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

Medical Specialty Ward
URU AROTAU
STUDENT NURSE ORIENTATION

Ngā Manu Teka
Practice Development Unit

Updated July 2023

Contents

DOCUMENT CONTROL

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WELCOME

Welcome to Medical Specialty Ward- Te Whatu Ora Te Pae Hauora O Ruhaine | Midcentral Hospital. We hope you will enjoy your clinical placement here, applying theoretical knowledge to practice, expanding your knowledge base and advancing your nursing skills. More importantly, we hope that you will learn how to establish rapport and work in partnership with patients, family/whānau and the multidisciplinary team.

This booklet will provide background information about Medical Specialty Ward, and the team that you will work with, what resources you will find useful during your clinical placement.

This is primarily an acute Medical Ward, with a 13 bed Covid isolation ward. The ward specializes in the care of patients with Renal, Respiratory conditions and Gastro specialities. As a medical ward we also care for patients with

- Acute and Chronic conditions such as diabetes, heart conditions such as heart failure, neurological conditions, and stroke
- Delirium and dementia
- Palliative and end of life management
- Patients with eating disorders
- A variety of other medical conditions and procedures

There may be opportunities for you to observe and experience emergency care in the hospital setting during your placement here.

KEY CONTACTS

Charge Nurse	Jannine Jackson	(06) 356 9169 Ext 7050- 0273301869
Associate Charge Nurses	Prescilla Marama	(06) 356 9169 Ext 7050 0273301869
Nurse Educators	Subi Joseph Gemma Stone	Pager: 7055 subi.joseph@midcentraldhb.govt.nz gemma.stone@midcentral.govt.nz
Clinical Coach	Binu George	
Ward Clerk	Deidrie Farr	(06) 356 9169 Ext 7024

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

Team Members

In order to provide a holistic care and respond to the increasing complexity of patient needs, collaboration between MDT members is essential. As nurses, it is important you understand, and value these MDT members' roles. There is an expectation to collaborate with the members of the MDT to facilitate positive patient outcomes.

Clinical Nurse Specialists Respiratory, Gastro and Renal: The CNS works within and across health care systems and the continuum of care to deliver advanced nursing practice activities and outcomes. The CNS functions as an expert practitioner, consultant, leader, educator, researcher, and change agent in achieving clinical excellence and improved health outcomes.

Chaplain: Care for patients' spiritual needs as they request.

Dietitian: Assess patients' nutritional requirements and provide suggestions and education accordingly.

Social worker: Assess patients' social situation focusing on the person and their support systems. Based on the assessment, the social worker may refer the patient to other services for at home support, convalescent/continuing care, hospital discharge planning and personal/financial support.

Physiotherapist: Assess patients' mobility and organise appropriate mobility aids and provide specialist care for respiratory patients with breathing difficulties.

Occupational Therapist: Assess patients to improve their ability to perform tasks at a maximum level of independence in their daily lives. If any issues are identified the appropriate aids can be issued. They also perform cognitive assessments.

Speech Language Therapist: Assess patients who have problems with swallowing or speech and give appropriate advice regarding patients' diet for safe swallowing.

Pharmacist: Provide medication reconciliation, ensure correct charting of drugs and no contraindications, and provide patient education about their medications as appropriate.

Preceptor

You will be allocated a primary preceptor and follow their rostered duties which may include morning, afternoon, nights and weekends. There may be times your primary preceptor is not on duty and you will be allocated a secondary preceptor.

EXPECTATIONS OF THE STUDENT NURSE

- On the first day please complete the Student contact details form (page 19) and give it to the Charge Nurse or nurse in charge of the shift.
- It is expected that you arrive on time and if you are going to be late or unwell and cannot come in please ring and ask to speak to the Charge Nurse/nurse in charge of the shift. Hours of work are:
    - Morning duty 0700-1530 hours
    - Afternoon duty 1430-2300 hours
    - Night duty 2245-0715 hours
- We endeavour to give you continuity of preceptor(s) wherever able. If you are unable to work the days that you have been rostered, you need to discuss this with the Charge Nurse or your Clinical Lecturer.
- You must complete the full shift that you are allocated to work.
- The preceptor you are working with needs to be aware of your learning objectives.
- Your preceptor will work with you to help you learn about assessment and management of a variety of conditions relevant to the setting.
- A working knowledge of drug calculations is essential.
- You are required to review your knowledge of normal temperature, pulse, respiration rate, blood pressure, pain assessment and blood glucose levels.
- Third year nursing students commencing their final placement need to identify which preceptor will be completing their documentation requirements and ensure their preceptor has an adequate timeframe to complete this.
- Please ensure that your uniform meets your institution standards.
- Please complete the Preceptor Evaluation Form (Page 18) and give this to the Charge Nurse.

Health and safety

Everyone 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 and near misses 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. You will be expected to be able to locate emergency equipment such as the emergency trolley. You must ensure that fire exits are always kept clear, and corridors uncluttered, and trip hazards are remedied. Exits must be always clear.

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.

MAHI TAHI – (Better Together) procedures MDHB- 7858

The Mahi Tahi Better Together programme is guided by the concept of Motu Rākau Mānuka, which translates to a grove of tea tree. The Pae Ora team has provided this guiding concept based on the mānuka tree, which is known to many as a healing tree. This unassuming shrub might well be considered the backbone of Te Wao Nui a Tāne. Mānuka is the hardworking healer, tenacious yet humble, quietly supporting the land and the people in the background. Māori traditionally used mānuka for a variety of reasons.

WHAT IS PATNER IN CARE?

Mahi Tahi Better Together is an initiative that recognises the important role people and whānau have in the ongoing care of patients. This involves staff asking people if they wish to have a "Partner in Care" during their hospital journey. A Partner in Care is someone who helps the patient, usually a relative or friend, in their day-to-day life. They are not the same as a visitor or someone who provides care professionally or through a voluntary agency. The Partner in Care role enables significant people to be more active in the persons care while in hospital. Each Partner in Care will be given a complete overview of the Mahi Tahi Better Together programme and an orientation on the ward by the relevant staff member. The orientation will include discussions on amenities, security, emergency and evacuation procedures, privacy, appropriate behaviour, parking and refreshments.

Partners in Care will:

- Have open access to hot drink facilities, fridge and a microwave.
- Have free parking.
- Be able to request a meal to eat alongside the patient.
- Be given an access card, where applicable.
- Be able to request a recliner chair to sleep on overnight, if available
- Have access to public toilets, as well as shower facilities at Te Whare Rapuora

TE MĀWHENGA TŪRORO: PATIENT DETERIORATION

Acute deterioration can happen at any point during a patient's admission to hospital. If acute deterioration is recognised early (Early Warning Score) and responded to appropriately, patient outcomes can be improved. The Deteriorating Patient programme resulted in the implementation of the national Early Warning Score (EWS) observation chart, which has been adapted for Primary Care into some Integrated Family Healthcare Centres (IFHCs), in District Nursing, Child and Neonates and Maternity.

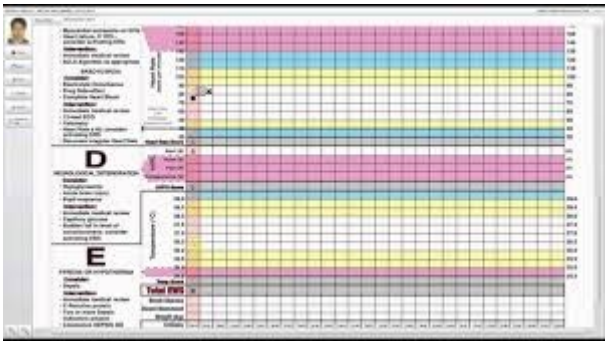
KORERO MAI AND SHARED GOALS OF CARE

Following on from the successful introduction of the national early warning score process, MidCentral DHB embarked on the next stage of the Deteriorating Patient Programme, Korero Mai. Patients, families and whānau often recognise subtle signs of patient deterioration even when

vital signs are normal. Korero Mai refers to a patient, family and whānau escalation of care process as part of the recognition and response system.

Unwanted or unwarranted treatments at the end of life can contribute to suffering for patients, families and whānau, moral distress for clinicians, and unnecessary expenditure for the health system. Documented shared goals of care represent the outcome of a shared decision-making process between the patient, whānau and the clinical team. At a minimum, the overall direction for an episode of care (e.g. curative, restorative, palliative or terminal) and any agreed limitations on medical treatment need to be identified.

Effective communication is necessary to get patients' values and preferences for care and ensure informed choices can be made about complex medical treatment options. Ideally these conversations occur prior to episodes of acute deterioration without the pressures of an evolving and emergent clinical crisis. The benefit of working within the 'Goals of Care' framework is that it encourages clinicians to think carefully about a patient's prognosis and likely response to treatment and to determine what treatment options are most important within the context of that person's overall life trajectory. This process respects patients' autonomy; it helps identify those who may wish to decline treatments that might otherwise be given by default, and raises awareness of the importance of discussing with patients and/or their whānau what their real wishes are with regard to medical treatment. It helps to ensure that patients are offered care appropriate to their condition and not subjected to burdensome or futile treatments. In all of these aspects, the SGOC framework adopts an approach supported by the nursing profession. It also provides an incentive for treatment decisions to be made in a considered fashion by the team primarily responsible for the patient's care rather than in response to a crisis—e.g. a MET call/Rapid Response Team/Cardiac Arrest callout—which often occurs after hours and is attended by medical staff who do not know the patient and are unable to speak to their relatives or other substitute decision makers.

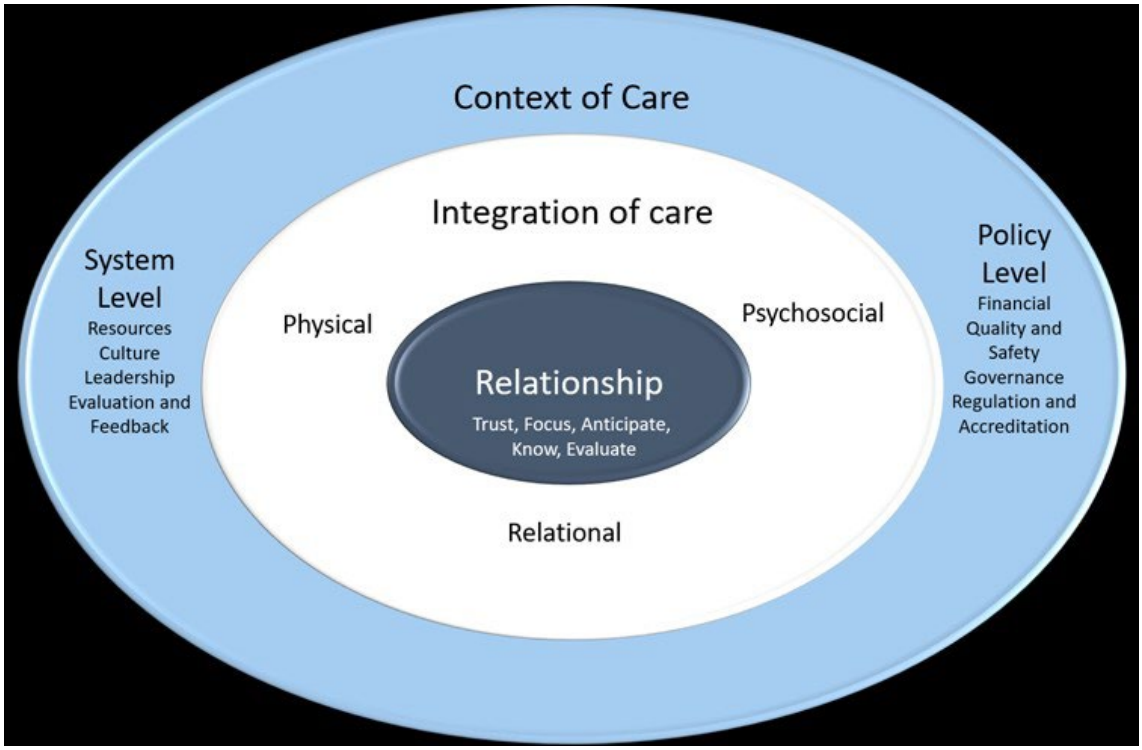


Locate and familiarise yourself with the EWS documents and escalation process.

THE FUNDAMENTALS OF CARE

Fundamental care involves actions on the part of the nurse that respect and focus on a person's essential needs to ensure their physical and psychosocial wellbeing. These needs are met by

developing a positive and trusting relationship with the person being cared for as well as their whānau[1].



This is being implemented currently by the Nursing and Midwifery Directorate.

MIYA BOARDS

MidCentral DHB is the first to roll-out of the next-generation Miya Precision platform. Miya Precision is being used across 17 wards and the Emergency Department (ED) at Palmerston North Hospital, and two wards at Horowhenua Health Centre. It delivers real-time patient flow information and bed management updates to MDHB staff and can be accessed by clinicians using an iPad at the bedside, workstation, and patient journey boards installed in each ward.

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[1] Feo, R., Conroy, T., Jangland. E., Muntlin Athlin, Å., Brovall, M., Parr, J., Blomberg, K., & Kitson, A. (2017). Towards a standardised definition for fundamental care: A modified Delphi study. Journal of Clinical Nursing, 27, 2285-2299. doi: 10.1111/jocn.14247

The software has successfully integrated with five clinical information systems at MDHB, including WebPas, CareStream Radiology, Clinical Portal and Pathology to provide clinical staff with detailed patient information displayed on the ward's journey board. Clinicians at the bedside can use Miya Precision to view the patient's admission history, demographics and test results, making it simple and fast for them to make the right care decisions based on real-time information.

Miya Precision's Hospital Operations Centre is also providing a high-level overview of hospital bed occupancy in real-time, with the ability to drill down into individual departments and wards for more detailed insight. This allows staff to quickly allocate the best beds for each individual patient, minimising wait times and keeping the patient journey as smooth as possible.

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.

EXPECTATIONS REGARDING CLINICAL LOAD

- Year Two/ 600 Level: a clinical placement in a medical/surgical area. Students take 2-3 patients, with preceptor support, as they progress through the 3/6-week placement.
- Year Three/ 700 Level: In the final 9-week transition placement the expectation is that by week 5 the student manages the preceptor's entire patient case load largely independently.

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.

- ☐ Emergency trolley
- ☐ "Notes on Injectable drugs" Book
- ☐ Kitchen/ Staff bathroom
- ☐ Clean utility
- ☐ Stationery supplies
- ☐ Patients' charts and documents
- ☐ Linen supplies
- ☐ Sling Hoist and its spare battery, St
- ☐ Dr's office
- ☐ Procedure room
- ☐ Visitor toilet
- ☐ Photocopy machine
- ☐ NHI label printer
- ☐ Nebuliser
- ☐ Charge nurse office
- ☐ Roster
- ☐ Staff tea room
- ☐ Dirty utility
- ☐ Patient education pamphlets
- ☐ Patient lounge/ public phone
- ☐ Drug room
- ☐ Equipment storage (IV, ECG)
- ☐ Weighing scales, sitting scale.
- ☐ Manual BP machine
- ☐ emergency bells
- ☐ Blood glucose machine
- ☐ Lampson Tube system
- ☐ Fire alarm/extinguisher/hose

ORIENTATION TO KEY PEOPLE AND ROLES

WHO/WHAT	(√) when completed (x) if not applicable
Charge Nurse	
Clerical Support	
Clinical Nurse Specialists	
Enrolled Nurses	
Health Care Assistants	
Multi - Disciplinary Team Members	
Nurse Educator	
Preceptors	
Registered Nurses	

EMERGENCY RESPONSE

The emergency number for Fire, Cardiac Arrest and Security is 777. In an emergency, 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 Forms and Process	
Fire Extinguishers	
Fire Hoses	
Portable Oxygen	
Red Phone (fire emergencies)	
Suction	

WARD ROUTINE

TIME	ACTION

0700	For AM Shift
	▪ Handover from night staff to AM staff in the clinical resource room, followed by bedside handover.
	▪ Bedside handover includes
	  ○ Introduce self to patients
	  ○ Check oxygen, suction and equipment in working order
	  ○ Checking medication chart, ensuring no omissions
	  ○ Check drug infusions and fluid balance charts
	▪ Ensure patient beside board is up to date.

0715	▪ Ensure all risk assessment are completed and prevention measures are in place. ▪ Make your plan of care for the shift. ▪ Prepare medications to administer at appropriate times. ▪ Take blood sugar levels on patients with diabetes prior to breakfast.
0800-0900	▪ Attend doctors ward rounds, these generally start at 0800. Ensure medical staff discuss the plan of care for the patient with you ▪ Ensure you are with your patient(s) when the team arrives. Do a complete assessment for skin integrity, dressing changes needed and hygiene needs e.g. shower, bed bath and hair wash. ▪ Document ▪ Ensure patients required to be nil by mouth for diagnostic tests are aware ▪ Take vital signs as noted in Care Plan.
0900-1030	▪ Morning tea –at the beginning of the shift liaise with your buddy nurse to organise tea and meal breaks. ▪ Attend to patient's hygiene needs. Delegate to HCA's as appropriate. ▪ 0915 Rapid Rounds- Liaise with Allied Health professionals at the MDT meeting and complete necessary referrals. ▪ Update documentation. ▪ Complete TrendCare categorisations & predictions before1000hrs
1100-1330	▪ Dressings – CVL, wound dressings. ▪ Check IV lines. ▪ Pressure area care – turn/reposition patient and document. ▪ Half-hour lunch break should occur at this time. Handover your patient to your preceptor before leaving the unit.
1400-1530	▪ Check results of any routine blood tests. ▪ Complete TrendCare actualisations after 1400hrs

	▪ Bedside handover to afternoon staff following handover in meeting room. ▪ Negotiate with your preceptor to attend clinical teaching sessions/tutorials. ▪ Total fluid balance charts for the shift. ▪ Empty drainage bags. ▪ Check linen and rubbish bags. ▪ General clean and restock of own work area – report low stocks.
TIME	ACTION
1430-1700	For PM shift ▪ Bedside handover to afternoon staff following handover in clinical resource room. ▪ Bedside handover includes ○ Introduce self to patients ○ Check oxygen, suction and equipment in working order ○ Checking medication chart, ensuring no omissions ○ Check your drug infusions and fluid balance charts ○ Ensure patient beside board is up to date. ▪ Ensure all risk assessment are completed and prevention measures are in place. ▪ Initial patient head to toe assessment and documented in notes. ▪ Make your plan of care for the shift.
1700-1900	▪ Complete TrendCare categorisations & predictions before 1700hrs ▪ Half-hour dinner break –at the beginning of the shift liaise with your buddy nurse to organise tea and meal breaks. ▪ Vital signs/fluids/ monitoring as per care plan. ▪ Document any changes in the plan in the notes. ▪ Ensure Trend Care is up to date.
1930-2100	▪ Complete TrendCare actualisation after 1900hrs ▪ Settle patients for the night. Do a complete assessment for skin integrity, dressing changes as needed. ▪ Vital signs/fluids/monitoring as per care plan.
2100-2300	▪ Dim lights on ward ▪ Check results of any routine blood tests. ▪ Vital signs/fluids check as required. ▪ Update clinical record.
2245-2315	Empty ▪ Rubbish bags ▪ Catheter bags

	▪ Linen Skip ▪ General clean and restock of own work area – report any low stocks. ▪ Handover to night staff followed by beside handover.
Time	Action
2245-2400	For Night Shift ▪ Bedside handover to afternoon staff following handover in handover room. ▪ Bedside handover includes ○ Introduce self to patients if they are awake ○ Check oxygen, suction and equipment in working order ○ Checking medication chart, ensuring no omissions ○ Check your drug infusions and fluid balance charts ○ Ensure patient beside board is up to date. ▪ Ensure all risk assessments are completed and prevention measures are in place. ▪ Make your plan of care for the shift. ▪ *Total previous 24-hour fluid balance.*
2400-0300	▪ Complete TrendCare categorisations & predictions before 0100hrs ▪ 4 hourly vital signs/fluid checks. ▪ Ensure Trend Care is up to date *We encourage periods of rest and sleep for patients during the night where this is possible. If your patient is stable, please allow them to rest. Turn the lights as low as possible and minimise external sources of noise.*
0400-0600	▪ Complete TrendCare actualisations after 0400hrs ▪ Review medications for all patients – fax morning requirements to pharmacy. ▪ Full range of routine blood tests sent to lab now – if requested. ▪ Toilet all high risk of falls patients. ▪ Empty catheter bags. ▪ Check linen skip and rubbish has been emptied. ▪ Discard any reconstituted drugs at the end of your shift. ▪ General clean and restock of own work area – report low stocks.
0700	▪ Welcome morning staff ▪ Handover

COMMON MEDICATIONS

Administration of IV therapy is in accordance with the IV and Related Therapies Policy available on the intranet. According to the Basic Certification Standard please note “Students (nursing, midwifery, radiologic technology, anaesthetic technology), and their respective clinical lecturers/clinical teaching associates are expected to adhere to the standards and principles of this document”.

DRUG GROUP	EXAMPLES
Beta blockers	Metoprolol Carvedilol Bisoprolol
Calcium channel blockers	Diltiazem Felodipine Amlodipine
Ace inhibitors	Cilazapril Quinapril
Diuretics	Frusemide Spironolactone
Statins	Atorvastatin Simvastatin
Antiplatelets	Aspirin Ticagrelor Clopidogrel
Anticoagulants	Enoxaparin Dabigatran Warfarin Rivoroxaban
Nitrates	Duride GTN spray
Analgesia	Morphine Fentanyl
Fibrinolytic Agents	Alteplase and Doronease
laxatives	Lactulose Laxol Movilcol
Antimemetic	Cyclizine Domperidone Ondansetron Metoclopramide
Antibiotics	Amoxicillin Penicillin Augmentin Ceftriaxone Cephazolin Flucloxacillin Gentamycin Tazocin Vancomycin Metronidazole
Anta acids	Omeprazole Milk of Magnesia Mylanta Acidex
Diabetes	Gliclazide Metformin Galvumet Vildaglaptin Insulin- Novarapid Lantus Humulin Protophane Penmix Actrapid

Sedatives	Lorazepam Diazepam melatonin Zopiclone Haloperidol Risperidone
Antiepileptic	Epilim Leviceteram
Steroids	Prednione Dexamethasone

Please Contact the pharmacist, refer medsafe, NZ formulary for drug information.

WHERE IS IT?

The pharmacy or other wards in the hospital:

Pharmacy imprest on intranet

DOCUMENT MANAGEMENT SYSTEM CONTROLLED DOCUMENTS

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

DOCUMENTS	DOCUMENT ID
Patient observation and early warning score (EWS) (note: ISBAR tool – very useful communication tool)	5842
Clinical Record Content and Maintenance	MDHB-672
Fluid balance Chart	
Clinical Documentation and management	MDHB-471
Shared Goals of Care plan	
Administration Of Medicines	MDHB 11
Adult IV opioid Protocol for patients in pain with existing IV access	MDHB-1034
Chest Drain (intercostal catheter) insertion underwater seal drain management and catheter removal	MDHB-1073
Mahi Tahi (Better together) procedure	MDHB - 7858
Discharge	3612
Neurological observation	52
Peritoneal Dialysis	MDHB -4965
Restraint minimisation	MDHB 4274
Safe mobility, assessment, and Management, reporting and recording	MDHB 680
Airvo3: High flow nasal cannula (HFNC) oxygen therapy and non-invasive ventilation (NIV)	MDHB 8550
AIRVO 2 – High Flow Nasal Oxygen	MDHB 7734
Warfarin Therapy Adult Guidelines	

For more procedures follow the Lippincott manual on the Intranet.

Useful Abbreviations

Abbreviations should be avoided in clinical records whenever possible to prevent misinterpretation and miscommunications between staff. You may see the below list of common abbreviations used on handover sheets.

ACS	Acute coronary syndrome
AF	Atrial fibrillation
AKI	Acute kidney injury
ABG	Arterial blood gas
BPAP	Bilevel positive airway pressure
CABG	Coronary artery bypass graft
CPAP	Continuous positive airway pressure
CHF	Congestive heart failure
COPD	Chronic obstructive pulmonary disease
CVL	Central venous line
CAP	Community acquired pneumonia
D/C CV	D/C Cardioversion
ECG	Electrocardiogram
EF	Ejection fraction
FBC	Fluid balance chart or Full blood count (depending on context)
GTN	Glyceryl trinitrate
HTN	Hypertension
ICD	Implantable cardioverter-defibrillator
IDC	Indwelling catheter
IHD	Ischaemic heart disease
IVAB	Intravenous antibiotics
IVC/ PIVC	Intravenous cannula/ Peripheral intravenous cannula
IVF	Intravenous fluids
ESRF	End stage renal failure
SPO2	Oxygen saturation in blood
NIV/NIPPV	Non invasive ventilation/ Non invasive positive pressure ventilation
NRT	Nicotine replacement therapy
PICC	Peripherally inserted central catheter
PPM	Permanent pacemaker
SOB(OE)/(AR)	Shortness of breath (On exertion)/(At rest)

TnT	Troponin T
T1RF/T2RF	Type 1 respiratory failure/ Type 2 respiratory failure
AT &R	Assessment Treatment and Rehabilitation
CBG/ BGL	Capillary Blood glucose / Blood Glucose level
CNS	Clinical Nurse Specialist

EVALUATION OF YOUR PRECEPTOR

Please return your evaluation to your Charge Nurse

Name of Preceptor_____ Date_____

E = Excellent VG = Very Good S =

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.

Day 1 Onwards Objectives	Week 1
• Meet the Educator or the clinical Coach	• Meet the staff
• Orientation to the ward	• Ward Orientation on routine
• Meal breaks and Shift break	• Plan your learning goal plan with the Preceptor for the week
• Introduction to staff and the preceptor	• Start to familiarise with the hospital policies and protocols
• Expectation of the student explained.	• Access patient files - maintain confidentiality
• Infection control practices and Isolation	• Assist with normal assessments and medication administration process
	• Complete the drug calculation test
	• Participate and support the patients care and activities
	• Write patient clinical progress notes with the RN and according to the documentation standards
Other Activities	**WEEK 2**
• Attend Ward in-services	• Have a patient allocated, managing planning, implementation and care of plan
• Work on nursing competencies	• have the preceptor to evaluate the week
• Work on Treasure Hunt	• Follow up with the Nurse educator and Lecture
• Work on Drug Calculation test	• Plan your goals to achieve
• Admission and Discharge Process	• Handing over to the next shift
• Trend care and Risk assessment	
Other Activities	**Week 3**
• Continue the same	• Work on week 1 and 2
• Patient Education	• Patients 2-3
• Intranet Overview	• Evaluate the type of patients you look after
• Respiratory Assessment	• Engage in MDT meetings and referrals
• GI assessment	• Wound care and skin assessment
• Renal Assessment	• Providing Patient education on DBE, inhalers, peak flow, Fluid restriction. DVT, Encourage • mobility
Other Activities	**Week 4, 5 and 6**
• Continue the same	• Follow up with the Nurse educator and Lecture at week 4 and 6 or as required
• Pain management principles	• Undertake 2-3 patient load and do the assessment
• Septic screening	• Engage in MDT and referral
• Blood Transfusion basics	• Complete and achieve the goal plan
	• Complete the overall evaluation of the clinical placement and preceptor

What makes a successful student?

Phone Etiquette:

- Answer the phone whenever you are able to. This shows willingness to learn and help the team.
- An example of professional phone etiquette: “Good morning/ afternoon Medical Specialty ward Student Nurse (name). How can I help?”
- Take a message, noting the caller’s name and phone number and quickly pass on message.
- Make sure you **do not** disclose patient information over phone, always refer to your RN preceptor.

Ask lots of meaningful questions:

- What is the clinical indication for this change to treatment?
- Would it be useful to document this error/near miss in Riskman?
- What can I do to help?
- Can I document this in the notes? For example: patient family request, update daily care plan or complete admission/ discharge documentation.

Ask to go places with the patient:

- Theatre
- Radiology (CT/ X-Ray)
- Endoscopy
- Pharmacy
- Medlab

Ask to do and see things (always with patient informed consent):

- Dressings
- Procedures
- Vital Signs
- ECG
- Blood Sugar Checks
- IDC insertion
- IVC insertions and management
- Chest Drain management
- Airvo management
- End of Life Care management

Always have a note book and pen!

Take notes of conditions to further research later.

Just remember…

A clinical placement is a perfect opportunity to show a future employer why they should employ you when you are a new graduate RN.