch but not acutely painful
- Capillary refill less than 3 secs
- "Woody" feeling in lower leg

Arterial Leg Ulcers

- Generally on the malleolus or foot
- Smaller and deeper than venous
- Minimal exudate
- Pale wound base
- Lack of hair on leg
- Thin, shiny skin
- Thickened toe nails
- Pedal pulses faint or undetectable
- Pain may be severe due to ischaemia
- Pain worse at night or when the leg is elevated

Mixed Venous/Arterial: signs of each. **Vasculitic:** purple edges, slough, necrotic, thin fragile skin; moderate to severe constant pain; related to rheumatoid disease; rapid onset; no trauma. **Malignant:** Crusty/rolled edges which may be raised; no pain; may heal and break down. **Pyoderma gangrenosum**: uncommon.

Wound Dressing Process	Tick
1. Choose the cleanest available surface to place your bag on (not a food preparation/dining surface).	
2. Take off cardigan/long sleeved jacket.	
3. Clean hands & leave hand gel and any potential products you may want to use in top of bag rather than putting down on the floor or other surface.	
4. Warm the N/S or Microdacyn as per care plan.	
5. Open the dressing pack (only) in case a change of product is indicated.	
6. Put on gloves and remove old dressing – Use Remove wipes if indicated. Use Saline to moisten if it is adhered (if forceps are used discard them).	
7. Inspect the dressing, paying attention to any odour and the amount and type of drainage on the dressing. Serous and haemo-serous drainage are normal. Purulent drainage is not. What you are looking for is whether the dressing has adhered to the wound – if so review product choice - and whether there is sufficient padding to ensure that there is no exudate on the outside of the dressing (as this is a route for bacteria to get in).	
8. If lower limb, leg must be washed (patient or carer may have done this).	
9. Ask about any dressing or wound related pain.	
10. Dispose of old dressing into suitable receptacle, remove gloves and clean hands.	
11. Assess the wound including tissue type, size, colour, type & amount of exudate. NB – it may be easier to assess well after cleansing the wound.	
12. Assess the skin for irritation from wound fluid, oedema, dryness etc.	
13. Select products to be applied based on assessment of wound and Care Plan/Wound Assessment & Management Form. Refer to Skin, Wound & Dressing Formulary in the DN bag.	
14. Once product is opened, it does not go back into the bag. NB: Antimicrobial wound products may be left at the patient's house for subsequent use within 2 weeks. Seal & date packet.	
15. Sterile scissors are single use only for cutting primary products, removal of sutures and other sterile procedures, cutting drains or removing loose wound tissue. These are disposable.	
16. Only place sterile products on the sterile field (ie not unopened packets).	
17. Clean hands & put more gloves on if required ie coming into contact with wound fluids.	
18. Clean the wound; generally granulating wounds are irrigated and sloughy wounds are swabbed. Can use metal forceps for removal of slough and biofilm.	
19. Take a photo of the wound if required & with permission; use Bradma & measuring tape. If so clean hands before & after taking photo.	
20. Apply primary dressing and any topical skin products required (moisturizer/barrier cream).	
21. Apply secondary dressing if required.	
22. Secure the dressing.	
23. Apply any compression or other bandaging.	
24. Remove gloves if used and clean hands.	
25. Document.	

Supra-Pubic Catheter Removal & Replacement	
1.	Assist patient into supine position or as comfortable as possible.
2.	Cleanse hands, put on unsterile gloves, remove dressing and dispose of same in plastic bag.
3.	Check for ooze or any signs of infection at site (and report).
4.	Check the patient's abdomen. Don't proceed if the abdomen appears distended or the bowel constipated. Remove gloves.
5.	Cleanse hands. Using a sterile no-touch technique, open & arrange dressing pack. Open sterile SPC equipment, pour solutions, open lubricant, open outer wrapper around catheter pack using 'no touch' technique & draw up water for balloon. Draw up 30-60 mLs 0.9% NaCl. Cleanse hands & put on unsterile sterile gloves.
6.	Place a continence sheet under the catheter.
7.	Instill 30-60 mLs of 0.9% NaCl solution into the bladder immediately prior to catheter removal – this helps to stabilise the bladder. Leave syringe attached. • ***NB 1: if the catheter is blocked and the bladder is full this will not be necessary.*** • ***NB 2: if there is a catheter valve & bladder is full this will not be necessary.***

8.	Deflate catheter balloon by attaching the syringe to the balloon port of catheter and withdrawing the water; the valve port should be allowed to aspirate naturally. If it does not aspirate naturally try to aspirate slowly; if done forcefully, the valve mechanism may collapse. Remove the syringe. Remove unsterile gloves.
	• *If the catheter balloon will not deflate – try:*
	  • *injecting an additional small volume of sterile water then slowly aspirating again.*
	  • *changing patient's position.*
	  • *NB: do not cut the catheter.*

9.	Cleanse hands, put on sterile gloves. Lubricate tip of catheter with gel and place in large sterile container, position sterile guards on patient abdomen, position sterile large container on the between the patient's legs.
10.	Using forceps, clean around the SPC stoma with normal saline solution and allow to dry, taking care not to touch old catheter with sterile gloves (if you need to pick it up do so using a piece of gauze).
11.	Apply lubricant around the catheter insertion site to ease passage of the catheter.
12.	Rotate the catheter, using a piece of gauze to hold it, to ensure free movement.
13.	Ask the patient to keep still and relax, hands by sides.
14.	Using sterile gauze remove the existing catheter evenly and slowly with a gentle twisting motion. Observe the catheter depth during removal as a guide for new catheter insertion. Inspect the old catheter for intactness.
15.	Insert the new catheter into the suprapubic tract and advance it into the bladder. Don't force the catheter. Stop insertion if the patient complains of discomfort.
16.	As urine begins to drain from the catheter, insert the catheter about 2" (5 cm) further to make sure that the catheter is in the bladder and not the suprapubic tract.
17.	Inflate the balloon using a syringe filled with sterile water to prevent catheter dislodgment. Inflate the balloon slowly with 3 to 5 mL to ensure that the balloon isn't inflated outside the bladder.

Supra-Pubic Catheter Removal & Replacement	
	Assess the patient for pain and discomfort before inflating the balloon fully. Check the manufacturer's instructions for the volume required.
18.	Gently rotate the catheter to ensure that the balloon has not been inflated in the tract.
19.	Connect the catheter to a closed urinary drainage system using sterile no-touch technique to prevent catheter-associated urinary tract infection.
20.	Secure the catheter and drainage bag tubing. Place the drainage system below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of urinary tract infection.
21.	Apply combine dressing/gauze swabs and tape/tegaderm dressing to the SPC stoma (not required if SPC stoma is mature).
22.	Dispose of used equipment, ensure the patient is comfortable, cleanse hands.
23.	Put bed back in correct position.
24.	Document removal/change of SPC and the condition of the site in patient's notes.

DAILY ROUTINE

0800

- Check message book and area pigeon hole
- Review workload for the day
- Check diary, notes in drawer, CHIPS running sheet to ensure that you have all the patients that need to be seen that day
- Check that all are within your scope of practice
- Check with EN/RN colleagues that their workload is manageable
- Prioritise patients with (eg) IV, S/C pump, compression bandaging, pilonidal sinus
- Group patients who live close together using map co-ordinates
- PN staff – write unallocated work on the whiteboard

0830

- Take notes in black box
- Take dressing bag and IV bag
- Check for any patient/car supplies that have been ordered
- Collect car keys
- Visit patients
- Write up CHIPS run sheet as you go

1200 (appx)

- Return to rooms. Check message book & pigeon holes.
- Review morning's work with EN/RN
- PN staff use joint diary to allocate next visit; outer area staff use individual diary
- Return morning notes to filing cabinet for date of next visit
- Hand in morning run sheet
- Check work for pm

1230 (appx) Lunch

1300

- Review pm work with team; reallocate work if necessary to assist others
- Some people will have meetings, education sessions etc

1600

- CHIPS running sheets to be handed in; if you expect to be out at this time hand in running sheet prior to going out and complete a second one for the later visits

1600 – 1630

- Put all notes in filing cabinet for date of next visit
- Ensure all patients are written in diary for next visit
- Put bags out for restocking – do not leave in car
- Check pigeonhole & message book prior to leaving; any new patients for the next day need to be phoned & visit time arranged
- Outer areas complete workload numbers and fax to ACN

PATIENT JOURNEY THROUGH THE DN SERVICE

1. Referral from health professional screened by referral nurse. MDHB-172 Referral Management & Response and MDHB-1277 Service Provision Policy.
2. Referral allocated to appropriate area and placed in correct file depending on contract. Documented in message book and put in area cubby hole. MDHB-172 Referral Management & Response.
3. New patients are phoned within the shift when possible (otherwise the following day) to check they are aware of referral, give a/h contact details & arrange next visit or inform patient that area nurse will ring them to arrange visit. MDHB-172 Referral Management & Response.
4. Area nurse – ring to arrange visit time/day.
5. Prior to visiting check the referral and ensure you have all the correct documentation (eg care plans, assessments etc). MDHB-173 Patient documentation; MDHB-171 Patient Health Assessment, Care Planning, Delivery & Evaluation DNS and MDHB-3365 Patient Health Assessment, Diagnoses, Goals & Outcomes, Care Planning, Ongoing Surveillance & Evaluation. *NB: HITH patients will have their care plans put in their notes by HTCN; PEDAL & R@H patients will have notes at house & a base file. M14 patients MAY already have a base file set up by the PCC but more likely we will need to do it*. If IV patient check fax copy of drug chart and make sure you have Notes on Injectables page.
6. First visit – do assessment(s), care plan(s) and required nursing care. Complete ACC documentation if applicable. MDHB-173 Patient documentation. Tick boxes on front page stamp to indicate what has been done. Ensure patient has DN contact details and give (& explain) information about the DN Service and MCH Rights and Responsibilities Pamphlet. Complete GP letter, any referrals required (eg Wound Service), any imprest/ordering required. Assess suitability for self-wound care/clinic / ensure patient is aware of next visit. Think about discharge planning. Write on CHIPS run sheet. MDHB-1799 CHIPS Data Collection.
7. Reschedule patient in shared diary for next visit and put notes in appropriate slot. *NB: catheter patients may go in the "catheter" drawer.* If patient requires an evening visit discuss with ACN. MDHB 3141 Workload Allocation System and Team Workload Processes in DN Policies, Procedures & Processes Book.
8. At each visit document care given using focused charting and review any new needs. See ACC process if new injury occurs (other than the one on original referral). Re-assess suitability for self-wound care/clinic and prepare for any discharge needs. Sign and date Referral Update stamp as applicable.
9. Informal reassessment occurs each visit but formal reassessment is 6 weeks after admission and 6-12 weekly after that depending on patient circumstances. MDHB-168 Clinical Review and Documentation Audit. Wound measuring/tracing should be 2 weekly for acute wounds & at least 3 monthly for long term chronic wounds. This may also be driven by ACC requirements for wound updates.
10. Discharge according to criteria. Discuss any ACC patients with ACC Coordinator prior to discharge. Ensure discharge needs/plans are in place. Advise patient that they will be discharged and need to return to their GP for any future problems. Tell them that they will get a copy of the letter sent to their GP advising them of the care given while under the DN Service. Complete GP letter, cancel imprest if applicable. Put notes in discharged patient file. Discharge on CHIPS.

DISTRICT NURSING SERVICES

Te Whatu Ora
Health New Zealand
Te Pae Hauora o Ruahine o Tararua
MidCentral

MIDCENTRAL DISTRICT NURSING SERVICE

Provides a comprehensive range of specialised nursing within the primary care setting throughout the MidCentral Health Region 0800-2300 7 days a week

SPECIALISED NURSING DOM 101	ACC HOME NURSING	PALLIATIVE CARE	HOSPITAL IN THE HOME (HITH)
Patient under the care of General Practice Team (GPT) **Dom 2** O_2 **Dom 3** Stoma **Dom 4** Continence **Dom 8** IV **Dom 10** Enteral **Dom 11** Chronic Wound **Dom 12** General Nursing	Patient under the care of GPT	Patient under the care of Arohanui Hospice & GPT	Patient under MCH hospital consultant
Entry Criteria Patients with health care needs that cannot solely be met by GPT or other primary providers **AND** who are at risk of further deterioration without provision of specialised nursing care **AND** whose health would not be compromised by receiving community care	**Entry Criteria** Injury related accident with nursing needs	**Entry Criteria** Palliative care needs	**Entry Criteria** Patient medically stable Patient, carer, District Nurses & specialist agree to care being provided at home Patient has transport & telephone
Care Provided • IV therapy • Acute/complex wounds • Chronic wounds & leg ulcers • Ostomy support • Post discharge rehabilitation • Palliative care (non-hospice) • Medication management • Gastrostomy management • Other short term needs • Health recovery support to prevent hospital admission (Post ED Assessment & Liaison – PEDAL; Acute Nursing at home).	**Care Provided** • IV Therapy • Wound Care • Continence management **(Not personal care - refer to ACC)** • Health recovery support to prevent hospital admission - Acute Nursing at Home or PEDAL	**Care Provided** • Symptom management • Home based End of Life Care • Pressure area care • Personal care • Psychological support • Family support • Bereavement support	**Care Provided** • Early discharge from hospital ward for: ○ IV antibiotics to treat cellulitis, orthopaedic, cardiac, respiratory & other infections ○ IV fluids, TPN & treatment of chronic diseases ○ Management of profound neutropenia
Care at home or clinic	*Care at home or clinic*	*Care at home*	*Care usually at home*

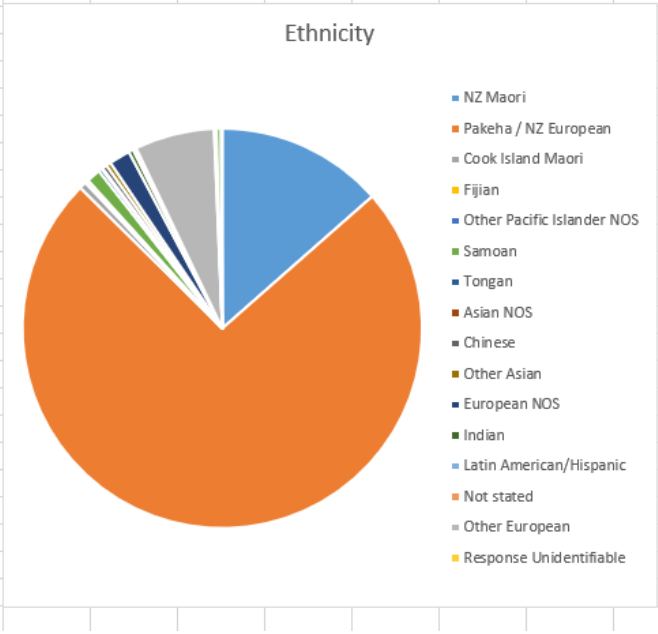
District Nursing Service Key Demographics Summary

The following indicators are based on active unique clients (not episodes) in community

INDICATOR:

EXPLANATION: This indicator shows all unique clients by Ethnicity Grouping.

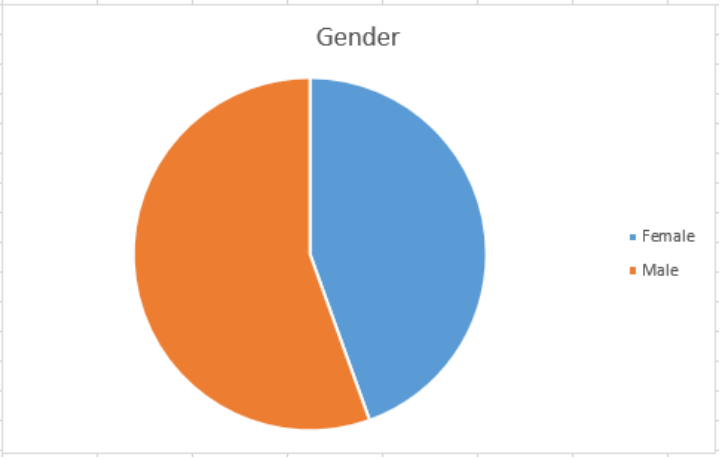
Ethnicity	Count of NHI	%
NZ Maori	143	14%
Pakeha / NZ	782	74%
Cook Island I	6	1%
Fijian	1	0%
Other Pacifi	2	0%
Samoan	12	1%
Tongan	3	0%
Asian NOS	1	0%
Chinese	4	0%
Other Asian	4	0%
European NO	18	2%
Indian	4	0%
Latin Americ	1	0%
Not stated	2	0%
Other Europ	68	6%
Response Ur	1	0%
Don't Know	1	0%
South East A	4	0%
Niuean	1	0%
Grand Total	**1058**	**100%**



INDICATOR: GENDER

EXPLANATION: This indicator shows all unique clients by Gender.

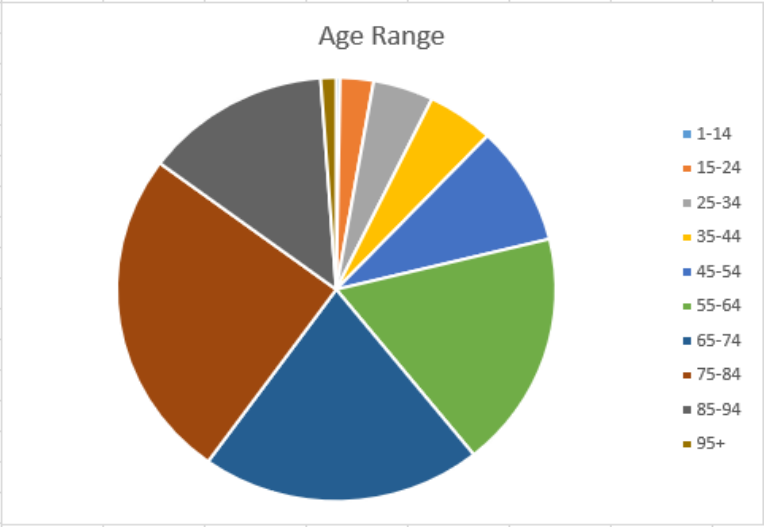
Ethnicity	Count of NHI	%
Female	471	45%
Male	587	55%
Grand Total	**1058**	**100%**



INDICATOR: AGE

EXPLANATION: This indicator shows all unique clients by Age Range.

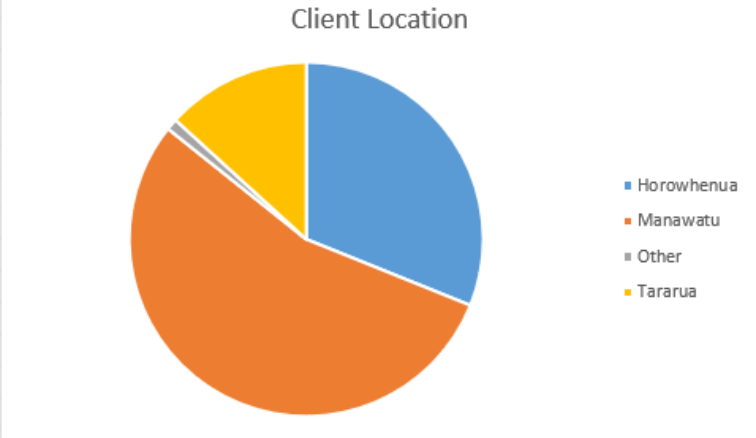
Ethnicity	Count of NHI	%
1-14	3	0%
15-24	26	2%
25-34	47	4%
35-44	52	5%
45-54	96	9%
55-64	191	18%
65-74	219	21%
75-84	267	25%
85-94	145	14%
95+	12	1%
Grand Total	**1058**	**100%**



INDICATOR: CLIENT

EXPLANATION: This indicator shows all unique clients by Client Location.

Ethnicity	Count of NHI	%
Horowhenua	329	31%
Manawatu	578	55%
Other	11	1%
Tararua	140	13%
Grand Total	**1058**	**100%**



EVALUATION OF YOUR PRECEPTOR

Please return your evaluation to your Charge Nurse

Name of Preceptor_____ Date_____

E = Excellent **VG =** Very Good **S =** Satisfactory **NI =** Needs Improvement

Please read the following statements then tick the box that best indicates your experience

My Preceptor:	**E**	**VG**	**S**	**NI**
Was welcoming and expecting me on the first day				
Was a good role model and demonstrated safe and competent clinical practice				
Was approachable and supportive				
Acknowledged my previous life skills and knowledge				
Provided me with feedback in relation to my clinical development				
Provided me with formal and informal learning opportunities				
Applied adult teaching principles when teaching in the clinical environment				

Describe what your preceptor did well

Describe anything you would like done differently

Signed: _____ Name: _____

YOUR CONTACT DETAILS

We care about your well-being as well as your education. If you don't arrive for a planned shift, if there is illness on the ward or in the case of an emergency we need to be able to contact you. Please could you provide the ward with your contact details and an emergency contact using the form below.

Your Name	
Your Home Phone number	
Your mobile phone number	
Name of emergency contact	
Phone number of emergency contact	

From time to time the staff on the ward may need to contact your lecturer regarding your progress, for support or in the case of problems. Please would you supply the contact details of the Lecturer/CTA that will be supporting you during this placement, in the form below?

Name of Lecturer/CTA	
Phone number of Lecturer/CTA	

This information will be kept for the length of this placement and then disposed of. It will not be shared with anyone else without your permission unless there is an emergency.