STAR 4 SERVICES FOR TREATMENT, ASSESSMENT AND REHABILITATION
URU WHAKAMAUORA

STUDENT NURSE ORIENTATION

Developed by: Nga Manu Teka: Practice Development
September 2020

Contents

DOCUMENT CONTROL

Version	Issue & Circulation Date	Brief Summary of Change
1.	September 2020	Adapted from STAR 2 orientation to include Horowhenua Health Centre specific information.
2.		
3.		
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WELCOME

Welcome to Horowhenua Health Centre and STAR 4. 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 4 is a multi-skilled inpatient ward caring for people, over 16 years, who require assessment, treatment and rehabilitation (AT&R). It is a 20 bed inpatient ward with facilities that include single and double bedded patient rooms, a physiotherapy gym, assessment kitchen area, bathrooms, 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.

KEY CONTACTS

Charge Nurse	Diane Hague	06 350 9159 ext. 4450 Page
Nurse Educator	Barb Smith	06 350 9159 ext. 7031 Page 068 Barbara.smith@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 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 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.
- 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 familiarise yourself with these hazards and their management. All accidents are to be reported to the Charge Nurse and a Riskman completed.

EMERGENCIES

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

OBJECTIVES

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

- Ask lots of questions
- Ask to go places, e.g. Physio gym, radiology
- Ask to do and see things, e.g. Dressings, procedures.

Objectives may include but are not limited to:

- To familiarise 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 programme is guided by the concept of Motu Rākau Mānuka, which translates to a grove of tea tree. The Pae Ora team has provided thisguiding 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

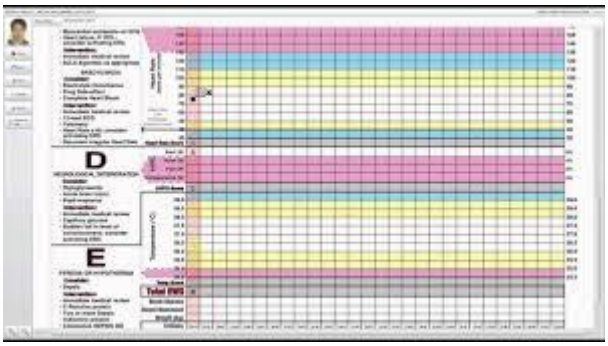
Acute deterioration can happen at any point during a patient's admission to hospital. If acute deterioration is recognised early (Early Warning Score) and responded to appropriately, patient outcomes can be improved. The Deteriorating Patient programme resulted in the implementation of the national Early 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, 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.

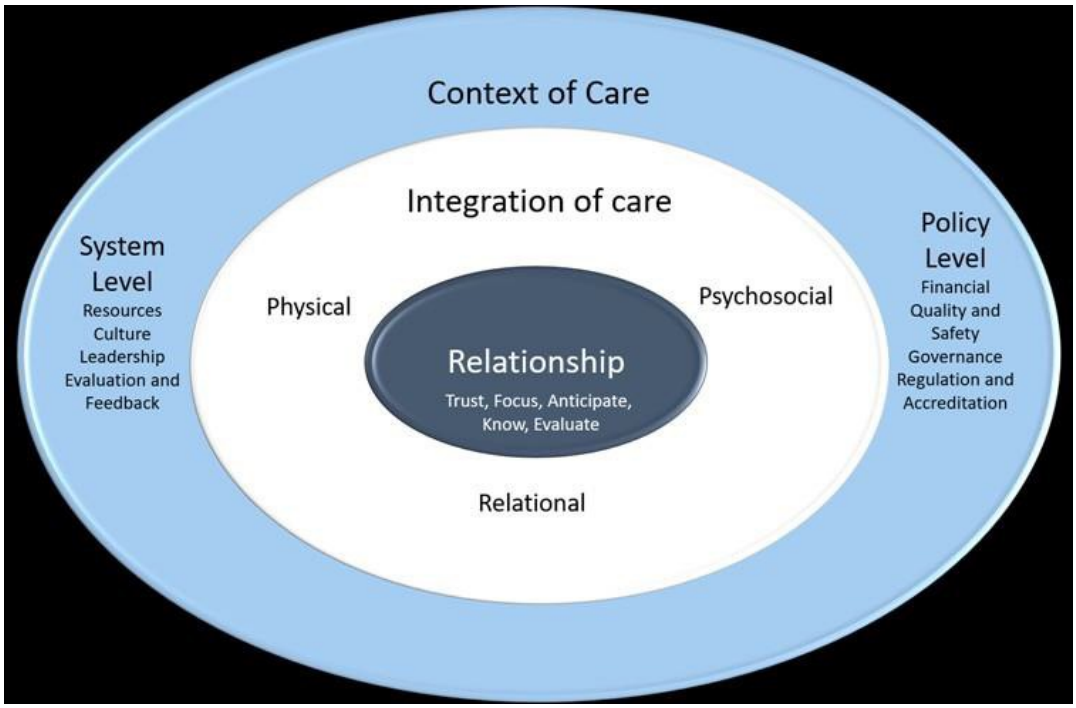
Effective communication is necessary to get patients' values and preferences for care and ensure informed choices can be made about complex medical treatment options. Ideally these conversations occur prior to episodes of acute deterioration without the pressures of an evolving and emergent clinical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

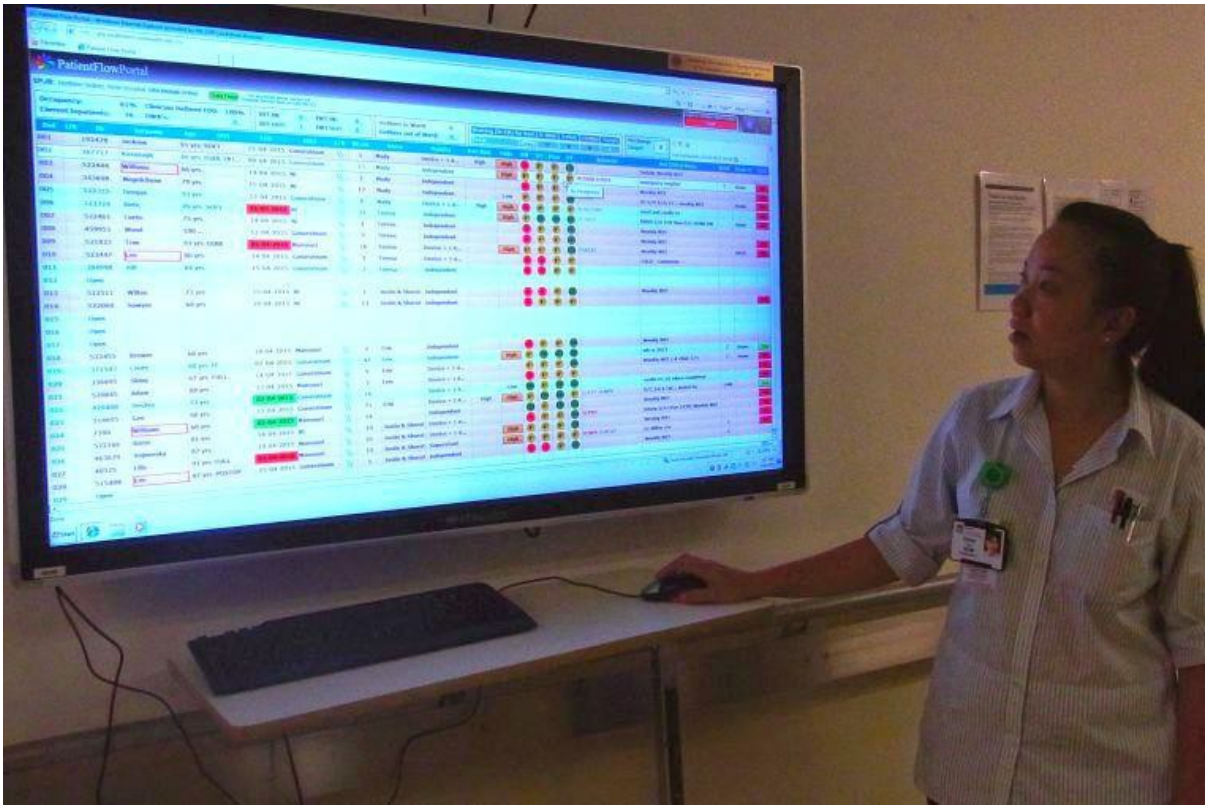


This is being implemented currently by the Nursing and Midwifery Directorate.

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.

[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.
Horowhenua Health Centre have a specific staff information orientation which the Charge Nurse will give you a copy of on arrival.

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
- Oxygen therapy
- Suction equipment
- Resus trolley and AED
- ECG

COMMUNICATION/DOCUMENTATION
- To be familiar with documentation standards and utilise FOCUS charting documentation
- Demonstrate effective communication skills when relating to patients and other health professionals.
- To be aware of different forms used in STAR 4
- To be of aware of responsibilities related to direction/delegation
- 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.
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**
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 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

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

- Metoprolol
- Cilazapril
- Aspirin
- Digoxin
- Paracetamol
- Simvastatin
- Metformin
- Laxsol
- Cholecalciferol

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 4 have been admitted to hospital with a wide range of medical conditions including:

- CVA/Stroke
- Falls resulting in fractures
- Exacerbation of COPD
- Pneumonia
- Dementia
- Diabetes
- Congestive Heart Failure
- Fraility/Deconditioning
- Palliative Care

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.)* Lippincott procedures are now used at MidCentral health and available through the controlled documents portal.

FOCUS CHARTING

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 centred 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 RN
1100 hours Nursing	Hip pain related to surgical site	E: Patient states pain decreased to 1/10. 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 4 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

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.

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.