



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

STUDENT NURSE ORIENTATION

MAIMOATIA TE KOHIWI

OLDER PEOPLE'S ACUTE ASSESSMENT AND LIAISON (OPAL) UNIT

Developed by: Nga Manu Teka: Practice Development
Revised: January 2024

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KEY CONTACTS

| | | |
|----------------|-------------------|---------------------------------|
| OPAL | Ward Clerk | 06 350 9159 ext. 7250 |
| Charge Nurse | Stephanie Russell | 06 350 9159 ext. 7251 |
| Nurse Educator | Jan Waldock | 06 350 9159 ext. 7250 Pager 403 |
| | | |

DOCUMENT CONTROL

| Version | Issue & Circulation Date | Brief Summary of Change |
|----------|--------------------------------------|--|
| 1. | November 2019 | |
| 2. | January 2024 | Update contacts; Duty times; Expectations; Orientation |
| 3. | | |
| Authors | Yvonne Stillwell: | |
| Location | MDHB: student | |
| Contact | Jan Waldock | |
| Approved | November 2019. Revised as above 2024 | |

WELCOME

Welcome to Te Whatu Ora Te Pae Houora o Ruahine o Tararua MidCentral and OPAL. We hope that you enjoy your time with us and that you find it a worthwhile and interesting learning experience. This package will give you some brief information about what you can expect from your time with us.

Timely care for Older People with Frailty (OPF) with acute illness is a multifaceted approach with proven benefits. Providing the right care in the right place and at the right time will not only improve the quality of care for this group of patients but it will also improve functional outcomes, reduce in-hospital complications and facilitate timely transfer of care back to the community, by promoting early mobilisation to prevent deconditioning, focusing on what's important to the patient and developing an integrated and coordinated care plan in conjunction with the patient, carers and the primary care team.

The OPAL Unit is a dedicated 31 bedded (27 acute care and 4 delirium) for older people with frailty, with 6 of these beds in side rooms. Admission and exclusion criteria includes:

- Age 75 or over (65 and over for Maori & Pasifika) with frailty and
 - an acute medical illness (e.g. infection) and/or
 - geriatric syndromes such as immobility, multi-morbidity, incontinence, dementia, polypharmacy, psychosocial problems, delirium and falls.

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.

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

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 a Partner 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, Te Whatu Ora Te Pae Houora o Ruahine o Tararua MidCentral 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

Compassionate
Ka whai aroha

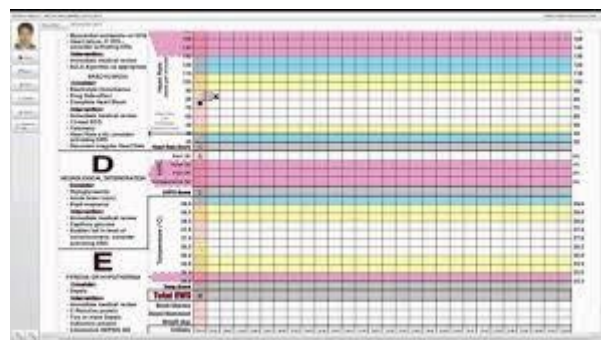
Respectful
Ka whai ngākau

Courageous
Ka mātātoa

Accountable
Ka noho haepapa

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 Shared Goals of Care (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.

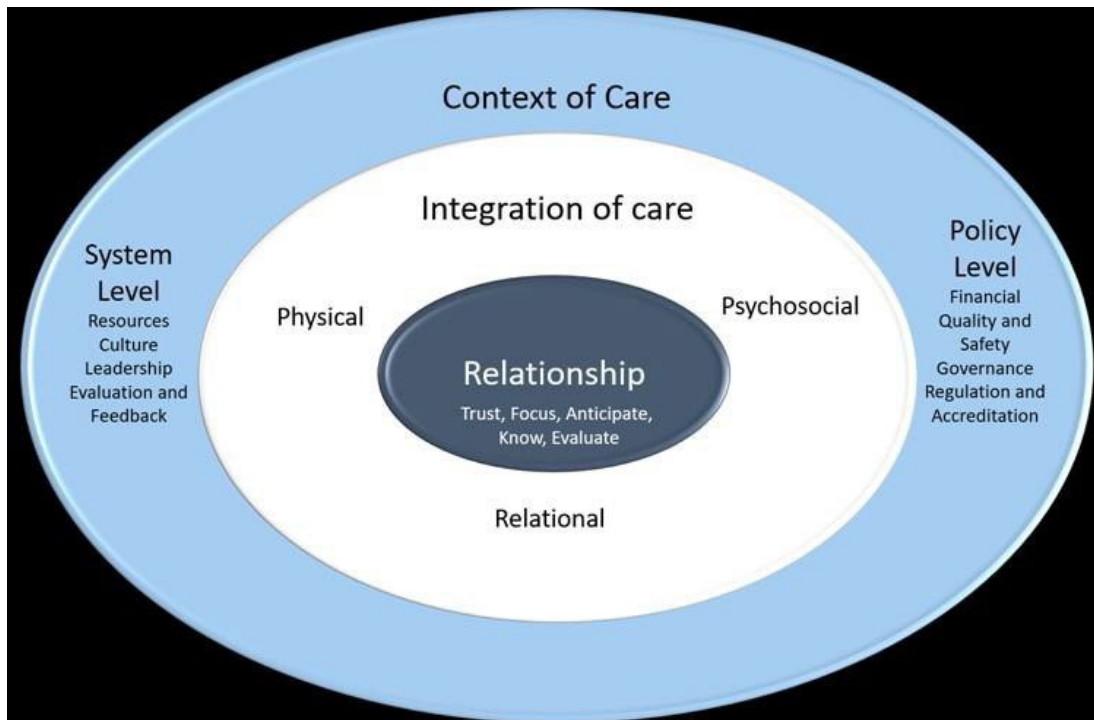


Locate and familiarise yourself with the EWS documents and escalation process.

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 whānau¹.

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



This model has been implemented by the Nursing and Midwifery Directorate.

MIYA BOARDS

Te Whatu Ora Te Pae Houora o Ruahine o Tararua MidCentral 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), 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.



The software has successfully integrated with five clinical information systems at Te Whatu Ora Te Pae Houora o Ruahine o Tararua MidCentral, 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.

EXPECTATIONS OF THE STUDENT NURSE

- On the first day please complete the Student contact details form (page 21) and give it to the Nurse Educator, Charge Nurse or nurse in charge of the shift.
- It is expected that you arrive on time, ready for handover 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 as soon as possible before 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 possible. If you are unable to work the days that you have been rostered, you need to discuss this with the Nurse Educator 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 and daily goals.
- Familiarity with the Rockwood Clinical Frailty Scale, the Early Warning Score and Behavioural Observation Chart will assist you in understanding the conditions of patients and their management.
- 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. Please 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 and always display your name badge where it can be seen.

Please contact the Charge Nurse, Nurse Educator or nurse in charge of the shift at least one week prior to the placement for your roster. Your Clinical Lecturer will confirm your start dates and times. If you are unable to attend your placement, please ring the ward and advise the Charge Nurse/Nurse Educator and your Clinical Lecturer.

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.

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

Compassionate
Ka whai aroha

Respectful
Ka whai ngākau

Courageous
Ka mātātoa

Accountable
Ka noho haepapa

be completed while on that placement. Use your initiative to make the most of your placement, for example:

- Ask lots of questions
- Ask to go places relevant to the patients care, e.g. Theatre, radiology
- Ask to do and see things, e.g. Dressings, procedures.
- Attend in-service as appropriate

Objectives may include but are not limited to:

- Documentation
- Gain an understanding of the multidisciplinary team
- Infection prevention and control
- Patient assessment-including risk assessments
- Time management and prioritising care
- Vital signs – accurate recording and interpretation
- Wound management

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. You are required to complete a clinical area orientation checklist. This is provided by your academic institution: once completed give this to your Clinical Lecturer.

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.

ORIENTATION TO KEY PEOPLE AND ROLES

| WHO/WHAT | (√) when completed (x) if not applicable |
|----------------------------|---|
| Associate Charge Nurses | |
| 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 situation, please follow the direction of the nursing and medical staff. Locate the following:

| WHAT | (v) 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 | <p>For AM Shift</p> <ul style="list-style-type: none"> ▪ Handover from night staff to AM staff in the clinical resource room, followed by bedside handover. ▪ Bedside handover includes <ul style="list-style-type: none"> ○ 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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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 before 1000hrs |
| 1100-1330 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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. |

| | |
|-------------|--|
| | <ul style="list-style-type: none"> ▪ General clean and restock of own work area – report low stocks. |
| TIME | ACTION |
| 1430-1700 | <p>For PM shift</p> <ul style="list-style-type: none"> ▪ Bedside handover to afternoon staff following handover in clinical resource room. ▪ Bedside handover includes <ul style="list-style-type: none"> ○ 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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ Dim lights on ward ▪ Check results of any routine blood tests. ▪ Vital signs/fluids check as required. ▪ Update clinical record. |
| 2245-2300 | <p>Empty</p> <ul style="list-style-type: none"> ▪ 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 | <p>For Night Shift</p> <ul style="list-style-type: none"> ▪ Bedside handover to afternoon staff following handover in handover room. ▪ Bedside handover includes <ul style="list-style-type: none"> ○ 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. ▪ <i>Total previous 24-hour fluid balance.</i> |
| 2400-0300 | <ul style="list-style-type: none"> ▪ Complete TrendCare categorisations & predictions before 0100hrs ▪ 4 hourly vital signs/fluid checks. ▪ Ensure Trend Care is up to date <p><i>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.</i></p> |
| 0400-0600 | <ul style="list-style-type: none"> ▪ 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 | <ul style="list-style-type: none"> ▪ Welcome morning staff ▪ Handover |

COMMON MEDICATIONS

This placement is a good opportunity for you to familiarise yourself with the mode of action, administration, risks and nursing considerations related to a number of medications within these drug groups.

Oral medications

You may check and give oral medications under the direct supervision of a registered nurse (RN) if they are confident for you to do so, remembering the 10 rights of safe medication administration:

The ten rights of safe medication administration:

1. Right patient
2. Right medication

3. Right dose
4. Right time
5. Right route
6. Right reason (e.g. if BP is 90/50 should you administer an antihypertensive medication?);
7. Right response to the medication e.g. analgesia
8. Right documentation
9. Right formulation e.g. immediate release or slow release
10. Right to refuse after being offered an informed choice.

Subcutaneous (SC) and Intramuscular (IM) medications

A student nurse may administer SC and IM injections under the direct supervision of a RN.

Intravenous medications

2nd year students - IV infusions may be prepared under the supervision of a RN. The 2nd year student nurse may not administer IV infusions.

3rd year students – IV infusions may be prepared and administered under the direct supervision of a RN after completion of the student workbook (please see the Clinical Lecturer for the same).

Controlled Drugs

Controlled drugs are kept in the locked controlled drugs cupboard, inside the general drugs cupboard at all times. Student nurses are not permitted to double check or sign for controlled drugs.

As per hospital policy, student nurses, who are fully endorsed by their Tertiary institutions, will be supported from their 2nd year of training onwards, to develop the skills necessary to safely administer IV and related therapies.

| Drug Name | Classification | Mode Of Action |
|--------------|----------------|----------------|
| Actrapid | | |
| Aspirin | | |
| Augmentin | | |
| Azithromycin | | |
| Ceftriaxone | | |
| Cefuroxime | | |

| Drug Name | Classification | Mode Of Action |
|----------------|----------------|----------------|
| Cilazapril | | |
| Clexane | | |
| Codeine | | |
| Dabigatran | | |
| Diazepam | | |
| Digoxin | | |
| Dilantin | | |
| Fentanyl | | |
| Flucloxacillin | | |
| Frusemide | | |
| Gentamycin | | |
| GTN | | |
| Haloperidol | | |
| Ibuprofen | | |
| Ipratropium | | |
| Lactulose | | |
| Lantus | | |
| Laxsol | | |
| Metoclopramide | | |
| Metoprolol | | |
| Morphine | | |
| Novorapid | | |
| Ondansetron | | |

| Drug Name | Classification | Mode Of Action |
|-------------|----------------|----------------|
| Paracetamol | | |
| Phenytoin | | |
| Rivaroxaban | | |
| Salbutamol | | |
| Sevredol | | |
| Simvastatin | | |
| Tazocin | | |
| Tegretol | | |
| Tramadol | | |
| Warfarin | | |
| Zopiclone | | |
| | | |

GLOSSARY OF CONDITIONS/TOOLS

Atrial Fibrillation: an irregular and often rapid heart rate that can increase your risk of stroke, heart failure and other heart-related complications. During atrial fibrillation, the heart's two upper chambers (the atria) beat chaotically and irregularly — out of coordination with the two lower chambers (the ventricles) of the heart. Atrial fibrillation symptoms often include heart palpitations, shortness of breath and weakness. Episodes of atrial fibrillation can come and go, or you may develop atrial fibrillation that doesn't go away and may require treatment. Although atrial fibrillation itself usually isn't life-threatening, it is a serious medical condition that sometimes requires emergency treatment. It may lead to complications. Atrial fibrillation can lead to blood clots forming in the heart that may circulate to other organs and lead to blocked blood flow (ischemia). Treatments for atrial fibrillation may include medications and other interventions to try to alter the heart's electrical system.

Comprehensive Geriatric Assessment (CGA): is defined as a multidisciplinary diagnostic and treatment process that identifies medical, psychosocial and functional limitations of a frail older person in order to develop a coordinated plan to maximize overall health with aging. The health care of an older adult extends beyond the traditional medical management of

illness. It requires evaluation of multiple issues, including physical, cognitive, affective, social, financial, environmental and spiritual components that influence an older adult's health. CGA is based on the premise that a systematic evaluation of frail, older persons by a team of health professionals may identify a variety of treatable health problems and lead to better health outcomes. CGA programs are usually initiated through a referral by the primary care clinician or by a clinician caring for a patient in the hospital setting. The content of the assessment varies depending on different settings of care (e.g. home, clinic, hospital, nursing home).

Delirium: a temporary but severe form of mental impairment that can lead to longer hospital stays and negative long-term outcomes, is commonly acquired by elderly patients in acute care settings. Up to a third of patients 70 years old and above experience delirium, and the rate is much higher for those in intensive care or undergoing surgery. There is no single factor that brings on delirium. People who already have dementia or are particularly frail are at higher risk of acquiring the condition. Once in hospital, delirium can be caused by a combination of numerous factors, including surgery, infection, isolation, dehydration, poor nutrition and medications such as painkillers, sedatives and sleeping pills. The short-term effects of delirium can differ from patient to patient. The primary symptoms are shifting attention, poor orientation, incoherence and poor cognition, hallucinations, aggression or lethargy.

Diabetes: There are over 240,000 people in New Zealand who have been diagnosed with diabetes (mostly type 2). It is thought there are another 100,000 people who have it but don't know. Diabetes is most common among Māori and Pacific Islanders. They're three times as likely to get it as other New Zealanders. The number of people with both types of diabetes is rising – especially obesity-related type 2 diabetes. At any given time, one-third or more of patients in most hospitals have high blood sugar, typically caused by diabetes. These patients are at higher risk of serious complications: infections, falls, pressure ulcers and harmful or even deadly high or low blood sugar swings.

Frailty: The concept of frailty describes vulnerable people who have an increased risk of adverse outcomes, including falls, loss of independence, worsening disability, need for residential care and death.¹ This vulnerability can be attributed to accumulated losses in physiological, psychological and/or social functions, which impairs the ability of the person to cope with, and recover from, challenges to their health, i.e. illness, injury, surgery. For a person with frailty, even a small challenge, such as being prescribed a new medicine, a minor infection or a fall without injury, can cause a dramatic and disproportionate change to their health state, e.g. from lucid to delirious, independent to dependent, mobile to immobile. There is currently no consensus as to how frailty is defined clinically, however, a combination of the following parameters may be considered as part of a diagnosis:

- Unintentional weight loss, usually associated with a loss of muscle mass (i.e. sarcopenia)
- Weakness (grip strength)
- Slow walking speed
- Self-reported exhaustion
- Low physical activity
- Cognitive impairment
- Social isolation, depression
- Disability and chronic disease

- Clinical presentations, e.g. falls, incontinence or delirium

Heart Failure: Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. In some cases, the heart can't fill with enough blood. In other cases, the heart can't pump blood to the rest of the body with enough force. Some people have both problems. The term "heart failure" doesn't mean that your heart has stopped or is about to stop working. However, heart failure is a serious condition that requires medical care.

Hypercapnic respiratory failure (Type II) is characterized by a PaCO₂ higher than 50 mm Hg. Hypoxemia is common in patients with hypercapnic respiratory failure who are breathing room air. The pH depends on the level of bicarbonate, which, in turn, is dependent on the duration of hypercapnia. Common aetiologies include drug overdose, neuromuscular disease, chest wall abnormalities, and severe airway disorders (e.g., asthma and chronic obstructive pulmonary disease (COPD)).

Hypoxemic respiratory failure (Type I): characterized by an arterial oxygen tension (Pa O₂) lower than 60 mm Hg with a normal or low arterial carbon dioxide tension (Pa CO₂). This is the most common form of respiratory failure, and it can be associated with virtually all acute diseases of the lung, which generally involve fluid filling or collapse of alveolar units. Some examples of type I respiratory failure are cardiogenic or non-cardiogenic pulmonary oedema, pneumonia, and pulmonary haemorrhage.

Pneumonia: Pneumonia is a bacterial or viral infection of the lungs. Symptoms can include fever, chills, shortness of breath, coughing that produces phlegm, and chest pain. Pneumonia can usually be treated successfully at home with antibiotics but hospitalization may be required in some cases. In New Zealand, pneumonia has a mortality rate of between five and 10 per cent.

Respiratory Failure: Respiratory failure is a syndrome in which the respiratory system fails in one or both of its gas exchange functions: oxygenation and carbon dioxide elimination. In practice, it may be classified as either hypoxemic or hypercapnic.

Sepsis: Sepsis is a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail. If sepsis progresses to septic shock, blood pressure drops dramatically, and may lead to death. Anyone can develop sepsis, but it's most common and most dangerous in older adults or those with weakened immune systems. Early treatment of sepsis, usually with antibiotics and large amounts of intravenous fluids, improves chances for survival.

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.*)

Compassionate
Ka whai aroha

Respectful
Ka whai ngākau

Courageous
Ka mātātoa

Accountable
Ka noho haepapa

Compassionate
Ka whai aroha

Respectful
Ka whai ngākau

Courageous
Ka mātātoa

Accountable
Ka noho haepapa

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.