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

Te Uru Whakamauora
Healthy Aging & Rehabilitation
STAR PN – Older Adult Mental Health (OAMH)

STUDENT NURSE ORIENTATION

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WELCOME

Welcome to Palmerston North Hospital and our STAR PN OAMH unit. 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.

STAR PN is comprised of two clinical ward-based specialties who were once known as STAR 1 and 2. These clinical areas are made up of a 24-bed rehabilitation wing, 7-bed older adult mental health (OAMH) wing and the Te Korowai Aroha a Tane room; a 32-bed unit in total working within the Healthy Aging and Rehabilitation Cluster (HAR) of Palmerston North Hospital. Facilities include single, double and four bedded patient rooms, a physiotherapy gym, hydrotherapy pool, assessment kitchen, bathrooms, recreation room, dining room and courtyards.

Our team values all people and their experiences and contributions – past, present, and future. We affirm their rights to health services that provide specialist experiences, training and skills in an environment that fosters choice, promotes wellness, and values individual differences. The development of therapeutic relationships that allow this to happen is our key task.

Te Whatu Ora MIDCENTRAL HEALTH VALUES

We have a set of values and expect all staff are:

Compassionate (Ka whai aroha), Respectful (Ka Whai ngākau), Courageous (Ka mātātoa), & Accountable (Ka noho haepapa).

The values are a great way of making sure that we are all clear about what is important to us as staff and how we should all behave towards patients, family/whānau, visitors, partners, and each other. We want people and their whānau to say that the care and service they receive from all of us is of consistently high quality, safe, effective, and personalised. At the end of the day, if we stick to our values, we will provide services that are better for our people and better for each other.

Our service aims:

To conduct a comprehensive assessment that not only includes identification of the patients' illness and/or disability, but also the patient's individual needs, abilities, and goals

To provide the most appropriate options for the patient's treatment, and to support and to maximise their individual level of health and independence.

Restore/optimise a patient's function

To assist the patient to achieve the best quality of life possible, while having awareness of their current and potential limits to functional ability.

Protect and process the Protection of Personal and Property Rights (PPPR)/ Mental Health Act (MHA) legal status of patients

Facilitate the patient in reaching their full potential and maximize their ability to participate in their Community

Other services provided include:

- Expertise and advice to acute medical/surgical and other hospital services, general practice teams, home and community care providers and aged residential care.
- Referrals are received from other departments within the hospital, from general practitioners, other health professional groups including mental health key workers and medical specialists.
- Patients may be admitted acutely via Emergency Department if accepted by the Psycho-geriatrician and medically cleared

Please note – After hours there are no acute admissions directly to the service unless the patients have been seen in the Emergency Department and been accepted by the on-call duty Psychiatrist.
This Psychiatrist must remain the responsible clinician of that person until such a time that the patient is transferred to the care of the Older Adult Mental Health Psychiatrist.

STAR OAMH wing admits those who:

- Are not safe/coping at home and have been seen by the Community Mental Health Team/CNS, or referred by their GP and accepted by the Older Adult Mental Health Psychiatrist
- Have acute or chronic age-related mental health disorders
- Have moderate to severe dementia with behavioral and psychological symptoms of dementia (BPSD)
- Have significant functional loss inhibiting independence
- Have significant behavioral issues related to their condition
- Require multidisciplinary input

STAR OAMH wing does not admit those who:

- Are acutely ill
- Require convalescence
- Require terminal or palliative care

The aim of the older adult mental health unit is:

- Manage symptoms
- Restore the client to their maximum possible level of function
- Teach adaptive and compensatory skills
- Increase the level of safety for self and others
- Increase capacity for self-care or assistance with self-care
- Provide assistance for maintaining life roles
- Promote a greater understanding/clarification for the client and the family/whānau to assist
- them to adjust to the impact of their disability
- Provide input into the assessment of support needs
- Provide information, education, and support for caregivers
- Ensure that all processes consider and meet the needs of Māori
- Assist with complex discharge planning.

We use an interdisciplinary team approach and continuity of care is maintained as much as possible. The team consists of but is not limited to:

Associate director of Nursing (ADoN): The ADoN has an overall responsibility for the administration, service delivery and the quality of the services delivered.
Charge Nurse (CN): The CN reports to the ADoN and is responsible for the day-to-day overall management of OAMH wing.
Associate Charge Nurse (ACN): The ACN reports to the CN and is responsible for the day to day running of the ward. They oversee the intake of admission through to discharge and are responsible for the liaison between all staff and services, utilisation of resources, and facilitation of multidisciplinary team (MDT) meetings.
Nurse Educator (NE): The Nurse Educator is responsible for promoting, facilitating, and providing clinical education and practice development. It supports clinical leaders and nurses to maximise health care delivery, enhance patient outcomes, promote clinical excellence and evidence based professional practice.
Consultant Psychiatrist: A Psychiatrist is a qualified medical doctor who has obtained additional qualifications to become a specialist in the diagnosis, treatment, and prevention of mental illness. In addition to their clinical work, psychiatrists train doctors who are working towards a post-graduate qualification in psychiatry (Psychiatric Registrars). They also teach and train House Surgeons, trainee interns (6th year medical students) and medical students.
Psychiatric Registrar: Is a doctor who is training in psychiatry and growing in experience and knowledge. They work under the supervision of a Consultant Psychiatrist.
House Surgeons: These are doctors who look after the medical needs of clients on the ward.
Administration Staff: Administration staff is essential for the establishment and maintenance of client information and data. They provide secretarial support, process client-related information and facilitate the smooth transfer of this information throughout the services. Administration staff includes the receptionists who attend the telephone enquiries, typist for clinical notes.
The Physiotherapist: When required, a Physiotherapist is available to provide assessment/input into mobility aids/strategies that may be required to assist an individual with their ambulation needs. This may include having patients attend regular physiotherapy sessions at the hospital gym. This information will be written in patient notes and be verbally provided to oncoming staff in handover. Equipment will be provided on a need’s basis including wheelchairs, frames and hoists and are available for transferring.
The Occupational Therapist: The Occupational Therapists assesses and assists patients to improve their ability to perform tasks of daily living.
They help to develop, recover, or maintain daily living skills, improve their basic motor functions and abilities as well as compensate for permanent loss of function. Daily living activities such as showering, toileting, dressing, kitchen skills, cooking and eating, and home visits are involved in the assessment process. A Sensory Room is available and used as a therapeutic intervention under the supervision of a trained staff member who is trained in sensory modulation. The sensory room is a specially designed quiet therapeutic space with sensory tools that explores and utilises an individual’s sensory preferences to reduce distress, alert or calm the individual. Sensory modulation techniques help to promote self-care, well-being, resilience, and recovery.
The Social Worker: All patients are seen by a social worker and an assessment of their social situation and in assisting them to maximise their health and wellbeing is completed. This assessment focuses on people their social environment. The assessment may identify the need for referrals to be made to other agencies and organisations - e.g. Stroke foundation, WINZ, etc.

The Speech Language Therapist
If required, a speech language therapist (SLT) assesses patients that may have a speech or swallowing problem. The SLT’s instructions will be written on the communication board at the patient’s bedside, patient notes and on the handover sheet. Appointments will be written on the patient allocation whiteboard in the nurses’ station.

Registered Nurse: The nurse's role includes administration of medication, client education and supporting clients to understand their diagnosis and assisting clients to develop strategies to minimise the impact of illness in their quality of life. RNs also provide care coordination and monitoring of client symptoms and risks. They are trained in de-escalation and Safe Practice Effective Communication (SPEC) if an event occurs. Documentation, therapeutic use of self and the handing over of information are also, important factors in being an RN.

Enrolled Nurse: Enrolled nurses practice under the direction of a Registered Nurse to implement nursing care for people who have stable and predictable health outcomes in situations that do not call for complex nursing judgment. The responsibilities of Enrolled nurses include assisting clients with the activities of daily living, recognising the changing needs of clients and performing delegated interventions from the nursing care plan.

Health Care Assistant: The role of the Health Assistant is to provide support to Registered Nurses by assisting them with patient care as directed and by completing housekeeping and clerical tasks.

KEY CONTACTS

Charge Nurse	Ange Hay	06 350 9159 ext. 7030
Nurse Educator	Julie Marsh	06 350 9159 ext. 7031 Julie.marsh@midcentraldhb.govt.nz

Please contact the Charge Nurse or your Clinical Lecturer 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.

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 Nurse Educator, 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 1445-2315 hours
    - Night duty 2245-0715 hours
- We endeavor 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 Nurse Educator or your Clinical Lecturer in suitable time.
- 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. 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.

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 familiarize 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 go places, e.g., Theatre, radiology
- Ask to do and see things, e.g., Dressings, procedures.

Objectives may include but are not limited to:

- To familiarize yourself with the layout of the department in order to work with and assist patients and nursing staff, especially in emergency situations.
- To be aware of the departmental policies and legalities.
- To observe the skills and techniques of nursing assessment, relating the data collected to the patient cares and treatments given.
- To participate in discussion with your preceptor to develop insight into the decision-making process.
- To learn and practice new procedures.
- To be aware of the psychological needs of patients in their new environment.

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 program 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 program 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

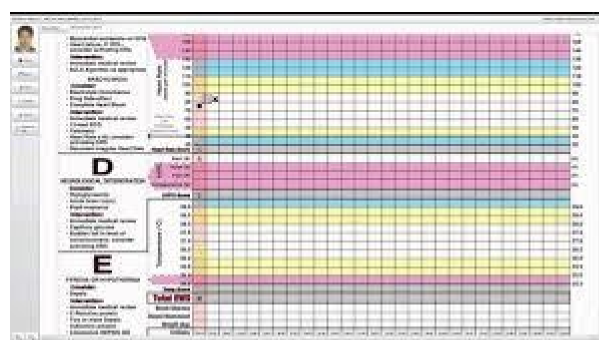
TE MĀWHENGA TŪRORO: PATIENT DETERIORATION

Acute deterioration can happen at any point during a patient's admission to hospital. If acute deterioration is recognized early (Early Warning Score) and responded to appropriately, patient outcomes can be improved. The Deteriorating Patient program 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 Centers (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 MidCentral embarked on the next stage of the Deteriorating Patient Program, 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.

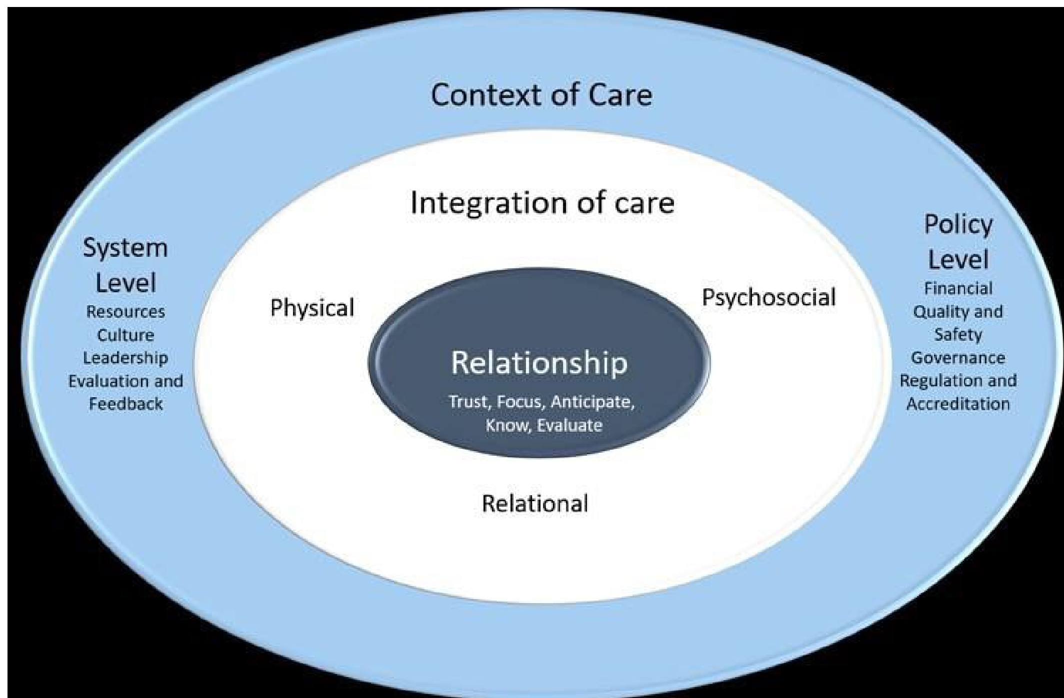
Effective communication is necessary to get patients' values and preferences for care and ensure informed choices can be made about complex medical treatment options. Ideally these conversations occur prior to episodes of acute deterioration without the pressures of an evolving and emergent clinical 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 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 familiarize 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

Te Whatu Ora MidCentral was 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. 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.

GOAL OF ORIENTATION

ASSESSMENT
- Assessment of patients
- Documentation of assessment
- Understanding of Early Warning Score (EWS)

INVESTIGATIONS/INTERVENTIONS
Understanding the use of equipment and procedures: (Under direct supervision)
- Safe mobilisation and falls prevention
- Medication administration
- Continence management
- Maintaining skin integrity
- Communicating with patients
- Accompany patients for diagnostic procedures (with patient, family/whanau and CN permission)
- Suction equipment/Resus trolley/AED
- ECG

COMMUNICATION/DOCUMENTATION
- To be familiar with documentation standards and utilise FOCUS/BATOMI charting documentation
- Demonstrate effective communication skills with patients/MDT/Whanau
- To be aware of different forms used in STAR PN OAMH wing
- To be of aware of responsibilities related to direction/delegation
- Increase your knowledge around relevant legislation including The Mental Health (Compulsory Assessment and Treatment) Act 1992
- To demonstrate patient handovers verbally and written

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	(√) 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. ▪ Ensure patient beside board/social profile is up to date.
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 HCAs as appropriate. ▪ 0915 Rapid Rounds- Liaise with Allied Health professionals at the MDT meeting and complete necessary referrals. ▪ Update documentation. ▪ Complete Trend Care categorisations & predictions before 1000hrs
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 Trend Care 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**
1445-1700	For PM shift ▪ Bedside handover to afternoon staff following handover in clinical resource room. ▪ Bedside handover includes 　o Introduce self to patients 　o Check oxygen, suction, and equipment in working order 　o Checking medication chart, ensuring no omissions 　o Check your drug infusions and fluid balance charts 　o 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 Trend Care 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 Trend Care 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 Trend Care 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 Trend Care 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

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. Patients in star are taking a wide range of medications. Below is a list of common medications you may like to familarise yourself with:

- Quetiapine
- Olanzapine
- Haloperidol
- Lithium
- Diazepam
- Sertraline
- Pregabalin
- Lorazepam
- Clonazepam
- Laxsol
- Sodium Valporate
- Melatonin
- Risperidone
- Mirtazapine
- Paracetamol

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.

COMMON PRESENTATIONS

Below is a list of common presentations that it would be useful to have read up on before you come for your placement with us. Patients in STAR 2 have been admitted to hospital with a wide range of medical conditions including:

- Dementia
- Depression
- Frailty
- Bi-Polar Disorder
- Anxiety
- BPSD
- Psychosis with/without delusions
- Schizophrenia

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.)*

FOCUS CHARTING/BATOMI

Both EN and RN's within this clinical setting use a combination of BATOMI and Focus charting in order to document in the patient's clinical notes. BATOMI, a mental status examination commonly used in the mental health setting, is an assessment of a patient's level of cognitive (knowledge-related) ability, appearance, emotional mood, and speech and thought patterns at the time of evaluation. It considers an individual's behaviour, affect, thought, orientation, memory/motivation, intellectual functioning, and insight.

Focus charting is an exception-based problem focussed progress note system, with information recorded on assessment forms, observation charts, flowcharts, care plans or care pathways not being duplicated unless required as part of a focus or problem of concern in the patient's progress notes. This improves clarity and minimises duplication of information.

Focus charting communicates essential patient information and assists the interdisciplinary health care team to provide continuity and quality of care. It assists the nurse to identify patient centered problems (the focus of concern) and then utilise assessment data to plan interventions and evaluate the patient response. Changes required to the nursing care plan will also be identified through this process.

The focus of concern is identified in the 'Focus/Patient Problem' column of the clinical notes and the progress notes column records (A) assessment data, (I) intervention actions undertaken by the nurse and (E) evaluation of the patients' response.

Focus: A focus is usually identified from the nursing diagnosis in the nursing care plan or when the nurse identifies a focus/patient problem during assessment. The key describing word within the diagnosis is highlighted or underlined and transposed to the focus/patient problem column of the nursing progress notes. Signs and symptoms, patient behaviour, a special need, an acute change, or significant event can also be recorded as a focus.

Three categories are used to organise the focus note and assist the writer to record in a logical and complete manner:

- (A) Assessment: Is the subjective and/or objective information supporting the stated focus or describing the observations at the time of a significant event.
- (I) Intervention: Describes the actions taken in the past, present or future of the health care team member. This will also indicate any changes to the nursing care plan.
- (E) Evaluation: Describes the patient outcome/response to the interventions or how the care plan goals have been attained.

Example:

Date/Time	Focus/Patient Problem	Patient progress notes
09/11/2008 1000 hours Nursing	Hip pain related to surgical site	A: Patient reports increased R) hip pain. Intensity 3/10 at rest, 5/10 on movement. Dull throbbing ache over suture line. Nil visible redness or swelling noted. Has full range of movement. I: Returned to bed and positioned on unaffected side utilising 30-degree tilt. Codeine phosphate administered as charted. A. Smith A Smith RN--
1100 hours Nursing	Hip pain related to surgical site	E: Patient states pain decreased to 1/10. A. Smith A Smith RN

NB: Any documentation must be co-signed when you are a student.

Remember the different uses for the focus column are based on the purpose of writing an entry in the patient's clinical notes. Consider your main focus of concern for your patient this shift. Do you need to report on:

- Patient problem/ focus/ concern from the care plan.
- Identify an exception to the expected outcome.
- Document a new finding.
- Acute change in patients' condition
- Documenting a significant event or unusual episode in patient care
- Activity or treatment not carried out.
- Compliance with a standard of care or organisational policy.
- Medical Diagnosis

State the main focus of your concern in the focus column and then write a nursing progress note on your Assessment data, Interventions that you performed and any alterations to the nursing care plan and then your Evaluation of the patients' response to this nursing care. Always review the ten standardised patient problem and outcomes in the STAR 2 nursing care plan which are:

1. Nutrition
2. Hygiene
3. Mobility

4. Communication/decision making
5. Elimination
6. Skin integrity
7. Pain
8. Sleep/rest
9. Anxiety/coping strategies
10. Knowledge deficit

And document under the following.,

- **Behaviour** (Anxious/ settled/ grandiosity/ eye contact/ organized/ cleanliness/ ….)
- **Affect** (How does pt reports m Vs how would you judge their mood)
- **Thoughts** (speech)
- **Orientation** (time, place, &person)
- **Motivation** (participation in ADL's, & diversional therapy)
- **Insight** (understanding/ acceptance of treatment)

If your patient is progressing as predicted towards achieving the goals and outcomes you have set with them then it is acceptable to report on the progress towards achieving this as an Evaluative statement. Remember the interventions will be recorded in the care plan.

LEGISLATION

There are a number of Acts, Regulations and Legislation relevant to health care and mental health. These include (but are not limited to):

- Mental Health Assessment and Treatment Act 1992 (and amendments 1999).
- Privacy Act Health and Disability Commissioners Act.
- Health Practitioners Competency Assurance Act.
- Human Rights Act
- Medicines Act Crimes Act.
- Health Information Code.

Full copies of all NZ Acts of Parliament, amendments, Bills and Regulations can be found at http://www.leglislation.co.nz/

MENTAL HEALTH ACT SUMMARY

Section 8A - Application for formal psychiatric assessment.
By anyone who is over 18 has seen the proposed client within the last three days. Must be accompanied by a Medical Practitioners Certificate.
Section 8B - Medical Practitioners Certificate application.
It is followed by Sec. 8A. and expires after 72hrs. Must be examined by a Dr and reasonable grounds for believing that the person is suffering from a mental disorder.
Section 9 - Notice to attend an assessment.

Given by a duly authorised officer (DAO). Date, time, place and with whom.
Dr must not be the same Dr who issued 8B.
Section 10 - Certificate of preliminary assessment by a Psychiatrist.
If the client is found to be mentally disordered a copy of the certificate must go to the:
The client, any welfare guardian of the client, the applicant for the assessment, the client's principle caregiver, the client's GP.
Section 11 - Notice to undergo a 5-day assessment period.
Can be either inpatient or outpatient.
Section 12 - Certificate of further 5-day assessment by a Psychiatrist.
Same provisions as apply to section 10.
A letter of reason for continuance to go to the Director of Mental Health by a Psychiatrist (DAHMS).
Section 13 - Further assessment and treatment for 14 days.
Second period of assessment and treatment.
Same provisions as apply to section 11.
Section 14 - Certificate of final assessment.
Can be adjourned 2 times to a maximum total of 6 weeks in 12 months.
If the client is to remain under the act an application for compulsory treatment order is to be made.
Section 16 - Review of a consumer's condition by a Judge (2nd opinion required).
Section 29 - OUT-PATIENT community order (6 months) made by a Judge
No power to detain the client for the purpose of treatment.
Community treatment can be converted temporarily/ permanently to an inpatient order
Section 29 (3) (A) - Responsible Clinician can direct a consumer to be treated as an inpatient for up to 14 days. Cannot be any more than twice in a six-month period.
Section 29 (3) (B) - Responsible Clinician directs consumer subject to a community treatment order (CTO) to be assessed. CTO ceases and reassessed under section 13 & 14 of the act.
*****It is possible for a consumer subject to a CTO to have an informal admission for a short period.
Section 30 - IN-PATIENT order (6 months). Made by a judge.
Section 76 - Clinical reviews if still mentally disordered extension of 6 months.
Clinical review at 3 months and again at 6 months

Duly authorised officers (DAO)

DAOs are health professionals designated and authorised by a DAMHS to perform certain functions and use certain powers under the Act. DAOs must have appropriate training and experience to respond to concerns about a person's mental health and to contribute to the assessment and treatment of people with mental health problems. Section 93(1)(b) of the Act assumes that DAOs will often be the first point of contact for members of the public seeking information or assistance when they are experiencing mental health difficulties or are concerned about someone else's mental health.
DAOs are required to provide general advice and assistance under section 37.
They provide advice and assistance to public about MHA and services available for those who are suffering from mental health issues
They organise psychiatric assessment as necessary
They can take reasonable steps such as (example, call police for assistance) to take a person to take for assessment/ treatment / return people on leave on AWOL

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.