Diploma in Enrolled Nursing

Enrolled Nurse Practice: Acute Care
NURS502

Course Booklet – October 2013
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COURSE TITLE: ENROLLED NURSE PRACTICE: ACUTE CARE

Previous Versions

Date of this Version: August 2010
Effective from: January 2011

NURS502/5546.407

<table>
<thead>
<tr>
<th>CPIT Credits</th>
<th>30</th>
<th>Level</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>EFTS</td>
<td>0.250</td>
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<td></td>
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<tr>
<td>Teaching hours</td>
<td>50</td>
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</tr>
<tr>
<td>Clinical hours</td>
<td>150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simulation hours</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours of self-directed learning</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total hours of student learning</td>
<td>300</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pre-requisites:
NURS401 The Discipline of Nursing
NURS402 Applied Structure and Function of the Human Body
NURS403 Applied Social Science for Enrolled Nurses
NURS404 Clinical Skills for Enrolled Nurses

AIM

The aim of this course is for students to gain and apply the knowledge, skills and attitudes in an acute care (medical/surgical/peri-operative) setting which meet the requirements of the Nursing Council of New Zealand competencies for the enrolled nurse scope of practice.

LEARNING OUTCOMES

On successful completion of this course the student will be able to:

1. Identify and describe causes, signs and symptoms, underpinning pathophysiology, treatment and nursing interventions for acute changes in physical health status.

2. Describe the continuum of care for consumers experiencing an acute alteration in physical health status.

3. Reflect on the implications of socio-economic and socio-cultural realities on consumers and their family/whānau due to acute physical health alterations.

4. Recognise and respond appropriately including assessing and initiating interventions to rapidly changing situations in acute care settings.

5. Maintain a safe environment for self/clients/patients/families/whānau and coworkers.

6. Apply the principles of safe medication storage and administration within the legal framework and institutional policy of the specific clinical setting.
7. Meet the Nursing Council of New Zealand competencies for the Enrolled Nurse scope of practice.

ASSESSMENT

Basis of Assessment

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Assessment Method and Context</th>
<th>Pass Criteria</th>
<th>Weighting</th>
<th>Outcomes Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Test - MCQ</td>
<td>60%</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Portfolio</td>
<td>Pass</td>
<td>2, 3, 4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Clinical Competency Assessment</td>
<td>Met/Not Met</td>
<td>5, 6, 7</td>
<td></td>
</tr>
</tbody>
</table>

Requirement for Successful Completion

Students must achieve a minimum of 60% in assessment 1, a pass in assessment 2 and meet the competencies in assessment 3.

LEARNING AND TEACHING APPROACHES

Simulation, role play, clinical practice, lectures, Tutorials, Group discussions, Guest speakers, Self directed learning, on line learning.

LEARNING AND TEACHING RESOURCES


# Diploma in Enrolled Nursing
## Enrolled Nurse Practice: Acute Care
### NURS502

#### Proposed Timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-18 October</td>
<td>8-10: Orientation</td>
<td>8-10: Respiratory – Acute nursing management</td>
<td>9-11: 12 students joining year 1</td>
<td>Instructions for Moodle:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10-12: Classifications of shock</td>
<td>10:30-11: Introduction to simulation</td>
<td>Medication workbook</td>
<td>Respiratory and Bedrest Care Plan, Patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-3: Frameworks</td>
<td>11-12: Respiratory simulation</td>
<td></td>
<td>Wiremi Tahu (total hours = 5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early warning Score</td>
<td>1-2: 6 students joining year 1</td>
<td></td>
<td>Add notes to a notebook (that you will</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ISBAR</td>
<td>Medication workbook</td>
<td></td>
<td>take into clinical practice) so that you</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3-4: Observation Charting</td>
<td>2-4 Cardiac acute care nursing management</td>
<td></td>
<td>can refer to.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Identify and describe signs and symptoms</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>treatment and nursing interventions for:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Gastrointestinal acute changes and surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Musculoskeletal changes and surgery</td>
<td></td>
</tr>
<tr>
<td>21-25 October</td>
<td>9-3: Perioperative:</td>
<td>8-4: Cardiac simulation</td>
<td>8-12: Gastrointestinal post-operative nursing</td>
<td>Instructions for Moodle:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A &amp; P revision for Respiratory Cardiovascular systems</td>
<td>IV and Drug Administration within scope of practice</td>
<td>diagnoses</td>
<td>Medication Workbook (6 hours)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Funnell et al. (2009) read chapter 44 on perioperative nursing</td>
<td>Drug calculations</td>
<td>1-4: Musculoskeletal surgery</td>
<td>SDL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revise each days material</td>
<td>Simulation</td>
<td></td>
<td>Practise drug calculations online</td>
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<tr>
<td></td>
<td>Bring questions to class</td>
<td>Wound</td>
<td></td>
<td>Funnell et al. (2009) read Chapter 28 on</td>
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<tr>
<td></td>
<td></td>
<td>SC and IM injections</td>
<td></td>
<td>medications</td>
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<td></td>
<td></td>
<td>Revise</td>
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<td>• stoma care</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>• Drug Administration Workbook</td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- **Black:** Lecture
- **Red:** Simulation Clinical Hours
- **Green:** Moodle – essential activities to complete

*The NURS502 course is finished on 13 December 2013. You must be available from 15 October to 13 December 2013.*
<table>
<thead>
<tr>
<th>Date</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 October - 1 November</td>
<td></td>
<td>8-4: Acute Medical/Surgical Scenarios Medication Workbook due</td>
<td>8-9: Pre reading</td>
<td>8-3: Acute group work and presentation</td>
<td>Instructions for Moodle: Worksheets 1) Blood Transfusion, and 2) Adult Observation Charting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-4: Scenarios</td>
<td>9-11: Acute pharmacology</td>
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<tr>
<td></td>
<td></td>
<td>Fluid balance charting</td>
<td>11-12: Pain Management</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Vital signs recordings</td>
<td>1-4: Scenarios</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Circulation recordings</td>
<td>Calculation drug test</td>
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</tr>
<tr>
<td></td>
<td>LABOUR DAY</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4-8 November</td>
<td>8-4: Scenarios</td>
<td>8-4: Neurological acute nursing management Simulation</td>
<td>8-10: Implications of nursing children and the young person</td>
<td>8-10: Acute nursing principles in various consumer diagnoses</td>
<td>Instructions for Moodle: Worksheets. Make contact with site visit to the clinical area to introduce yourself and obtain your duties. Prepare for clinical. Ask yourself: What do I want to achieve throughout this acute clinical experience. Read course booklet re portfolio requirements and the Summative assessment form.</td>
</tr>
<tr>
<td></td>
<td>Fluid balance charting</td>
<td></td>
<td>10-12: Psychological impact on the consumer’s journey with an acute health alteration.</td>
<td></td>
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<tr>
<td></td>
<td>Vital signs recordings</td>
<td></td>
<td>1-3: DEU concept for clinical learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Circulation recordings</td>
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<td>11-14 November</td>
<td>CLINICAL</td>
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<td>18-22 November</td>
<td>CLINICAL</td>
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<td>25-29 November</td>
<td>CLINICAL</td>
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<tr>
<td>2-6 December</td>
<td>CLINICAL</td>
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<tr>
<td>9-13 December</td>
<td>CLINICAL</td>
<td></td>
<td></td>
<td></td>
<td>MAKE UP CLINICAL HOURS Make up clinical hours Monday, Wednesday, Thursday, Friday pm: Tuesday pm. You must provide a medical certificate for any days absent from clinical. You must be available on Tuesday, 10 November pm shift to make up time.</td>
</tr>
<tr>
<td></td>
<td>CLINICAL</td>
<td></td>
<td></td>
<td></td>
<td>RESIT</td>
</tr>
<tr>
<td></td>
<td>Tuesday, 10-12</td>
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</tr>
<tr>
<td></td>
<td>Multi Choice Exam</td>
<td></td>
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</tr>
</tbody>
</table>
Assessment One

Multi Choice Test
Learning Outcome: 1
Time Allowance: 1 hour plus 10 minutes reading time
Date: Tuesday, 10 December 2013, 1000–1200
Resit Date: 13 December 2013, 1000–1200

This test will consist of 60 multi-choice questions. To achieve a pass you must achieve 60% correct which equals 36 marks out of 60.

Assessment Two

Portfolio
Learning Outcomes: 2, 3 & 4
Date Due: 4 December 2013. All sections must be completed.

The portfolio consists of activities and these all must be completed and passed.

Our clinical lecturer will be marking the portfolio. It is each individual student to ensure that these are submitted to the clinical lecturer by the due date.

Please refer to the Assessment 2, Portfolio Marking Grid, p. 12 this provides the overall criteria to pass Assessment 2: Portfolio.

Individual assessment details and instructions refer to pp. 5-12.

Confidentiality must be maintained with no identifiable information. This being the client’s name, hospital identification number, date of birth, hospital location or client address.

2.1: Consumer Acute Care Experience
Learning Outcome: 2
Date Due: 27 November 2013

2.2: Socio-economic and Socio-cultural Realities
Learning Outcome: 3
Date Due: 19 November 2013
2.3: Rapidly changing situations in acute care settings.

Learning outcome: 4

Date Due: 2 December 2013

A Complete one head-to-toe assessment (not including the 2.1 Consumer Acute Experience head-to-toe) using the provided form (refer to pp. 13-17 to formulate a nursing care plan). You must include assessment, nursing diagnoses, objectives and nursing interventions.

B Describe a situation where you have experienced a consumer health situation rapidly changing (word count 200).

Assessment Three

Clinical Competency Assessment

Learning Outcomes: 5, 6 & 7

3.1: Daily Clinical Practice Diary Goals (p. 19) – one each week whilst in clinical

3.2: Date Due: 21/22 November 2013 - Formative Assessment

3.3: Date Due: 5/6 December 2013 - Diploma in Enrolled Nursing Clinical Assessment (Summative) (p. 22)
**Student Verbal Consent Form**

**Student Declaration of Informed Consent**

I__________________________ (ID number) confirm that verbal permission has been sought from my patient to undertake this learning activity and that the patient is aware that no identifying information will be included in my work.

Student Signature: ________________________________

Verifying Nurse (Signature): ________________________________

Date: ________________________________
Assessment Instructions

Assessment Two

Portfolio

Learning Outcomes: 2, 3 & 4

The portfolio consists of activities and these all must be completed and passed.

Please refer to the Assessment 2, Portfolio Marking Grid, p. 12 that provides the criteria to pass.

Confidentiality must be maintained with no identifiable information. This being clients name, hospital identification number, date of birth, hospital location or client address.

2.1: Consumer Acute Experience

Learning Outcome: 2

Instructions

Through the consumer experience of undergoing an acute health episode you will be caring for and examining the admission, acute and discharge phases.

You will be assessing, contributing to and delivering nursing care to the consumer.

Activity: Consumer Acute Care Experience will be provided

Complete the following sections.

Section One

A. General

Gender: Male / Female
Age:
Health concern:

Baseline Recordings:
Temperature: Pulse: Respirations: B/P: O2 saturations: Other:
B: Consumer Acute Health Concern

Instructions

1. Explain your understanding of the health concern that your client has presented with. Relate this to structure and function of the body system highlighting the deviations that you have accessed.
2. Access an article from the library as well as your textbook to support your discussion.
3. All information must be referenced.
4. Word limit (500 words).
5. Assignment format used:
   - Introduction, body, conclusion
   - Confidentiality maintained
   - Library article should be recent (i.e., last five years) in publication

C Reflect on the consumer’s experience of health care (100 words)

Instructions

- Include a description on how the consumer is experiencing their journey of the acute episode.

Some things that you may want to think about:

Is he/she nervous, frightened because of the unknown, have past experiences, knowledge deficit, pain or breathlessness?

D Submit your head-to-toe assessment (using assessment man format)

E Summarise the recovery period including consumer and/or support person’s education that enables him/her to be discharged from hospital (word count 200).

F During your clinical practice experience you may be involved in preparing the consumer in an invasive procedure or other examination procedures.

Include a peri-operative checklist or other documentation, as required.

Maintain confidentiality.
2.2: Socio-economic and Socio-cultural realities

Learning Outcome: 3

Activity
Choose a consumer who is experiencing either a medical or surgical acute physical health alteration. Using the consumer’s medical and nursing documentation, as well as having a conversation with him/her, complete the following aspect:

Discuss two implications of socio-economic realities and two social-cultural realities for the individual and their family/whanau (word count 200).

Pass / Resubmit / Fail

Marker Name: ___________________________  Marker Signature: ______________________

Comments:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

2.3: Rapidly changing situations in acute care settings

Learning outcome: 4

A: Activity

Instructions
Complete one head-to-toe assessment (not including the 2.1 Consumer Acute Experience head-to-toe) using the provided form (refer to pp. 13-17 to formulate a nursing care plan. You must include assessment, nursing diagnoses, objectives and nursing interventions.

Assessment Head to Toe:

Marker Name: ___________________________  Marker Signature: ______________________

Date: __________

Comments:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
B: Describe a situation where you have experienced a consumer health situation rapidly changing (word count 200).

Instructions
During your experience in clinical practice choose a situation a consumer's health status rapidly changed.

Reflect on how you felt.

Questions you may ask yourself may be:

*What did I feel in this situation? Did I have the knowledge and skill? Was it within my scope of practice?*

You may like to explain how your nursing practice has developed and changed because of this experience.

Marker Name: __________________________ Marker Signature: __________________________

Date: __________

Comments:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Assessment Three

Clinical Competency Assessment

Learning Outcomes: 5, 6 & 7

Activity

3.1: Personal Learning Goals
You must identify personal learning goals from each Domain of Competence for Enrolled Nurses using your formative assessment as a guide.

3.2: Formative Assessment
You must formulate a self assessment on your practice. This will be based on where you feel you are in relation to the summative assessment criteria. A separate green form is provided for this process.

3.3: Diploma in Enrolled Nursing Clinical Assessment (Summative)
To achieve a pass you must achieve the level of competence indicated by the shaded boxes for each of the NCNZ competencies. A separate white form is provided.
## Enrolled Nurse Practice: Acute Care (NURS502) Assessment 2: Portfolio Marking Grid

<table>
<thead>
<tr>
<th>OVERALL MARK</th>
<th>PASS MARK</th>
<th>NO PASS MARK</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTENT</td>
<td>In order to achieve a pass mark in Enrolled Nurse Practice: Acute Care (NURS502) each portfolio activity is accurately discussed. There needs to be sufficient evidence that all instructions and criteria for each portfolio activity have been validly and correctly addressed.</td>
<td>Topic and relevant points not fully or accurately covered. Answers too brief. Evidence of plagiarism.</td>
</tr>
<tr>
<td>STRUCTURE</td>
<td>In order to achieve a pass mark the correct templates are used for each portfolio activity. Each section is addressed correctly.</td>
<td>Failure to present ideas in a logical assessment/portfolio/template format. The assessment flaws interfere with the meaning of the assignment discussion.</td>
</tr>
<tr>
<td>LINKS TO PRACTICE</td>
<td>You have provided links to the statements and ideas of the service user(s) and the families (if appropriate) you are caring for in the clinical setting.</td>
<td>Confidentiality has not been maintained. Answers and statements or ideas are not linked to the service user or the practice area.</td>
</tr>
<tr>
<td>PRESENTATION</td>
<td>No flaws. Grammar and spelling is correct. All presentation criteria required is met. There is correct paragraph layout and correct sentence structure. Word limit correct, 10% of word count as outlined in assessment instructions. The correct layout has been used and includes student ID on each page cover page/title page-acknowledgment of own work has been included/marking guide/an index/dividers between portfolio activities.</td>
<td>Flawed presentation. Sentence and paragraph structure not present and incorrect grammar and spelling throughout. Presentation and layout criteria required are not met.</td>
</tr>
</tbody>
</table>

Student Number: ____________________________

Portfolio: Pass / Resubmit / Fail

Marker’s Name: ____________________________ Signature: ____________________________ Date: _______________

Moderator’s Name: __________________________ Signature: ____________________________ Date: _______________

Overall Comments: ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
# Head-To-Toe Assessment

## Instructions
Using the following head-to-toe assessment guidelines fill in the relevant client/resident information on the sheet provided. Once you have completed the assessment turn over the page and document how you will plan, implement and evaluate this client’s care.

### Initial Impression
- Time, date of assessment, vital signs: T, P, BP, R, weight - O₂ sats
- Age
- Gender

### Current Health History
- Medical conditions

### Past Health History
- Medical, surgical, psychological, psychiatric

### Mental-Emotional
i) General appearance and behaviour
ii) Orientated to time and place and person
iii) Thought processes:
   - clarity of ideas/speech
   - appropriate ideas/speech
iv) Memory - short term ability
   - long term ability
v) Attention/concentration span
vi) Problem solving
vii) Comprehension

### Cultural/Spiritual Beliefs

### Developmental
- What developmental stage is the client at? Has the client achieved the expected developmental stage? Life events, life changes, coping with grief/loss.

### Special Senses

#### Vision - Hearing
- Smell
- Glasses, hearing aid
- Wax (cerumen) Hearing aid
- Communication patterns, level of social interaction

#### Respiration
- Difficulty with breathing (dyspnoea), shortness of breath
- Respiratory rate, oxygen saturation on air/O₂ therapy
- Coughing, sputum (colour, consistency, amount)

#### Cardiovascular
- Chest pain, dizziness, bruising, pulse rate, skin colour (pale, cyanosed),
  - Oedema, varicose veins,
  - Blood pressure (lying/standing),
  - Circulation (colour, venous return, warmth)
- Calf pain, redness, swelling, calf and thigh measurements
Nutrition
- Condition of mouth
- Dentures
- Ability to chew and swallow
- Oral hygiene practices
- Eating/Drinking, food/fluid likes, dislikes, food/fluid intake, ability to swallow, appetite, nausea, vomiting - fluid balance chart
- Special diets
- Food allergies

Integumentary
- Hygiene practices, skin integrity, lesions, skin temperature, temp of extremities
- changes in hair/nails, tissue turgor
- wound care, pressure areas

Elimination
Bladder and Bowel Assessment
- Daily bowel/bladder patterns - medications to assist
- Incontinence, nocturia, pain, changes to colour, smell, frequency, urinary output, catheter cares
- Diarrhoea, constipation, abdominal pain, bowel sounds, flatus

Reproduction
- Discharge, lesions, tenderness
- Swelling, menstruation
- PMT, menopause symptoms
- Breasts - discharge, tenderness

Endocrine
- Diabetes, blood sugar results
- Excessive thirst, hunger, sweating or urinating

Musculoskeletal
- Mobility and activity patterns, mobility aids, safety concerns
- Exercise programmes, pain, stiffness, swollen joints
- Changes in balance, co-ordination

Neurological
- Changes in sensation, tingling, numbness, heat and cold
- Colour, warmth, movement, sensation of extremities, presence/absence of pulses, venous return to extremities

Environment
- Home environment
- Safety within home/hospital environment, e.g., potential for falls
- Ability to perform activities of daily living safely
- Rest and sleep patterns

Social Influences
- Family/friend/community supports available and utilised

Medications
- Effects and possible side effects

Allergies
Diploma in Enrolled Nursing

HEAD-TO-TOE ASSESSMENT

Mark on diagram in red any areas where skin integrity is impaired. Use blue pen to mark location of pain - indicate severity by 1-5 numerical rating scale.

CURRENT HEALTH HISTORY:

PAST HEALTH HISTORY:
Mark on diagram in red any areas where skin integrity is impaired. Use blue pen to mark location of pain - indicate severity by 1-5 numerical rating scale.

**CURRENT HEALTH HISTORY:** ______________________________________

**PAST HEALTH HISTORY:** ______________________________________
Using the information collected on the head-to-toe assessment, formulate a Nursing Care Plan.

<table>
<thead>
<tr>
<th>Client Needs/Nursing Diagnosis</th>
<th>Objective/Goal</th>
<th>Nursing Intervention/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem related to cause</td>
<td>Client centred goal</td>
<td>How you will achieve the goal</td>
</tr>
<tr>
<td>Who</td>
<td>What</td>
<td>When</td>
</tr>
</tbody>
</table>

**Timedock:**
# Daily Clinical Practice Diary

Please use this to keep a daily diary of activities and significant experiences you feel will help you and the staff evaluate your daily performance.

**Areas for Possible Focus:**
- Communication skills
- Time management skills
- Holistic assessment skills
- Nursing care plans
- Documentation
- Clinical skill performance
- Team work
- Participation in learning opportunities
- Knowledge of drugs/safe drug administration practice
- Ability to provide rationale for nursing actions
- Linking theory to practice

<table>
<thead>
<tr>
<th>Student Daily Focus and Activities/Review of day</th>
<th>Brief Comment from Allocated Nurse: Suggested Focus for Next Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday Date:</td>
<td>What the Student Did well:</td>
</tr>
<tr>
<td>Focus:</td>
<td>Suggested Focus for Next Shift:</td>
</tr>
<tr>
<td>Review of Day:</td>
<td>Nurse Initials:</td>
</tr>
<tr>
<td>Tuesday Date:</td>
<td>What the Student Did well:</td>
</tr>
<tr>
<td>Focus:</td>
<td>Suggested Focus for Next Shift:</td>
</tr>
<tr>
<td>Review of Day:</td>
<td>Nurse Initials:</td>
</tr>
<tr>
<td>Wednesday Date</td>
<td>What the Student Did well:</td>
</tr>
<tr>
<td>Focus:</td>
<td>Suggested Focus for Next Shift:</td>
</tr>
<tr>
<td>Review of Day:</td>
<td>Nurse Initials:</td>
</tr>
<tr>
<td>Thursday Date</td>
<td>What the Student Did well:</td>
</tr>
<tr>
<td>Focus:</td>
<td>Suggested Focus for Next Shift:</td>
</tr>
<tr>
<td>Review of Day:</td>
<td>Nurse Initials:</td>
</tr>
<tr>
<td>Friday Date:</td>
<td>What the Student Did well:</td>
</tr>
<tr>
<td>Focus:</td>
<td>Suggested Focus for Next Shift:</td>
</tr>
<tr>
<td>Review of Day:</td>
<td>Nurse Initials:</td>
</tr>
</tbody>
</table>
**Personal Learning Goals (NURS502) [Optional – for specific feedback]**

**Goal**

Student ID: ________________________ Preceptor: ____________________________

**Course:** Enrolled Nurse Practice: Acute Care  **Placement:** ____________________________

*You must identify one personal learning goal from each Domain of Competence for Nurse Assistants using your formative assessment as a guide. Four goals must be submitted.*

<table>
<thead>
<tr>
<th>PASS CRITERIA</th>
<th>Student: I have completed the above work according to guidelines</th>
<th>Lecturer</th>
</tr>
</thead>
</table>
| NB: You must achieve all criteria to pass.  
Date goal set: ____________________________ | ☐ for Yes) | Pass  
Resit  
Fail |

Domain: ____________________________  
Competency: ____________________________

Your goal:

Steps required:

Evaluation:

If goal not achieved outline an action plan to achieve the goal

Influence / change in practice:

<table>
<thead>
<tr>
<th>Preceptor / Buddy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal achieved: Yes ☐  No ☐  Date: ____________________________</td>
</tr>
</tbody>
</table>

Comments: __________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

___________________________________________________________________________________
Constructive feedback is an essential component of the learning process during nursing practice placements and assists students to identify areas of practice that are well performed and areas of practice that may require further development. Please provide written feedback in the areas the student has identified below.

<table>
<thead>
<tr>
<th>Feedback requested</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction or rapport with patients</td>
<td></td>
</tr>
<tr>
<td>Organisation of workload and ability to adapt to changing situations</td>
<td></td>
</tr>
<tr>
<td>Patient assessment skills</td>
<td></td>
</tr>
<tr>
<td>Performance of clinical skills</td>
<td></td>
</tr>
<tr>
<td>Aspects of teamwork &amp; communication with team members</td>
<td></td>
</tr>
<tr>
<td>Involvement and participation in learning opportunities</td>
<td></td>
</tr>
<tr>
<td>Other comments</td>
<td></td>
</tr>
</tbody>
</table>

THANK YOU
Diploma in Enrolled Nursing Clinical Assessment (Summative)

Course Code: NURS502
Course Title: Enrolled Nurse Practice: Acute Care

Student Name: ________________
Clinical Placement: ________________
Placement dates: ________________

Learning Outcomes

On successful completion of this course the student will be able to:
1. Maintain a safe environment for self, clients/patients/families/whānau and co-workers.
2. Apply the principles of safe medication storage and administration within the legal framework and institutional policy of the specific clinical setting.
3. Meet the Nursing Council of New Zealand competencies for the Enrolled Nurse scope of practice.

Student and RN Preceptor/CLN/ALN Information

Summative assessment occurs near the end of a clinical course and identifies what students have learned and their level of competence (within the student role) in a particular area of practice.

This summative clinical assessment form is based on the Nursing Council of New Zealand (NCNZ) competencies for the enrolled nurse scope of practice (2018). Students are assessed against each competency using the identified clinical indicators. The NCNZ indicators, which are obtainable from the NCNZ website, are written examples of student behaviour in relation to each competency, however other examples may also be appropriate. Indicators may vary in other clinical contexts reflecting the different learning outcomes and the context in which they are assessed.

Students are expected to meet the level of competence indicated by the shaded boxes for each of the NCNZ competencies in order to pass this summative assessment. The behaviours associated with each level of competence (within the student role) are identified in the table below.

The summative assessment is completed by the RN preceptor(s) who has/have worked with the student (or Academic Liaison Nurse (ALN) and Clinical Liaison Nurse (CLN) in a Dedicated Education Unit (DEU)). The assessor(s) should refer to the student's formative assessment completed at the mid-way point, and discuss and include the outcome of the action plans under each of the Domains of Practice, in this summative assessment. The assessor(s) is/are also encouraged to write additional comments and provide clinical examples which support the assessment, however please note that the final pass or fail grade will be decided by the Course Leader. It is also important that any changes are initialised and dated.

General Information

Students are expected to advance their clinical knowledge, skills and attitudes within each clinical course and across the enrolled nurse programme.

<table>
<thead>
<tr>
<th>Behaviours Associated with Level of Competence (all within Student Role)</th>
<th>Concurrency Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td>Concurrency Statements</td>
</tr>
<tr>
<td>Dependent</td>
<td>The student is unable to provide safe and accurate care. The student's practice lacks co-ordination, efficiency and planning. The student requires continuous support and direction.</td>
</tr>
<tr>
<td>Marginal</td>
<td>The student is not always safe and accurate in their care. The student's practice is at times uncoordinated and disorganised. The student requires frequent support and direction.</td>
</tr>
<tr>
<td>Supervised</td>
<td>The student generally provides safe, accurate care. The student's practice is usually efficient, co-ordinated, organised and confident. The student requires minimal supportive care.</td>
</tr>
<tr>
<td>Independence (within student role)</td>
<td>The student consistently provides safe and accurate care. The student's practice is efficient, co-ordinated, organised and confident. The student functions independently within the student role and consults with other team members when appropriate.</td>
</tr>
</tbody>
</table>
## Domains of Practice

### Domain One: Professional Responsibility

**Competency 1.1** — Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislative requirements.
- Indicator: Accepts responsibility for actions and decision making within the enrolled nurse scope of practice and ensures that their clinical practice adheres to all legal and ethical requirements.
- Indicator: Maintains professional student behaviour at all times.
- Indicator: Seeks clarification of legal and ethical implications of policies and procedural guidelines from the RN.

**Competency 1.2** — Demonstrates the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice.
- Indicator: Demonstrates knowledge of differing health and socioeconomic status of Māori and non-Māori and appropriately apply the principles of the Treaty of Waitangi to their nursing practice.
- Indicator: Demonstrates ability to work in partnership with patients and their families/wānanga.

**Competency 1.3** — Demonstrates understanding of the enrolled nurse scope of practice and the registered nurse responsibility and accountability for direction and delegation of nursing.
- Indicator: Practices within the enrolled nurse scope of practice.
- Indicator: Demonstrates understanding of the RN's role to direct, delegate, monitor and evaluate nursing care.
- Indicator: Consults with RN to ensure that delegated tasks and responsibilities are within the enrolled nurse student level of competence.
- Indicator: Seeks guidance from RN when situations are beyond enrolled nurse student knowledge, competence or scope of practice.

**Competency 1.4** — Promotes an environment that enables human consumer safety, independence, quality of life, and health.
- Indicator: Identifies and reports situations that affect the clients/staff members' health and safety.
- Indicator: Adjusts the physical and social environment in order to maximise client wellbeing.
- Indicator: Responds appropriately to any basic first aid/emergency situations.
- Indicator: Supports the rights of consumers to maintain independent lifestyles with dignity in their own environment.

**Competency 1.5** — Participates in ongoing professional and education development.
- Indicator: Uses resources to increase knowledge.
- Indicator: Formulates and evaluates goals that will develop/improve nursing practice.
- Indicator: Obtains feedback from preceptor to develop/improve nursing practice.

**Competency 1.6** — Practices nursing in a manner that the health consumer determines as being culturally safe.
- Indicator: Demonstrates effective communication skills in a culturally appropriate manner.
- Indicator: Practices in a way that respects each client's identity and right to hold personal beliefs, values and goals.

**Comments:**

### Domain Two: Provision of Nursing Care

**Competency 2.1** — Provides planned nursing care to achieve identified outcomes.
- Indicator: Contributes to care planning and documentation of nursing care, involving clients and respecting their rights to make an informed decision.
- Indicator: Undertakes practice procedures and skills in a safe and competent way and works under direction of RN/Incubator.
- Indicator: Applies the principles of safe medication administration and accuracy while remaining in scope of practice.
- Indicator: Assists clients to undertake activities of daily living.
- Indicator: Delivers nursing care competently and safely within an acceptable timeframe.

**Competency 2.2** — Contributes to nursing assessments by collecting and reporting information to the registered nurse.
- Indicator: Completes assessment tools as delegated by the RN.
- Indicator: Observes client's health status and accurately records and documents findings.
<table>
<thead>
<tr>
<th>Competency 2.3</th>
<th>Recognises and reports changes in health and functional status to the registered nurse or directing health professional.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Communicates observations/findings to the RN.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Reports changes in health status in a timely manner to the RN and is aware of procedures for responding to concerns which are escalating in the health care setting.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 2.4</th>
<th>Contributes to the evaluation of health consumer care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Monitors and documents progress towards expected outcomes.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Contributes to the review of care plans in collaboration with the RN.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 2.5</th>
<th>Ensures documentation is accurate and maintains confidentiality of information.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Maintains clear, concise, timely, accurate and current client records within a legal and ethical framework.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Maintains confidentiality of documents/records and interactions with others.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 2.6</th>
<th>Contributes to the health education of health consumers to maintain and promote health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Provides accurate and culturally appropriate education to health consumers to maintain or promote health in consultation with the RN.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Demonstrates consumer understanding by seeking feedback on information given.</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

**Domain Three: Interpersonal Relationships**

<table>
<thead>
<tr>
<th>Competency 3.1</th>
<th>Establishes, maintains and concludes therapeutic interpersonal relationships.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Initiates, maintains and concludes therapeutic interpersonal interactions with clients.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Demonstrates respect, empathy and interest in client.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 3.2</th>
<th>Communicates effectively as part of the health care team.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Use appropriate communication techniques with client.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Communicates appropriately and effectively with members of the health care team.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 3.3</th>
<th>Uses a partnership approach to enhance health outcomes for health consumers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Understands stigma, discrimination related to health outcomes and contributes to fair and equitable nursing interventions.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Understands and uses the resources in the health consumer’s community to improve health outcomes.</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

**Domain Four: Interprofessional Health Care & Quality Improvement**

<table>
<thead>
<tr>
<th>Competency 4.1</th>
<th>Collaborates and participates with colleagues and members of the health care team to deliver care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Understands and values the roles, knowledge and skills of members of the health care team in relation to own responsibilities.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Collaborates with the clients and other health team members to develop a plan of care.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Maintains and documents appropriate information related to continuity of care and discharge planning.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 4.2</th>
<th>Recognises the differences in accountability and responsibilities of registered nurses, enrolled nurses and health care assistants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Clarifies enrolled nurse role in responsibilities in the context of health care settings.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Prioritises the delivery of nursing care to health consumers as guided by the registered nurse.</td>
<td></td>
</tr>
<tr>
<td>Indicator: Coordinates provision of care by health care assistants within the team as delegated by the registered nurse.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency 4.3</th>
<th>Demonstrates accountability and responsibility within the health care team when assisting or working under the direction of a registered health professional who is not a nurse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Practices within the boundaries of laws and standards as they apply to nursing.</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
RN Preceptor (CLN) overall comments:

| Signature: ___________________________ | [Print name] ___________________________ | Date: ___________________________ |

Student comments:

| Signature: ___________________________ | [Print name] ___________________________ | Date: ___________________________ |

Clinical lecturer (ALN) only:

- Recognizes own learning gaps and sets goals. Yes / No
- Assesses client needs and delivery of care in collaboration with RN. Yes / No
- Demonstrates ability to reflect on own practice. Yes / No
- Applies theory to clinical practice. Yes / No
- Achieved 100% pass in clinical calculations and passed the NURS502 Fluid & Medication Management Workbook. Yes / No

Comments:

| Signature: ___________________________ | [Print name] ___________________________ | Date: ___________________________ | REVIEW*: YES / NO |

* A lecturer assessment that indicates a review is required will result in a student's progression being reviewed by the Course Leader.

CPIT Use Only

Course Leader signature: ___________________________ (Name) ___________________________ Date: ___________________________ PASS / FAIL

PASS/FAIL grades can only be awarded by the Course Leader.

---

Students

The original of this clinical assessment will be kept on file in the Faculty of Health, Humanities & Science, Records Office. It is the responsibility of the student to copy this completed document at the conclusion of the clinical placement. Prior to submitting the original to the course leader, an administrative charge of $1.50 per copy will be charged. If the student requires the Faculty Records Office to take a copy of this document once final, copies are to be requested and collected from the reception desk in the Records Office (N112), usually on a 'while you wait' basis.

3. NURS502 Access Care Unit - November 2018 3/12/2011
General Information

Diploma in Enrolled Nursing Students

Skills that students have covered in Certificate in Nursing and the Diploma in Enrolled Nursing: Acute Care:

- Assessment using the "Head-to-Toe" Assessment,
- Vital signs – recording and charting
- Urinalysis and charting of this
- Communication
- Documentation
- Verbal recording
- Reading client notes and textbooks
- Meeting hygiene needs: hair, body, nails, eye care, mouth care, teeth, nose
- Giving suppositories (including positioning for these)
- Assisting onto and off bedpan, commode, toilet
- Assisting with urinals, uridome
- Positioning of clients, for example, with hemiplegia in bed/chair
- Lifting and transferring and use of lifting aids
- Bedmaking and changing draw sheets
- Assisting with meals and assessing nutritional intake and needs
- Weight
- Using oxygen therapy, nebulisers and inhalers
- Fluid and medication management in relation to being a second checker (not IV medication)
- Pass in drug calculations.
- Monitoring IV therapy and blood transfusions – observations
- Giving sub-cut and IM injections
- BSL’s
- Aseptic dressings and wound care
- Signs of Infection
- Neurological assessment, recordings and charting
- Neurovascular assessment, recordings and charting
- Pre operative check list/ documentation.
- Post operative considerations and nursing management
- Pain assessment
- Peak Flow

Students should be practising these skills as the opportunity arises during their clinical experience.

Learning outcomes have been identified for each week of the student’s placement. This is a good reference point for students, preceptor/buddy nurses, Academic Liaison Nurse (ALN) and Clinical Liaison Nurse (CLN) in a Dedicated Education Unit (DEU) to ensure that students are progressing.
Clinical Experience

During the first two days, students are generally preceptored/buddied only to orientate themselves to the new area. After this they are encouraged to take increasing responsibility for one to two patients while working with their preceptor/buddy. Over the clinical practice experience they are encouraged to take on a more independent role and complete documentation. Students are asked to write and update their own nursing care plan so they can learn this skill.

The students have written assessments to complete during their clinical practice experience. The lecturer (ALN) will be responsible for monitoring and marking these. Each student will be completing a self assessment at the end of week two, and a clinical assessment (summative) is to be completed in the final three days of placement by the preceptor/buddy staff nurse, ALN and CLN.

If there are any problems you are unsure of or need to discuss, please let the ALN and CLN know and they will be very happy to assist in any way. A first starting point is to keep referring to the Christchurch Polytechnic Institute of Technology, Enrolled nurse Practice: Acute course booklet which is located in each ward. Communication is extremely important for all of us to work together as a team and we look forward to working with you.
Diploma in Enrolled Nursing – Compulsory Requirements

Expectations

The student must do the following when caring for the health consumer in the acute care clinical environment:

1. **Head to Toe Assessment and Daily Plan**

   Complete a Head to Toe assessment and nursing care plan by:
   - Completing a bedside assessment.
   - Accessing and utilising medical and nursing notes.
   - Complete a time clock which includes all your interventions.
   - Must show the completed head to toe assessment and time clock to your preceptor **within one hour** of starting the shift.
   - Report changes immediately to your preceptor.
   - Report observations to your preceptor.

2. **Portfolio Component**

   This must be completed, as documented in NURS502 course booklet, by the due dates.

   All work must be submitted to the ALN (Clinical Lecturer) for marking.

3. **Clinical Competency Assessment**

   **Goals and feedback** on your practice must be obtained:
   - A daily goal must be written on the Daily Clinical Practice Diary form. You must identify personal learning goals for each Domain of Competence for Enrolled Nurses using your formative assessment form as a guide.
   - You must show the preceptor **within one hour** of starting shift.
   - Obtain written feedback form your preceptor before the end of shift.
   - Goals and feedback must be available at all times to the CLN and ALN.

You must undertake a **self-assessment** in the second week of practice and provide examples of your practice as well as goals that will enhance and broaden your nursing practice. The **completed formative assessment** will be submitted to the Clinical Liaison Nurse (CLN) and Academic Liaison Nurse (ALN) by the due date. A meeting will then occur with you.

**Portfolio assessments and student feedback forms** must be provided to the ALN before the due date of the summative assessment.
## Enrolled Nurse Practice: Acute Care – Guide for Student Progression in Clinical Practice

### WEEKS

#### Week One
- Orientation to agency, routines and policies.
- Fire procedure, location of emergency equipment.
- Practise and consolidate nursing skills.
- Develop therapeutic relationships with each consumer.
- Consumer load of one.
- Collect consumer assessment data from hand-over report.
- Collect data from medical/nursing notes.
- Observe and assist buddy EN/RN with consumers care.
- Use a head-to-toe assessment framework to assess and record consumer’s data and identify consumer’s problems.
- In consultation with buddy EN/RN, (under the direction & supervision of RN), deliver nursing care for 1 consumer.
- Plan your own nursing care plan (NCP) for your consumer.
- Update the agency/ward NCP each duty.
- Formulate learning goal.

#### Weeks Two
- Practice Nursing Skills.
- Collect data more systematically from medical/nursing notes.
- Complete nursing cares and preoperative documentation.
- Develop knowledge of common medical problems, treatment and diagnostic tests.
- Develop team work skills with preceptor/buddyEN/RN's.
- Write an assessment for every new consumer.
- Update consumer assessment daily.
- Write draft progress notes for buddy EN/RN to check before writing in consumer's chart.
- Write a daily timetable.
- Formulate learning goals.
- Complete a self-assessment and discuss this with your ALN.

#### Week Three
- In consultation with buddy EN/RN, deliver nursing care for one -two consumer’s under the direction and supervision of RN.
- Using your assessment, identify client problems and nursing diagnoses for each consumer.
- Write draft progress notes for preceptor/buddy EN/RN to check before writing in consumer’s chart.
- Write a daily timetable.
- Continue consolidating nursing skills.
- Complete nursing cares and preoperative documentation under the direction and supervision of RN.
- Develop knowledge of common medical problems, treatment and diagnostic tests.
- Continue to develop team work skills.
- Set your learning goals with your ALN.
<table>
<thead>
<tr>
<th>Week Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Liaise with other health professionals (e.g., Dr's, physio's, occupational therapists etc) more independently.</td>
</tr>
<tr>
<td>• Discharge planning (transfer forms, referral forms)</td>
</tr>
<tr>
<td>• Begin to give Consumer teaching and coaching according to consumer’s needs.</td>
</tr>
<tr>
<td>• Formulate learning goals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extra experience if available:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete a pre-operative consent form.</td>
</tr>
<tr>
<td>• Observe one consumer's surgical procedure and nursing management (operating theatre and PACU).</td>
</tr>
</tbody>
</table>