University of New England

School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

Second Year
HSNS 246 Integrated Nursing Practice 5
Primary and Community Health Care

STUDENT NAME:	JERRY VENANCIO
STUDENT CONTACT TELEPHONE:	0409220662
STUDENT ID NUMBER:	220252099
HOSPITAL/HEALTH AGENCY:	DUBBO PRIVATE HOSPITAL
WARD/UNIT:	THEATRE / GENERAL WARD
PRECEPTOR/FACILITATOR:	GABRIELLE ARNOLD
PRECEPTOR CONTACT TELEPHONE:	
PLACEMENT DATES:	FROM 04/10/22 TO 14/10/22

PRIOR TO SUBMISSION PLEASE COMPLETE:	Signature
I have written this document by hand, neatly in biro ensuring no whiteout, highlighter or pencil	
I have dated the beginning and initialled the end of every entry	
I am submitting this on completion of placement	
I have dated and signed the Formative and Summative assessments (as required) with my clinical facilitator or preceptor	
I have dated and signed the compulsory clinical competencies and procedure achievement summary with my clinical facilitator or preceptor	
All rostered shifts have been countersigned by supervising facilitator/Educator or RN (Not EEN or AIN)	

For more information, additional copies of documents or questions related to your Clinical Record Book please contact the Clinical School staff.

YOUR CLINICAL RECORD BOOK

Your Clinical Record Books have been designed to provide a record of your clinical placement experience. This record will provide you with guidance for your clinical development. You are personally responsible for your Clinical Record Book and you are required to follow the following instructions:

- Show your clinical book to your Clinical Partner/Facilitator when you commence your clinical placement to discuss your requirements for the placements.
- Keep this Clinical Record Book with you at all times during your clinical placements.
- Keep it clear from food and drinks.
- Do not use white out/ correction fluid or tape under ANY circumstances
- *Whilst on Clinical placement if no one is available to complete your clinical placement booklet, contact the Clinical Coordinator and they will negotiate with the agency for a report to be completed and forwarded to this university.*

CHECK LIST

DO THIS NOW

- ☐ Write your name, contact telephone number and student number on the front cover of this book.
- ☐ Complete your goals for this placement in your Clinical Record Book

DO THIS EVERY DAY

- ☐ Complete your ***Daily Attendance Time Sheet*** and have your Clinical Partner/ Facilitator/RN sign it. (Cannot be signed by an EEN or AIN)

DO THIS BEFORE YOU LEAVE THE PLACEMENT

- ☐ Make sure your Clinical Partner/Facilitator/RN has signed your ***Procedures Check List*** for procedures performed during this placement. (Cannot be signed by an EEN or AIN)
- ☐ Ensure your Clinical Partner/Facilitator has completed and signed your ***Australian Nursing Standards Assessment Tool (ANSAT)***. (Cannot be signed by an EEN or AIN)
- ☐ Review your *Personal Goals* set for this placement; date those you have achieved. Ask your Clinical Partner/Facilitator to help you identify goals for your next placement (if applicable).

AT THE CONCLUSION OF THIS PLACEMENT

- ☐ **Submit your completed clinical record book into the Moodle site.**
- ☐ **You MUST keep your original clinical record book as it may be called on for auditing purposes.**

CONTACT INFORMATION

The Clinical Office

Clinical Placement Assistants	Skye Loneragan Kelly Winter Kellie Lockyer Michelle Wright Sarita Perston
Contact details:	Phone: 6773 4388 Email: nursingplacements@une.edu.au
Work Integrated Liaison Officer	Alisa Kennedy
Work Integrated Learning Coordinator:	Belinda See
Contact details:	Phone: 6773 4388 Email: fcpwil_coord@une.edu.au

Students are reminded to contact the Clinical Office Staff via the AskUNE system.

If we are unable to answer your call it means we are either already on the phone or are in a staff meeting. Please remain on the phone, call back or contact the team via Askune.

Clinical Coordinator - Academic:	Liz Ryan
Contact details:	Email: fcpnursing_academic@une.edu.au Mobile: 0407 414 577

CLINICAL LEARNING GOALS

Clinical goals can be viewed as a well thought out itinerary for your learning. They can give you guidance through clinical experience, keep you focused on the most important areas and can be used to communicate to others, such as your preceptor or Clinical Facilitator RN. They can offer information such as what you hope to achieve during your clinical experience and where your interests lie.

Clinical goals may be prescribed (such as the competencies you need to achieve in your clinical placement book and you may also develop your own. In any sense the goals should be SMART (Fowler, 1998, cited in Levett-Jones & Bourgeois, 2011 2nd Edition).

S Specific

M Measurable

A Achievable

R Realistic

T Timely

Learning goals help you become a safe, effective, competent and confident registered nurse. Your goals will become progressively more sophisticated as you proceed through the program and each semester they will build upon and consolidate what you have already learnt.

When developing clinical goals you should consider the following

What do I want to learn? (goal)

Why do I want to learn it? (rational)

How are you going to learn it? (strategy)

How are you going to prove that you have achieved your goal? (evidence)

CLINICAL PLACEMENT ATTENDANCE RECORD

Day	Date	Time Start	Time Finish	Total Hours	Facilitator/preceptor Name, Signature and job title (Cannot be signed by an EEN or)
Week 1					
Monday					
Tuesday	4/10/22	0900	1630	7	Gifted. Grad RN
Wednesday	5/10/22	0700	1630	9	[illegible] RN
Thursday	6/10/22	0700	1630	9	[illegible] (MENZIES) RN
Friday	7/10/22	0700	1630	9	[illegible] RN INDER.
Saturday					
Sunday					
Week 2					
Monday	10/10/22	0730	1700	9	Rochelle Dela Cruz (RN)
Tuesday	11/10/22	0730	1700	9	Rochelle Dela Cruz (RN
Wednesday	12/10/22	0700	1630	9	[illegible] RN
Thursday	13/10/22	0700	1730	10	[illegible] R/2
Friday	14/10/22	0700	1630	9	[illegible] RN
Saturday					
Sunday					
Week 3					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
Week 4					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

No crediting of sick days/missed days/public holidays must be 'made up' either on this or on future placements, before the completion of the degree

Timesheet shift example: 07:00 - 15:30 = 8 hours (shows mandatory 30 minute break has been taken)

Goal What do I want to learn?	**Rational** Why do I want to learn it?	**Strategy** How am I going to learn it?	**Evidence** How am I going to prove that I have achieved my objective?
> I WANT TO LEARN HOW TO PROVIDE CARE TO PATIENT POST-OP AND PRE-OP	> TO HAVE KNOWLEDGE ON HOW TO HANDLE PATIENT AFTER SURGERY.	> TO BE HANDS ON TO PATIENT AFTER SURGERY AND HAVE THE IDEA ON WHAT TO DO.	> RECEIVING A PATIENT FROM OPERATING ROOM TO RECOVERY ROOM AND MONITORING PATIENT UNTIL TRANSFER TO WARD.
> I WANT TO LEARN ON HOW ECG PLACEMENTS OF LEADS AND TO HAVE KNOWLEDGE HOW TO INTERPRET ECG.	> TO ENHANCE MY KNOWLEDGE AND SKILLS IN PERFORMING ECG.	> TO PROPERLY LOCATE THE PLACEMENTS OF ECG LEADS AND TO HAVE BASIC KNOWLEDGE ON INTERPRETING.	> BY PERFORMING ECG TO PATIENT PROPERLY AND COMPETENTLY WITH THE SUPERVISION OF NURSE ON DUTY.
> I WANT TO LEARN THE BASIC INSTRUMENTS IN OPERATING ROOM.	> TO HAVE AN IDEA AND KNOWLEDGE ABOUT THE INSTRUMENT USED IN THE THEATRE.	> MEMORISING AND FAMILIARISING THE INSTRUMENTS AND EQUIPMENTS.	> BY KNOWING THE USE AND PURPOSE OF THE INSTRUMENTS. AND BY ASSISTING DURING SURGERY.
> I WANT TO LEARN ABOUT SCRUBING AND GOWNING IN OPERATING ROOM	> TO HAVE KNOWLEDGE AND ENHANCE MY SKILLS IN MAINTAINING STERILITY IN THEATRE.	> BY ALLOWING ME TO PERFORM AND PRACTICE SCRUBING AND GOWNING IN THE THEATRE WITH NURSE ON DUTY	> BY LETTING ME PERFORM AS PRACTICE BY THE NURSE ON DUTY HOW TO PROPERLY SCRUB AND GOWN TO MAINTAIN ASEPTIC TECHNIQUE IN OR.
> TO ENHANCE MY SKILLS AND KNOWLEDGE IN GIVING MEDICATION TO PATIENTS IN WARD.	> TO MAKE ME COMPETENT IN GIVING MEDICATION WITH OUT ANY ERROR DONE.	> DOUBLE CHECK MEDICATION ORDER WITH THE NURSE ON DUTY AND CHECK MIMS BOOK FOR ANY ADVERSE EFFECT.	> BY ALLOWING ME TO GIVE MEDICATION TO PATIENT WITH THE SUPERVISION OF THE NURSE.

Student Name:	JERRY VENANCIO	**Student ID:**	220252099
Course Name / Code:	HSNS 246	**Year Level:**	SECOND YEAR
Clinical Setting / Ward:	THEATRE / GENERAL WARD	**Placement Dates:**	04/10/22 - 14/10/22
Assessment type / date:	**Summative**		

Code: 1 = Expected behaviours and practices not performed
2 = Expected behaviours and practices performed below the acceptable/satisfactory standard
3 = Expected behaviours and practices performed at a satisfactory/pass standard
4 = Expected behaviours and practices performed at a proficient standard
5 = Expected behaviours and practices performed at an excellent standard
N/A = not assessed
****Note**: a rating 1 &/or 2 indicates that the STANDARD has **NOT** been achieved

Assessment item	Circle one number					
1. Thinks critically and analyses nursing practice						
• Complies and practices according to relevant legislation and local policy	1	2	3	(4)	5	N/A
• Uses an ethical framework to guide decision making and practice	1	2	3	(4)	5	N/A
• Demonstrates respect for individual and cultural (including Aboriginal and Torres Strait Islander) preference and differences	1	2	3	(4)	5	N/A
• Sources and critically evaluates relevant literature and research evidence to deliver quality practice	1	2	3	(4)	5	N/A
• Maintains the use of clear and accurate documentation	1	2	3	(4)	5	N/A
2. Engages in therapeutic and professional relationships						
• Communicates effectively to maintain personal and professional boundaries	1	2	3	(4)	5	N/A
• Collaborates with the health care team and others to share knowledge that promotes person-centred care	1	2	3	(4)	5	N/A
• Participates as an active member of the healthcare team to achieve optimum health outcomes	1	2	3	(4)	5	N/A
• Demonstrates respect for a person's rights and wishes and advocates on their behalf	1	2	3	(4)	5	N/A
3. Maintains the capability for practice						
• Demonstrates commitment to life-long learning of self and others	1	2	3	(4)	5	N/A
• Reflects on practice and responds to feedback for continuing professional development	1	2	3	(4)	5	N/A
• Demonstrates skills in health education to enable people to make decisions and take action about their health	1	2	3	(4)	5	N/A
• Recognises and responds appropriately when own or other's capability for practice is impaired	1	2	3	(4)	5	N/A
• Demonstrates accountability for decisions and actions appropriate to their role	1	2	3	(4)	5	N/A
4. Comprehensively conducts assessments						
• Completes comprehensive and systematic assessments using appropriate and available sources	1	2	3	(4)	5	N/A
• Accurately analyses and interprets assessment data to inform practices	1	2	3	(4)	5	N/A
5. Develops a plan for nursing practice						
• Collaboratively constructs a plan informed by the patient/client assessment	1	2	3	(4)	5	N/A
• Plans care in partnership with individuals/significant others/health care team to achieve expected outcomes	1	2	3	(4)	5	N/A
6. Provides safe, appropriate and responsive quality nursing practice						
• Delivers safe and effective care within their scope of practice to meet outcomes	1	2	3	(4)	5	N/A
• Provides effective supervision and delegates care safely within their role and scope of practice	1	2	3	(4)	5	N/A
• Recognise and responds to practice that may be below expected organisational, legal or regulatory standards	1	2	3	(4)	5	N/A
7. Evaluates outcomes to inform nursing practice						
• Monitors progress toward expected goals and health outcomes	1	2	3	(4)	5	N/A
• Modifies plan according to evaluation of goals and outcomes in consultation with the health care team and others	1	2	3	(4)	5	N/A

GLOBAL RATING SCALE - In your opinion as an assessor of student performance, *relative to their stage of practice*, the overall performance of this student in the clinical unit was:

Unsatisfactory Limited Satisfactory (Good) Excellent

DISCUSSED: YES NO ADDITIONAL PAPERWORK: YES (NO)

DATE: 10.10.22.

NAME: G. Arnold

SIGNATURE:

*complete this section ONLY if this is a summative assessment

Passed: (YES) NO

ANSAT – Australian Nursing Standards Assessment Tool

SUMMATIVE ASSESSOR FEEDBACK:

1. What has the student done well throughout this placement?

- very well organised
- willing to learn
- asking questions.
- involved with the team

2. What strategies can the student use to advance their learning in future placements?

- continue to ask questions
- read relevant literature

3. Any further comments?

SUPERVISOR COMMENTS:

Signature: G.Kd Date: 10.10.22

STUDENT COMMENTS:

Signature: JERRY VENANCIO Date: 10/10/22

Scoring rules:

- Circle N/A (not assessed) ONLY if the student has not had an opportunity to demonstrate the behaviour
- If an item is not assessed it is not scored and the total ANSAT score is adjusted for the missed item
- Circle ONLY ONE number for each item
- If a score falls between numbers on the scale the higher number will be used to calculate a total
- Evaluate the student's performance against the MINIMUM practice level expected for their level of education

PROCEDURE ACHIEVEMENT SUMMARY

The following lists the skills that the student nurse has received theoretical and/or practical education (i.e. their scope of practice)

A Registered Nurse is requested to sign and date the procedures in the appropriate column.

Students are expected to comply with local healthcare policy in the practice of any skill

Skills for consolidation this placement	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Collection of health history		10/10		
The initial and ongoing nursing assessment of a client/patient		10/10		
Managing the care of a client/patient		12/10		
Clinical handover (inclusive of case management)		12/10		
Patient education/health promotion		12/4		
General Assessment				
Assessing/recording/interpreting of vital signs (BP, HR, RR, SPO2, AVPU, Temp, Pain score)	RN	7/10		
Assessing/recording/interpreting of BGL	RN	7/10		
Assessing/recording/interpreting of GCS	RN	7/10		
Assessing/recording/interpreting of height, weight and waist circumference	RN	7/10		
Assessing/recording/interpreting of continual cardiac monitoring	RN	7/10		
Admission of the patient across the lifespan and provision of support				
Responding to changes in a patient's condition (recognition of the deteriorating patient)				
Bladder scanning				
Comprehensive pain assessment	RN	7/10.		
Pressure area assessment				
Falls risk assessment				
Pre/Post-operative assessment		12/10		
Conduct and interpret a 12 lead ECG		12/10		
Respiratory assessment		12/10		
Cardiac assessment				
Abdominal assessment				
Musculoskeletal assessment		12/10		
Neurological assessment		12/		
Mental health assessment				

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Infection Control				
Standard/additional precautions (including PPE)	[illegible] RN	7/10		
Hand hygiene	[illegible] RN	7/10		
Disposal of sharps	[illegible] RN	7/10		
Managing blood and body fluid spills	[illegible] RN	7/10		
Aseptic Technique/invasive devices				
Aseptic Non Touch Technique	[illegible]	10/10		
Collection of a specimen (MSU, CSU, Faeces, wound swab)	[illegible]	12/10		
Removal of an IVC	[illegible] RN	7/10		
Removal of sutures/staples/clips				
Wound care (including appropriate assessments)				
• Dry Dressing				
• Complex wounds (including irrigation, packing, etc)				
Insertion/removal/maintenance of an IDC				
Insertion/removal/management of a feeding tube (NGT/PEG)				
Patient Care				
Managing an appropriate patient load				
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)	[illegible] RN	7/10		
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, etc)	[illegible] RN	7/10		
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)	[illegible] RN	7/10		
Assisting with general elimination needs (toileting, bed pans, urinals, commodes)	[illegible] RN	7/10		
Assisting with elimination needs related to stoma care				
Assisting with mobility and use of mobility aids	[illegible] RN	7/10		
Assisting with pressure area care	[illegible] RN	7/10		
Assisting with lifting and positioning of patients using safe manual handling techniques	[illegible] RN	7/10		
Care of the immunocompromised person				
Care of the person under palliative care	[illegible] RN	10/10		
Basic life support	[illegible]	10/10		
Care of body after death				
Nasopharyngeal suctioning	[illegible]	10/10		
Culturally competent/culturally safe care	[illegible]	10/10		

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Communication and Documentation				
Effective patient communication	[illegible] RN	8/10		
Document and interpret a basic care plan and integrated patient notes	[illegible] RN	8/10		
Medication administration (adults & children)				
Initiation and ongoing management of oxygen therapy (Face mask/Nasal Prongs)	[illegible] RN	8/10		
Initiation and ongoing management of intravenous fluids	[illegible] RN	8/10		
Initiation and ongoing management of Patient Controlled Analgesia (PCA)	Education on [illegible] RN	7/10		
Calculate and administer doses of medications:				
• Oral	[illegible] RN	7/10		
• Sublingual/buccal	[illegible] RN	7/10		
• Topical/transdermal	[illegible] RN			
• PV/PR				
• Octic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous	[illegible] RN	7/10		
• Intravenous (bolus or infusion)	[illegible] RN	7/10		