EMERGENCY DEPARTMENT

URU AROTAU

STUDENT NURSE ORIENTATION

Developed by: Nga Manu Teka: Practice Development
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Contents

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WELCOME

Welcome to Palmerston North Hospitals' Emergency Department.

We hope that you enjoy your clinical 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 patients and their whānau.

Emergency nursing is the provision of specialised care to the triaged patient that is necessary to allow the individual to achieve their full health potential, demonstrating an awareness of the inherent dignity, worth and autonomy of the individual.

- This care will be provided by registered staff, members of a multidisciplinary team, who have a comprehensive base, a full range of skills and experience required for the total spectrum of illness presenting to the department.
- A safe environment will be maintained whilst legal and ethical and professional standards are upheld.
- The patient and/or significant others will be kept informed and assist in making informed decisions about their care.

There are many learning opportunities for you in this clinical setting. The ED team is keen and willing to help you gain confidence, experience and knowledge as you practice your clinical skills in this setting. They want to see you develop personally and professionally during the course of your placement with them. Your presence in our clinical setting is valued. We want you to contribute to discussions in regard to patient care, nursing systems and the overall nursing experience during your time with us.

KEY CONTACTS

Admin Support		06 350 8049
Charge Nurse	Ange Joseph	06 356 9169 ext. 8758 Page 046
Nurse Educator	Raewyn Ormsby-Lobo	06 356 9169 ext. 8752 Page 381 Raewyn.Ormsby-Lobo @midcentraldhb.govt.nz
Associate Charge Nurse/Nurse Educator	Joel Krakosky	06 3569169 ext.8752 Joel.Krakosky@midcentraldhb.govt.nz

Please contact the Nurse Educator to confirm your start dates and times.

PRECEPTOR

You will be allocated one main preceptor who will be responsible for helping you to identify and meet your objectives. We will endeavour to ensure that you work mainly with this preceptor. However due to shift work this is not always possible. 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).

EXPECTATIONS OF THE STUDENT NURSE

Hours of work are:

- Morning duty 0700-1530 hours or 0930 - 1800
- Afternoon duty 1430-2300 hours or 1730 - 0200
- Night duty 2245-0715 hours

- You are expected to be ready to commence handover at your shift start time.
- If you are going to be late or are unwell and cannot come in, please ring the ward prior to the commencement of your shift and ask to speak to the Charge Nurse or Nurse In Charge of the shift. You must also notify your Clinical Lecturer overseeing your placement of your lateness/absence.
- If you are unable to work the days that you have been rostered, you need to discuss this with your Nurse Educator/Clinical Lecturer.
- You are expected to complete the full shift that you are allocated to work. If you are unable to do so it needs to be discussed with your preceptor and you must inform your Nurse Educator/Clinical Lecturer that you are finishing early.
- It is your responsibility to inform the preceptor that you are working with about your learning objectives/ skills to be attained. Please discuss this with the preceptor at the start of each shift.
- If you are experiencing difficulty achieving your placement objectives it is your responsibility to discuss this with your Nurse Educator/Clinical Lecturer so that a plan for managing the issue can be made.
- Knowledge of drug calculations is essential and this must be reviewed prior to commencing placement.
- You must complete the e-learning module and quiz relating to safe handling and disposal of waste prior to having patient contact on the ward. If possible, please complete this prior to commencing placement. Instructions on how to do this are on page 6.
- It is essential that you review your knowledge of normal temperature, pulse, respiration rate, blood pressure and blood glucose level ranges prior to commencing placement. It is helpful for you to have your own thermometer.
- Third year nursing students commencing their final placement need to identify early in their placement which preceptor will be completing their documentation requirements. It is the student's responsibility to ensure that the preceptor is given the required documentation in a timely manner and has an adequate timeframe to complete it in.
- Ensure that your uniform meets your institution standards and that your uniform is clean, jewellery is removed and long hair is tied back. Rings, bracelets, Fit Bits and wrist watches

are not to be worn. We have a 'Bare below the Elbow' policy which will be enforced. Your name badge and student ID card must be visible at all times when you are in the clinical setting.

- Cell phones are only to be used in your tea and meal breaks.

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 staff should make themselves familiar with the response requirements for all emergencies during their orientation. Please ensure that fire exits are always kept clear and corridors uncluttered. Exits must be clear at all times.

OBJECTIVES

Before you start on the ward please consider what you want to achieve on this placement. Bring to the ward 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.

Objectives may include but are not limited to:

- Documentation
- Gain an understanding of the multidisciplinary team
- Infection prevention and control
- Time management and prioritising care
- Vital signs – accurate recording and interpretation

PARKING

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.

ORIENTATION TO THE CLINICAL AREA

It is important that you have an awareness of the environment in which you will be working to ensure the safety of yourself, the patient and other staff members.

STUDENT ORIENTATION CHECKLIST

Orientation will include:

- Early Warning Score (Observations chart) ☐
- Maternity Warning Score (Maternity Observation Chart) ☐
- Demonstration of ED Nursing Sheet including documentation standards ☐
- Introduction to Australasian Triage Scale (ATS) ☐
- Introduction to Preceptor(s) ☐
- Rostering and allocation ☐
- Scavenger Hunt – to be completed within first 3 days ☐
- Shift Times ☐
- Tour of department ☐
- Use of Maya Journey Board ☐
- Signature and emergency contact number ☐

You will be expected to demonstrate:

- Acuity monitor inputting ☐
- Asthma equipment – PF Recording, Spacer, Nebulising ☐
- Connect chest monitor leads correctly for GE Monitors/Telemetry/ECG ☐
- Daily Checks – essential equipment ☐
- Electro Cardiograph (ECG) ☐
- IV Fluids set up ☐
- IV trolley set up ☐
- Neurological Assessment ☐
- Oxygen therapy (include nursing responsibilities) ☐
- Telemetry monitor application ☐
- Urinalysis machine ☐

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. Locate items marked * within the first 48 hours: ***(√) when complete***.

Admission books	Sling Hoist
ADT. Ampoule	Sluice room
Alcohol Swabs	Staff meeting room
Anaphylactic reaction tray (adult & paediatric)*	Where to store your bags
Asthma Trolley	Stationary- i.e. nursing sheets, FBC, Drug charts
Blood Glucose machine	Suction Equipment
Cervical Collars	Tympanic thermometer covers
Charge Nurse Office	BP equipment
Controlled Drug Cupboard	Clinical policies & procedures
Defibrillator	Photocopier
Dirty utility rooms	Telemetry sets
Dressing Materials	Laboratory forms
ECG machine	"Notes on Injectable Drugs"
Emergency button (locate but not to use without RN instructions)	Linen supplies
Emergency buttons	Oxygen isolation "shut off" valve
Emergency trolleys	Bio-hazard bags
Fire equipment*	Roster
Fire exits*	Linen bags
IV fluids	Sterile Gloves
IV Syringes	Patient charts
IV Trolleys	Stationery supplies
Paedilyte	Gynae Trolley

Peak Flow meters	Plaster room
Portable Phone	Urinalysis equipment
Procedure manuals	Pt Slide
Sphygmomanometers (Portable)	Spare IV sets, tissues and green kidney dishes
Vomit (Emesis) bags	Weighing Scales
Chem Watch safety sheets	

ORIENTATION TO KEY PEOPLE AND ROLES

WHO/WHAT	(√) when completed (x) if not applicable
Chaplains	
Charge Nurse and ACNs	
Clinical Nurse Specialists	
Duty Nurse Managers	
Nurse Educator	
Nurse Practitioners	
Preceptors	
Ward Clerk	

EMERGENCY RESPONSE

The emergency number for Fire, Cardiac Arrest and Security is 777. In an emergency situation, please follow the direction of the nursing and medical staff. Locate the following:	
WHAT	(√) when completed (x) if not applicable
Duress Button Procedure	
Emergency Bells	
Emergency Equipment	
Emergency Phone Number	
Emergency Response Flip Chart	
EWS Form and Process	

MWS Form and Process	
Fire Extinguishers	
Fire Hoses	
Portable Oxygen	
Red Phone (fire emergencies)	
Suction	

CONTROLLED DOCUMENTS

Once on placement you will need to access relevant policies, procedures and guidelines. Ask your preceptor to help you find the Controlled Documents on the intranet. *(Note: you cannot access this outside of the organisation.)*

INDIVIDUAL AREAS OF THE EMERGENCY DEPARTMENT

Assessment: Divided into bays (R7, R8, R9, AA, AB, AC, AD) which contain a bed in each. They are used for a variety of patients with conditions ranging from Nausea and Vomiting, Abdominal Pain, mild to moderate Asthma, Fractures & Chest Pain, where the patient needs to be lying down and assessed for further treatment.

Triage Area: For the Triage Nurse and Receptionists. This is where patients are assessed in order to establish acuity. From here a decision will be made as to where the patient is placed in the department. There is an attached area for taking a patient into if the discussion needs to be private or any pre-tests done before returning the patient to the waiting room.

Minor Work Station includes:

- C1-C9: Basic examination cubicles.
- Fast tack 1, Fast Track 2 - Eye Room - Contains the slit lamp and other appropriate equipment.
- Suture Bay numbered SA-SB

Resus 1-2: For patients requiring resuscitation, or those that are deteriorating where extensive resuscitation will be required e.g. ruptured AAA or multi-system trauma. These patients often require one on one nursing; they are generally triaged a category 1 or 2.

Resus 3-6: Divided into four areas: Resus 4-6 for basic resuscitation: Resus 3 (Paeds) is set up for infants and children but has provision for adult overflow. These areas are generally used for collapses that are potentially compromised e.g. chest pain cardiac origin.

AD: This is our negative pressure room that is used for but not only for infectious patients
EDOA: A short stay area for ED patients requiring social input, or extended period of

observation. Patients placed in this area have a discharge plan in place.

Plaster Room: Has its own staff Monday to Friday 0800 – 1630 hours, with the exception of Public Holidays and weekends. ED staff, provide plastering services for acute presentation's that are out of these hours or when the plaster room is extremely busy.

ED Radiology: Patients collected by radiology – no waiting room.
Toilets/Shower: Located opposite the Radiology Room. Located opposite main drug cupboard and there is also a toilet in EDOA
Stores: General equipment store for ED. Please ensure this is kept secure. We are not a supply department to the hospital.
Staff Room: Area for relaxation and lectures. Meals may be taken in this area by ED staff, visiting army staff and students.
Family Room: For distressed relatives.
Interview Room: Used for a number of reasons including confidential talks with patients/family members
Transit Lounge: Technically not a part of the ED and is staffed separately. Some patients from ED have an observation period in the area pre-discharge.
Dirty Utility: One is situated along from the Resus Area used for testing urine samples etc. It contains clean and dirty sanitizers. One is adjacent to AD and one is in EDOA. The dirty utility room opposite AD is used for taking down suture trolleys and storing used linen awaiting removal. This room is also shared with the Plaster Room.

EMERGENCY NURSING SHEET

HOW TO FILL IN EMERGENCY NURSING SHEET
Triage Sheet (Front): By Triage Nurse only
Inside Sheet (left side): Important Screening information required to be filled in. Family Violence (by trained personnel- refer this to your preceptor)
Inside Sheet (Right side):
Date: Ensure that date in the nursing notes is correct.
Time: Time of original assessment by a nurse.
Patient Presenting problem:
ASSESSMENT: The reason the patient presented, e.g. abdo pain, chest pain. Assessment including subjective and objective date e.g. EWS (observations) and action required. Baseline observations on everyone who presents to an ED area. In a critically ill patient writing A, B, C, D helps with getting important subjective information documented. Note: Written information should be clear, concise, and correct.
Example 1: A 15-year-old male presents, with a 4-hour history of central abdominal pain, nausea, vomiting and anorexia. Pain shifted to right iliac fossa about 1 hour ago. On Assessment in ED patient is pale, tender and guarding RIF, vomiting and lying in a foetal position to relieve pain.
Example 2: A 52-year-old female presents with a 1-hour history of central chest pain at rest radiating to jaw and L) arm. It is associated with SOB, nausea and profuse sweating. It is unrelieved by nitrolingual spray. Her past history shows MI 2 years ago – hx identical. O/A in ED pale, nauseated, sweating profusely (diaphoretic), hx of pain as a/a EWS 2 Resp 20

INTERVENTIONS: Interventions/Investigations required

- SOB therefore oxygen given
- Pain therefore analgesia given

EVALUATION: This is evaluation of interventions and patient condition

Please note, often it is easier to write A, I, E in notes to given some structure to your documentation. Discuss this with the nurse educator.

Signature: All staff who have cared for a patient will sign this form. This form must be co-signed by your preceptor if you are signing and writing the notes.

Outside Sheet- Patient handover/Discharge

This is the end point of the patient's journey in ED. This must be filled out prior to the patient leaving ED. This includes to the ward, rest home or home. Observations must be completed within 30 minutes of discharge.

ABBREVIATIONS USED IN THE EMERGENCY DEPARTMENT

Abbreviation	Meaning	Abbreviation	Meaning
FOOSH	Fell on outstretched hand	ROM	Range of movement
TTUTD	Tetanus Toxoid up-to- date	POP	Plaster of Paris
DNW	Did not wait	BEPOP	Below elbow POP
PRN)	As required	BKPOP	Below knee POP
SOS)	Or as necessary	AKPOP	Above Knee POP
TCA	To see again	AEPOP	Above Elbow POP
#	Fracture	ROP	Removal of POP
XR	X-ray	ROS	Removal of sutures
NBI	No bone injury	LAC	Laceration
NBT	No bone trauma	COD	Change of dressing
NAD	No abnormality detected	DOA	Dead on arrival
RICE	Rest, ice, compression (crepe), elevation	KOED	Knocked out
Tmt	Treatment	FB	Foreign body
Tet tox	Tetanus Toxoid	Script	Prescription
MSU	Midstream urine	CABG	coronary artery bypass graft

PERL	Pupils equal, reacting to light	GP F/U	GP follow up
IAB	Ischaemic arm block	OPD	Outpatients department
CORD	Chronic obstructive resp. disease	MO	Medical Officer
Card Enz(CE)	Cardiac Enzymes	FBC	Full blood count
Glc (Gluc)	Glucose	U & E's	Urea and electrolytes
Urine HCG	Urine pregnancy test	WCC	White cell count
Mis (c)	Miscarriage	CNC	Clinical Nurse Coordinator
TL	Team Leader	ACNC	Associate Charge Nurse
TI	Trainee Intern	SN	Staff Nurse

ORIENTATION PROGRAMME FOR 3rd YEAR AND TRANSITION STUDENTS

OVERALL OBJECTIVES

- To familiarise yourself with the layout of the department in order to ensure you are able to participate and assist your preceptor with patient care, especially in emergency situations, making your experience in ED valuable and educational.
- To be aware of department policies and legalities.
- To observe the skills and techniques of assessment, relate the presentation of the patient and differential diagnosis to the care and treatment given in the decision-making process.
- To learn and practice new procedures.
- To be aware of the psychological needs of patients in their new environment.
- To observe and learn resuscitation measures and procedures.
- To administer IV medication (once you have completed the worksheet and obtained a 100% pass) under the direct supervision of your preceptor with the exception for IV opioids which you cannot administer.

GOAL OF ORIENTATION

1. ASSESSMENT

a) Assessment of patients using a systematic assessment framework – adult and child (ADPIE, Primary/secondary survey, PAT)

b) Documentation of assessment

c) Understanding of Early Warning Score (EWS), Maternity Warning Score (MWS)

2. INVESTIGATIONS/INTERVENTIONS

a) Understanding the use of equipment and procedures: (Under direct supervision)

- oxygen
- suction
- resus trolley and monitor/defib
- ECG
- GE Monitors
- Acuity
- Peak flows
- IV Pumps
- Airvo

3. COMMUNICATION/DOCUMENTATION

a) To be aware of documentation standards and to demonstrate good documentation.

b) Demonstrate good communication skills when relating assessment to other health professionals; ISBAR

c) To be aware of different forms/pathways required for different presentations

d) To be of aware of responsibilities related to direction/delegation

e) To demonstrate patient handovers

First Two Weeks in ED

1) EQUIPMENT:

a) You should be able to locate and use the following equipment and know where to find stock to replace used equipment as needed:

- Suction
- GE Monitors
- Oxygen Cylinders
- Oxygen Masks
- Emergency Bells
- Dressings
- Linen
- Asthma trolleys
- Urine Specimen Jars
- Observation Charts
- Nursing Notes
- ECG Machines
- IV Pumps
- Emergency Trolleys

2) ASSESSMENT:

a) You will be supernumerary for the first few days: in week one, learning where equipment is, the flow of patients throughout the department, necessary documentation and routine requirements for each patient. It is expected by the end of the first week you will be assisting your preceptor to assess each patient in your area, carry out any necessary investigations, give analgesia as needed and plan care for each patient.
b) You should be using your initiative within the first two weeks and anticipating basic requirements of new and existing patients in your area in conjunction with your preceptor.
c) We hope to move you throughout the department over the first two weeks so you can see how each area functions to ensure patient safety and flow is maintained.

3) MEDICATION:
a) On your first day you will be given a written drug test, with a resource booklet, to complete. Once completed and marked by the educator you will be required to sign a form and keep a record of your test so that you can then administer IV medication excluding opioids under the direct supervision of your preceptor.

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 principals 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 could 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.