University of New England
School of Health

Professional Entry Nursing Courses

CLINICAL RECORD BOOK

HSNS263
Integrated Nursing Practice 1

STUDENT NAME:	JERRY C. VENANCIO
STUDENT CONTACT TELEPHONE:	0404220662
STUDENT ID NUMBER:	220252099
HOSPITAL/HEALTH AGENCY:	MANILLA MULTIPURPOSE SERVICE
PRECEPTOR/FACILITATOR/ CLINICAL PARTNER:	ANGELA SOLES
PRECEPTOR CONTACT TELEPHONE:	02 67 85 4000
LOCATION (eg: town name):	MANILLA NSW 2346
WARD/UNIT:	COMMUNITY
PLACEMENT DATES:	FROM 6 /06 /22 TO 17 /06 /22

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 . This record will provide you with guidance for your clinical development

- 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 sign it. Must include evidence of at least one 30 miunte break.

DO THIS BEFORE YOU LEAVE THE PLACEMENT

☑ Make sure your Clinical Partner/Facilitator has signed your ***Procedures Check List*** for procedures performed during this placement.

☑ Ensure your Clinical Partner/Facilitator has completed and signed your ***ANSAT.***

☐ 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/Kellie Lockyer Michelle Wright TBC
Contact details:	Phone: 6773 4388 Email nursingplacements@une.edu.au
Work Integrated Learning Liaison Officer:	Alisa Kennedy
Work Integrated Learning Coordinator:	Jillian Fitzgerald
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 please leave your name, brief description of message, contact details and time you called and we will return your call as soon as possible.

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)

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?
COMMUNITY CARE SETTING	>TO HAVE IDEA OR KNOWLEDGE HOW COMMUNITY CARE BEING PROVIDED TO THE PATIENTS IN THE COMMUNITY	> READ AND CHECK THE POLICY AND PROCEDURE HOW DOES CARE REACHES IN THE COMMUNITY	> GOING ON FIELD WITH THE COMMUNITY NURSES AND SERVICING THE PATIENTS AT THEIR HOUSES.
WOUND CARE	> TO HAVE THE BASIC KNOWLEDGE ON HOW TO PROPERLY ASSES WOUNDS AND CLEAN, DRESSING IDEALLY	> PERFORMING WOUND CARE, CLEANING, AND DRESSING WITH THE SUPERVISSION OF NURSE ON DUTY	> COMPETENTLY PERFORM THE PROCEDURE GUIDED BY THE PRINCIPLE OF ASEPTIC NON TOUCH TECHNIQUE.
ESTABLISHING AND BUILDING RAPPORT TO THE CLIENTS	> IN ORDER TO HAVE A GOOD RELATIONSHIP IN PROVIDING CARE TO THE PATIENT'S	> BE OPEN MINDED > BE ACTIVE LISTENER > RESPECT MUST BE OBSERVED & OPPER CHOICES	> THE PATIENT IS ALLOWING AND NOT REFUSING DURING PROVIDING CARE AND SEEING THEY ARE HAPPY & THANKFULL.
GATHERING APPROPRIATE DATA FOR PATIENT DOCUMENTATION	> FOR PROPER DOCUMENTATION AND HISTORY TAKING. > FOR CLIENTS RECORDS	> ASKING APPROPRIATE QUESTIONS RELATED TO THE CONDITION. HOW, WHERE, WHEN THEY GOT THE PRESENT CONDITION.	> PUTTING ON THE RECORDS AND COMPETENTLY FILLING UP THE FORMS BY CHECKING WITH NURSES ON DUTY
> PATIENT EDUCATION	> NURSING EDUCATION WILL HELP PATIENT HOW TO CONTINUE CARING THEIR CONDITION AT HOME.	> GIVE APPROPRIATE TEACHING THAT PATIENT CAN UNDERSTAND AND GIVE DEMO IF POSSIBLE.	> PATIENT CAN PERFORM THE TEACHINGS BEING TOLD TO THEM. LIKE SIMPLE WOUND CARE.

CLINICAL PLACEMENT ATTENDANCE RECORD

Day	Date	Time Start	Time Finish	Total Hours	Facilitator/ preceptor Name, Signature, and Designation
Week 1					
Monday	6-6-22	0800	1630	8	Tammy Shields RN Tammy Shields,
Tuesday	7/6/22	0800	1630	8	ZBebington RN
Wednesday	8/6/22	0800	1630	8	N. Tham Sydn RN
Thursday	9/6/22	0800	1630	8	K. Back. (RN)
Friday	10/6/22	0800	1630	8	K. Back (RN)
Saturday					
Sunday					
Week 2					
Monday	13/6/22	0700	1530	8	J. Temple (RN)
Tuesday	14/6/22	0800	1630	8	ZBebington RN
Wednesday	15/6/22	0800	1630	8	ZBebington RN
Thursday	16/6/22	0800	1630	8	K. Back (RN).
Friday	17/6/22	0800	1630	8	K. Back (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.

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		15/6/22		
Respiratory assessment		8/6/22		
Cardiac assessment		8/6/22		
Conduct and interpret a 12 lead ECG		8/6/22		
Mental health assessment				
Calculate and administer doses of medications:				
• Intramuscular/subcutaneous		17/6/22		
• Intravenous (bolus or infusion)				
General Assessment				
The initial and ongoing nursing assessment of a client/patient		10/6/22		
Assessing/recording/interpreting of vital signs (BP, HR, RR, SPO2, AVPU, Temp, Pain score)		13/6/22		
Assessing/recording/interpreting of BGL		13/6/22		
Assessing/recording/interpreting of GCS				
Assessing/recording/interpreting of height, weight and waist circumference				
Admission of the patient across the lifespan and provision of support		14/6/22		
Responding to changes in a patient's condition (recognition of the deteriorating patient)				
Bladder scanning				
Comprehensive pain assessment				
Pressure area assessment		10/6/22		
Falls risk assessment		10/6/22		
Pre/Post-operative assessment				
Infection Control				
Standard/additional precautions (including PPE)		10/6/22		
Hand hygiene		10/6/22		
Disposal of sharps		10/6/22		
Managing blood and body fluid spills		10/6/22		

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Aseptic Technique/invasive devices				
Aseptic Non Touch Technique		7/6/22		
Collection of a specimen (MSU, CSU, Faeces, wound swab)		7/6/22		
Removal of an IVC				
Removal of sutures/staples/clips		10/6/22		
Wound care (including appropriate assessments)		15/6/22		
• Dry Dressing		7/6/22		
• Complex wounds (including irrigation, packing, etc)		7/6/22		
Insertion/removal/maintenance of an IDC		10/6/22		
Insertion/removal/management of a feeding tube (NGT/PEG)		15/6/22		
Management of a Central Line (PICC, CVL)				
Patient Care				
Managing the care of a client/patient				
Managing an appropriate patient load				
Assisting patients with nutritional needs (excluding patients with swallowing difficulties)				
Assisting with hygiene across the lifespan (mouth care, shaving, hair care and nail care, etc)		13/6/22		
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)		13/6/22		
Assisting with general elimination needs (toileting, bed pans, urinals, commodes)		13/6/22		
Assisting with elimination needs related to stoma care		15/6/22		
Assisting with mobility and use of mobility aids		13/6/22		
Assisting with pressure area care				
Assisting with lifting and positioning of patients using safe manual handling techniques		13/6/22		
Basic life support				
Care of body after death				
Nasopharyngeal suctioning				
Culturally competent/culturally safe care		7/6/22		
Communication and Documentation				
Effective patient communication		10/6/22		
Patient education				
Clinical handover				
Document and interpret a basic care plan and integrated patient notes		14/6/22		

	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
Medication administration (adults & children)				
Initiation and ongoing management of oxygen therapy (Face mask/Nasal Prongs)				
Initiation and ongoing management of intravenous fluids				
Initiation and ongoing management of Patient Controlled Analgesia (PCA)				
Calculate and administer doses of medications:				
• Oral				
• Sublingual/buccal	[illegible] (BACK)	10/6/22		
• Topical/transdermal				
• PV/PR				
• Octic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous				
• Intravenous (bolus or infusion)				

Name/Details of activity	
Attachments (eg. Attendance certificate)	
Summary of learning What have you learnt? How the CPD activity contributes to your body of knowledge and skills?	
Outcomes How can you apply this learning to your work and integrate the knowledge and findings into your practice?	
Further learning What further learning could you undertake?	

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Student Name:	JERRY VENANCIO	**Student ID:**	22025209
Course Name / Code:	HSNS 263	**Year Level:**	2nd YEAR
Clinical Setting / Ward:	COMMUNITY	**Placement Dates:**	6/6/22 - 17/6/22
Assessment type / date:	Final/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: 16/6/22

NAME: K. Back. (R.N)

SIGNATURE: K. Back.

*complete this section ONLY if this is a summative assessment

Passed: (YES) NO

SUMMATIVE ASSESSOR FEEDBACK:

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

Jerry har great asceptic technique! He built a great rapport with all our clients during hir 2 week placement.

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

Have more self confidence in own clinical practice. Do not be afraid to have a go!

3. Any further comments?

Great working with you!

SUPERVISOR COMMENTS:

Jerry war a great asset to have on placement. Thanks Jerry!

Signature: _____ Date: 17/6/22

STUDENT COMMENTS:

Signature: _____ Date: 17/6/22

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