University of New England

School of Health

Professional Entry Nursing Course

CLINICAL RECORD BOOK

First Year
HSNS173 Nursing Practice 2: Fundamentals for Nursing Practice 2

STUDENT NAME:
STUDENT CONTACT TELEPHONE:
STUDENT ID NUMBER:
HOSPITAL/HEALTH AGENCY:
WARD/UNIT:
PRECEPTOR/FACILITATOR:
PRECEPTOR CONTACT TELEPHONE:
PLACEMENT DATES: FROM / / TO / /

PRIOR TO SUBMISSION PLEASE COMPLETE **Student Declaration**	**Signature**
❑ I have written this document by hand, neatly in biro ensuring no whiteout, highlighter or pencil	
❑ I confirm the times and hours recorded are a true and accurate account to the attended hours.	
❑ I understand altering or falsifying records such as shift times, hours and ANSAT assessment results as per the UNE assessment policy is academic misconduct	
❑ I am submitting this within one week of placement completion	
❑ 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 PEP competencies and procedure achievement summary with my clinical facilitator or preceptor	
❑ All rostered shifts have been countersigned by supervising RN (Not EEN or AIN)	
❑ File name saved and uploaded as Student Number First Name SURNAME Unit Code (i.e. 2200123456 John_DOE HSNS263)	

Student Name	Date	Time	Signature

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

BEFORE PLACEMENT COMMENCES

- ❑ 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. Must include evidence of one 30 minute break

BEFORE YOU LEAVE THE PLACEMENT

- ❑ Make sure your Clinical Partner/Facilitator/RN has signed your ***Procedures Check List*** for procedures performed during this placement.
- ❑ Ensure your Clinical Partner/Facilitator has completed and signed your ***Australian Nursing Standards Assessment Tool (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 MyLearn 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:	Kate Mulvey Michelle Wright Ellie Monley
Contact details:	Phone: 6773 4388 Email Via AskUNE
Work Integrated Liaison Officer:	Alisa Kennedy
Work Integrated Learning Coordinator:	Jillian Fitzgerald
Contact details:	Phone: 6773 4388 Email: via AskUNE

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:	Anthea Fagan
Contact details:	Email: fcpnursing_academic@une.edu.au

After office hours:
UNE Emergency or Crisis Support: 1300 661 927
Crisis Support via Text: 0488 884 169
Go to the UNE website for further support:
https://www.une.edu.au/connect/respect-now-always

LEARNING OUTCOMES AND SETTING CLINICAL GOALS

Learning outcomes

Upon completion of this unit, students will be able to:

1. establish and maintain a professional relationship with patients, families and others in laboratory and clinical settings;
2. demonstrate ability to meet the hygiene, nutrition and elimination, mobility and comfort needs of patients with varying degrees of dependence safely and within scope of practice;
3. obtain a basic health history and conduct a general physical assessment demonstrating ability to take vital signs, blood glucose levels, urinalysis, and height and weight measurement, waist circumference and to document findings appropriately;
4. interpret health information from health assessment and identify and report abnormal findings to others within legal, ethical and scope of practice requirements; and
5. reflect on their performance in individual and collaborative learning experiences.

SETTING 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 (Levett-Jones & Reid-Searl, 2018).

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.

S SPECIFIC
M MEASURABLE
A ACHIEVABLE
R REALISTIC
T TIMLEY

- WHAT DO I WANT TO LEARN?
- WHY DO I WANT TO LEARN IT?
- HOW AM I GOING TO LEARN IT?
- HOW DO I PROVE I ACHIEVED MY GOAL?

1. Goal What do I want to learn? **2. Rational** Why do I want to learn it? **3. Strategy** How am I going to learn it? **4. Evidence** How am I going to prove that I have achieved my objective?	**ANSAT Criteria**

Goals set before placement commencement Student Signature, Date	Reviewed by Supervisor at Orientation; Name_____ Signature & Designation, Date	Developed before placement Supervisor comment: Name_____ Signature & Designation, Date	YES / NO

CLINICAL PLACEMENT ATTENDANCE RECORD

Day	Date	Time Start	Time Finish	Total Hours	Facilitator/preceptor Name, Signature (Cannot be signed by EEN or AIN)	Staff Role/Title: CNE, NUM, RN
Week 1						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Week 2						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Week 3						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Week 4						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
Sick days/missed days/public holidays must be 'made up' either on this or the next placement. Missing hours can prevent enrolment progression to the next year level of the degree.						

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

CLINICAL PLACEMENT ATTENDANCE RECORD

Make Up Placements Only

Day	Date	Time Start	Time Finish	Unit Code	Total Hours	Facilitator/preceptor Name, Signature (Cannot be signed by EEN or AIN)	Staff Role/Title: CNE, NUM, RN
Week 1							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
Week 2							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							

Sick days/missed days/public holidays must be 'made up' either on this or the next placement.
Missing hours can prevent enrolment progression to the next year level of the degree. **Timesheet shift example: 07:00 - 15:30 = 8 hours (shows mandatory 30 minute break has been taken**

PRIOR TO SUBMISSION MAKE UP TIMESHEET PLEASE COMPLETE Student Declaration	Signature
❑ I have written this document by hand, neatly in biro ensuring no whiteout, highlighter or pencil	
❑ I confirm the times and hours recorded are a true and accurate account to the attended hours.	
❑ I understand altering or falsifying records such as shift times, hours and ANSAT assessment results as per the UNE assessment policy is academic misconduct	
❑ I am submitting this within one week of placement completion	
❑ All rostered shifts have been countersigned by supervising RN (Not EEN or AIN)	
❑ I am aware it is my responsibility to advise the unit coordinator of timesheet submission to avoid delay with my grade.	

Student Name Unit Code	Date	Time	Signature

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)

***Bold indicates compulsory assessment required**

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	**Needs more supervised practice**		**Safe practice demonstrated**	
	Signature NAME (RN)	**Date**	**Signature NAME (RN)**	**Date**
Foundational Skills				
***Effective communication in English**				
***Clinical handover**				
*** Perform accurate, concise and appropriate recording and reporting of client data using appropriate nursing and medical terminology**				
***Culturally competent/culturally safe care**				
***Engages in reflective practice during debriefing**				
Patient education/ Health Promotion				
Infection Control				
***Standard/additional precautions (including PPE)**				
***Hand hygiene**				
Managing blood and body fluid spills				
Collection of a specimen (MSU, CSU, Faeces, wound swab)				
General Assessment				
***Assessing/documenting/interpreting of vital signs (BP, HR, RR, SPO2, ACVPU, Temp, Pain score)**				
***Assessing/recording/interpreting of BGL**				
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 (inc. recognition of the deteriorating patient)				
***Pressure area assessment**				
***Falls risk assessment**				

	Needs more supervised practice		Safe practice demonstrated	
	Signature NAME (RN)	**Date**	**Signature NAME (RN)**	**Date**
Patient Care				
***Establish and maintain a therapeutic relationship with person & families appropriate to the clinical setting & person.**				
***Planning and managing the care of a client/patient (inc. ALL - below)**				
• 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 mobility and use of mobility aids				
• Assisting with pressure area care				
• Assisting with transferring and positioning of patients using safe manual handling techniques				
Basic life support				
Assisting with elimination needs related to stoma care				
Care of body after death				
Aseptic Technique/invasive devices				
Collection of a specimen (MSU, CSU, Faeces)				
***Aseptic Non-Touch Technique**				
• Removal of an IVC				
• Removal of sutures/staples/clips				
• Maintenance of an IDC				
• Management of a feeding tube (NGT/PEG)				
• ***Dry Dressing**				
Medication admission (adults & children)				
***Calculate and administer doses of medications (inclusive of S4 and S8 medications, as per facility policy):**				
• ***Oral**				
• Sublingual/buccal				
• Topical/transdermal				
• PV/PR				
• Octic/Ocular				
• Intranasal				
• Intramuscular/subcutaneous				

Student Name:		**Student ID:**	
Course Name / Code:		**Year Level:**	
Clinical Setting / Ward:		**Placement Dates:**	
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

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** ☐

****Note**: a rating 1 &/or 2 indicates that the STANDARD has **NOT** been achieved

*complete this section ONLY if this is a summative assessment

Passed: YES NO

DISCUSSED: YES NO

ADDITIONAL PAPERWORK: YES NO

DATE: _____

NAME: **SIGNATURE:**

ANSAT – Australian Nursing Standards Assessment Tool

SUMMATIVE ASSESSOR FEEDBACK:
1. What has the student done well throughout this placement?
2. What strategies can the student use to advance their learning in future placements?
3. Any further comments?
SUPERVISOR COMMENTS: Signature: _____ Date: _____
STUDENT COMMENTS: Signature: _____ Date: _____

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

ADDITIONAL ACTIVITIES

Record details of any additional activities such as in services or learning opportunities.
This section is not compulsory. However, beneficial for your Professional Portfolio.
Further pages can be copied/printed and added as required.

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?	

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?	

Information on the following pages are provided as a guide for students and facilitators in the completion of this record book. This page and the following do not need to be submitted into the MyLearn site.

1. THINKS CRITICALLY AND ANALYSES NURSING PRACTICE

➢ *Complies and practices according to relevant legislation and local policy*

- Follows policies and procedures of the facility/organisation (e.g. workplace health and safety / infection control policies)
- Maintains patient/client confidentiality
- Arrives fit to work
- Arrives punctually and leaves at agreed time
- Calls appropriate personnel to report intended absence
- Wears an identification badge and identifies self
- Observes uniform/dress code
- Maintains appropriate professional boundaries with patients/clients and carers

➢ *Uses an ethical framework to guide their decision making and practice*

- Understands and respects patients'/clients' rights
- Allows sufficient time to discuss care provision with patient/clients
- Refers patients/clients to a more senior staff member for consent when appropriate
- Seeks assistance to resolve situations involving moral/ethical conflict
- Applies ethical principles and reasoning in all health care activities

➢ *Demonstrates respect for individual and cultural (including Aboriginal & Torres Strait Islander) preference and differences*

- Practices sensitively in the cultural context
- Understands and respects individual and cultural diversity
- Involves family/others appropriately to ensure cultural/spiritual needs are met

➢ *Sources and critically evaluates relevant literature and research evidence to deliver quality practice*

- Locates relevant current evidence (e.g. clinical practice guidelines and systematic reviews, databases, texts)
- Clarifies understanding and application of evidence with peers or other relevant staff
- Applies evidence to clinical practice appropriately
- Participates in quality activities when possible (e.g. assists with clinical audit, journal club)
- Shares evidence with others

➢ *Maintains the use of clear and accurate documentation*

- Uses suitable language and avoids jargon
- Writes legibly and accurately (e.g. correct spelling, approved abbreviations)
- Records information according to organisational guidelines and local policy

2. ENGAGES IN THERAPEUTIC AND PROFESSIONAL RELATIONSHIPS

➢ *Communicates effectively to maintain personal and professional boundaries*

- Introduces self to patient/client and other health care team members,
- Greets others appropriately
- Listens carefully and is sensitive to patient/client and carer views
- Provides clear instructions in all activities
- Uses a range of communication strategies to optimise patient/client rapport and understanding (e.g. hearing impairment, non-English speaking, cognitive impairment, consideration of non-verbal communication)
- Communication with patient/client is conducted in a manner and environment that demonstrates consideration of confidentiality, privacy and patient's/client's sensitivities

➢ *Collaborates with health care team and others to share knowledge that promotes person-centred care*

- Demonstrates positive and productive working relationships with colleagues
- Uses knowledge of other health care team roles to develop collegial networks
- Demonstrates a collaborative approach to practice
- Identifies appropriate educational resources (including other health professionals)
- Prioritises safety problems

➢ *Participates as an active member of the healthcare team to achieve optimum health outcomes*

- Collaborates with the health care team and patient/client to achieve optimal outcomes
- Contributes appropriately in team meetings
- Maintains effective communication with clinical supervisors and peers
- Works collaboratively and respectfully with support staff

➢ *Demonstrates respect for a person's rights and wishes and advocates on their behalf*

- Advocates for the patient/client when dealing with other health care teams
- Identifies and explains practices which conflict with the rights/wishes of individuals/groups
- Uses available resources in a reasonable manner
- Ensures privacy and confidentiality in the provision of care

3. MAINTAINS THE CAPABILITY FOR PRACTICE

➢ *Demonstrates commitment to lifelong learning of self and others*

- Links course learning outcomes to own identified learning needs
- Seeks support from others in identifying learning needs
- Seeks and engages a diverse range of experiences to develop professional skills and knowledge
- Supports and encourages the learning of others

➢ *Reflects on practice and responds to feedback for continuing professional development*

- Reflects on activities completed to inform practice
- Plans professional development based on reflection of own practice
- Keeps written record of professional development activities
- Incorporates formal and informal feedback from colleagues into practice

➢ *Demonstrates skills in health education to enable people to make decisions and take action about their health*

- Assists patients/clients and carers to identify reliable and accurate health information
- Patient/client care is based on knowledge and clinical reasoning
- Refers concerns to relevant health professionals to facilitate health care decisions/delivery
- Provides information using a range of strategies that demonstrate consideration of patient/client needs
- Prepares environment for patient/client education including necessary equipment

- Demonstrates skill in patient/client education (e.g. modifies approach to suit patient/client age group, uses principles of adult learning)
- Educates the patient/client in self-evaluation

➢ *Recognises and takes appropriate action when capability for own practice is impaired*

- Identifies when own/other's health/well-being affect safe practice
- Advises appropriate staff of circumstances that may impair adequate work performance
- Demonstrates appropriate self-care and other support strategies (e.g. stress management)

➢ *Demonstrates accountability for decisions and actions appropriate to their role*

- Provides care that ensures patient/client safety
- Provides rationales for care delivery and/or omissions
- Sources information to perform within role in a safe and skilled manner
- Complies with recognised standards of practice

4. COMPREHENSIVELY CONDUCTS ASSESSMENTS

➢ *Completes comprehensive and systematic assessments using appropriate and available sources*

- Questions effectively to gain appropriate information
- Politely controls the assessment to obtain relevant information
- Responds appropriately to important patient/client cues
- Completes assessment in acceptable time
- Demonstrates sensitive and appropriate physical techniques during the assessment process
- Encourages patients/clients to provide complete information without embarrassment or hesitation

➢ *Accurately analyses and interprets assessment data to inform practice*

- Prioritises important assessment findings
- Demonstrates application of knowledge to selection of health care strategies (e.g. compares findings to normal)
- Seeks and interprets supplementary information, (e.g. accessing other information, medical records, test results as appropriate)
- Structures systematic, safe and goal oriented health care accommodating any limitations imposed by patient's/client's health status

5. DEVELOPS A PLAN FOR NURSING PRACTICE

➢ *Collaboratively constructs a plan informed by the patient/client assessment*

- Uses assessment data and best available evidence to construct a plan
- Completes relevant documentation to the required standard (e.g. patient/client record, care planner and assessment, statistical information)
- Considers organisation of planned care in relation to other procedures (e.g. pain medication, wound care, allied health therapies, other interventions)

➢ *Plans care in partnership with individuals/significant others/health care team to achieve expected outcomes*

- Collaborates with the patient/client to prioritise and formulate short and long term goals
- Formulates goals that are specific, measurable, achievable and relevant, with specified timeframe
- Advises patient/client about the effects of health care

6. PROVIDES SAFE, APPROPRIATE AND RESPONSIVE QUALITY NURSING PRACTICE

➢ *Delivers safe and effective care within their scope of practice to meet outcomes*

- Performs health care interventions at appropriate and safe standard
- Complies with workplace guidelines on patient/client handling
- Monitors patient/client safety during assessment and care provision
- Uses resources effectively and efficiently
- Responds effectively to rapidly changing patient/client situations

➢ *Provides effective supervision and delegates safely within their role and scope of practice*

➢ Accepts and delegates care according to own or other's scope of practice

➢ Seeks clarification when directions/decisions are unclear

- Identifies areas of own or other's practice that require direct/indirect supervision
- Recognises unexpected outcomes and responds appropriately

➢ *Recognise and responds to practice that may be below expected organisational, legal or regulatory standards*

- Identifies and responds to incidents of unsafe or unprofessional practice
- Clarifies care delivery which may appear inappropriate

7. EVALUATES OUTCOMES TO INFORM NURSING PRACTICE

➢ *Monitors progress towards expected goals and health outcomes*

- Refers patient/client on to other professional/s
- Begins discharge planning in collaboration with the health care team at the time of the initial episode of care
- Monitors patient/client safety and outcomes during health care delivery
- Records and communicates patient/client outcomes where appropriate

➢ *Modifies plan according to evaluation of goals and outcomes in consultation with relevant health care team and others*

- Questions patient/client or caregiver to confirm level of understanding
- Updates care plans/documentation to reflect changes in care
- Uses appropriate resources to evaluate effectiveness of planned care/treatment

Search and Find

To assist you to familiarize yourself with each individual clinical area please locate the following equipment and supplies in the ward you have been placed in and write where they are found in the column provided.

EQUIPMENT	LOCATION
1. Fire Exits Fire Extinguishers and what fires they are used for. Fire Blanket Fire Hose	
2. Emergency Arrest Buzzer Emergency Trolley - Adult Emergency Trolley - Paediatric	
3. Defibrillator	
4. ECG Machine	
5. Procedure & Policy Manual	
6. Infection Control Manual Drug Cupboards – D.Ds Antibiotics Trolley Creams, lotions Ventolin etc. Water for irrigation Oral medications	
7. Syringes/needles etc.	
8. Patient charts X-Rays Old notes Notes for filing Stationery	
9. Sterile supplies	
10. Infusion devices	
11. Computer - for patient data	
12. Scrub sinks & gloves	
13. Bed unit - how do you elevate/work the bed?	

14. How does the patient call system and TV unit work?	
15 Airway Management Guedels airway- Resuscitation masks Suction equipment - How does it work? Oxygen masks & tubing	
15. Locate patients/staff toilets	
16. Linen Trolley	
17. Pan/Utility Room	
18. Locate Sphygmomanometer Glucometers Thermometers	
19. Stethoscopes	
20. Visitors Lounge	
Questions to ask your Preceptor!	
21 Where do staff have handover?	
22. What is the ward's phone number if you are sick?	
23. Where do you leave your bag/belongings? Where can you obtain meals?	
24. What is the ward routine for am shift, pm shift, night shift?	am shift pm shift night shift
25. How do the phones work?	

Have a great placement!