



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:	026785 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.

## 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](mailto:nursingplacements@une.edu.au)

**Work Integrated Learning Liaison Officer:**

Alisa Kennedy

**Work Integrated Learning Coordinator:**

Jillian Fitzgerald

**Contact details:**

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**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:**

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Goal	Rational	Strategy	Evidence
What do I want to learn?	Why do I want to learn it?	How am I going to learn it?	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 SUPERVISION 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 PATIENTS	> BE OPEN Minded > BE ACTIVE LISTENER > RESPECT MUST BE OBSERVED & OFFER CHOICES	> THE PATIENT IS ALLOWING AND NOT REFUSING DURING PROVIDING CARE AND SEEING THEM ARE HAPPY & THANKFUL.
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 PERS. 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
<b>Week 1</b>					
Monday	6-6-22	0800	1630	8	J. Shields RN <sup>Tommy</sup> Shields,
Tuesday	7/6/22	0800	1630	8	Z. Broughton <sup>ZS</sup> RN
Wednesday	8/6/22	0800	1630	8	N. Mann <sup>Aggie</sup> RN
Thursday	9/6/22	0800	1630	8	K. Back <sup>J. Paul</sup> (RN)
Friday	10/6/22	0800	1630	8	K. Back <sup>J. Paul</sup> (RN)
Saturday					
Sunday					
<b>Week 2</b>					
Monday	13/6/22	0700	1530	8	J. Temple <sup>J</sup> (RN)
Tuesday	14/6/22	0800	1630	8	Z. Broughton <sup>ZS</sup> RN
Wednesday	15/6/22	0800	1630	8	Z. Broughton <sup>ZS</sup> RN
Thursday	16/6/22	0800	1630	8	K. Back <sup>J. Paul</sup> (RN)
Friday	17/6/22	0800	1630	8	K. Back <sup>J. Paul</sup> (RN)
Saturday					
Sunday					
<b>Week 3</b>					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
<b>Week 4</b>					
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				
• Intravenous (bolus or infusion)				
<b>General Assessment</b>				
The initial and ongoing nursing assessment of a client/patient				
Assessing/recording/interpreting of vital signs (BP, HR, RR, SPO2, AVPU, Temp, Pain score)		10/6/22		
Assessing/recording/interpreting of BGL		13/6/22		
Assessing/recording/interpreting of GCS		13/6/22		
Assessing/recording/interpreting of height, weight and waist circumference				
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		14/6/22		
Comprehensive pain assessment				
Pressure area assessment				
Falls risk assessment		10/6/22		
Pre/Post-operative assessment		10/6/22		
<b>Infection Control</b>				
Standard/additional precautions (including PPE)				
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	
Safe practice demonstrated	Date	Needs more supervised practice	Date
RN Signature	RN Signature		
<b>Aseptic Technique/invasive devices</b>			
Aseptic Non Touch Technique			
Collection of a specimen (MSU, CSU, Faeces, wound swab)			
Removal of an IVC			
Removal of sutures/staples/clips			
Wound care (including appropriate assessments)			
<ul style="list-style-type: none"> <li>Dry Dressing</li> <li>Complex wounds (including irrigation, packing, etc)</li> </ul>			
Insertion/removal/maintenance of an IDC			
Insertion/removal/management of a feeding tube (NGT/PEG)			
Management of a Central Line (PICC, CVL)			
<b>Patient Care</b>			
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)			
Assisting with personal hygiene across the lifespan (bed, bath or assisted shower)			
Assisting with general elimination needs (toileting, bed pans, urinals, commodes)			
Assisting with elimination needs related to stoma care			
Assisting with mobility and use of mobility aids			
Assisting with pressure area care			
Assisting with lifting and positioning of patients using safe manual handling techniques			
Basic life support			
Care of body after death			
Nasopharyngeal suctioning			
Culturally competent/culturally safe care			
<b>Communication and Documentation</b>			
Effective patient communication			
Patient education			
Clinical handover			
Document and interpret a basic care plan and integrated patient notes			

Medication administration (adults & children)	Safe practice demonstrated		Needs more supervised practice	
	RN Signature	Date	RN Signature	Date
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				
• Topical/transdermal				
• PV/PR				
• Otic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous				
• Intravenous (bolus or infusion)				

*J. Reed (BAC)* 10/16/12

Student Name:	JERRY VENANCIO	Student ID:	220252099
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					
<b>1. Thinks critically and analyses nursing practice</b>						
• 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
<b>2. Engages in therapeutic and professional relationships</b>						
• 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
<b>3. Maintains the capability for practice</b>						
• 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
<b>4. Comprehensively conducts assessments</b>						
• 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
<b>5. Develops a plan for nursing practice</b>						
• 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
<b>6. Provides safe, appropriate and responsive quality nursing practice</b>						
• 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
<b>7. Evaluates outcomes to inform nursing practice</b>						
• 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 has great aseptic technique!  
He built a great rapport with all our clients during his 2 week placement.

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

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

3. Any further comments?

Great working with you!

**SUPERVISOR COMMENTS:**

Jerry was a great asset to have on placement. Thanker Jerry!

Signature: \_\_\_\_\_

*J. Jacobs*

Date: \_\_\_\_\_

17/6/22

**STUDENT COMMENTS:**

Signature: \_\_\_\_\_

*J. Jacobs*

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