DIRECTORATE NURSING SERVICES

Department of Health

EN TO SN CONVERSION COURSE

PRECEPTORSHIP BOOKLET

INTAKE:_____

Student' Name and Surname	
Id Card No.	
Course No.	
Course Intake	

MANAGEMENT OF CARE

By the end of the exposure to this concept, the preceptee will be able to:

- Show the ability in using the steps of the nursing process, this according to each of the patients' health state
- In the assessment phase, during and after the nursing handover, will be able to continuously and systematically assess the patients in one's care
- In the diagnosing phase, will be able to identify data clusters that indicate actual or potential problems; factors contributing or causing these problems; strengths or coping patterns which the patients may draw upon to prevent or resolve these problems
- During the planning phase, together with our patients, develops goals which if achieved prevent, reduce or eliminate the problem identified in the diagnostic phase; identifies the interventions most likely to achieve these goals
- During the implementation phase, the preceptee is able to carry out the nursing care planned to promote wellness; prevent disease/illness; restore health; facilitate coping with altered functioning
- The preceptee is able to reflect, evaluate and measure how well the patient has managed the goals specified

LITERATURE REVIEW

The *Nursing Process* refers to "a framework for organising and providing care through a prescribed sequence of unalterable steps" (Edwards and Manley, 1999). Patients respond to illness, disease, disability and indeed health in many and varied ways. As claimed by Salter and Beretta (1999), what patients want is not to be ill. Patients' desires were concisely summed up by Kidel (1985), in 'the hope of "cure"' and the fastest restoration of "business as usual". This variety of responses is only governed by the variety of individuals that make up a population. Consequently the same variety of patients is nursed by a variety of individuals called nurses. The synergy between our patient and the nurse may produce endless possibilities for diverse relationships between the two.

Some patients will be in need of compassion, reassurance and sympathy; unfortunately this is not always so as these may inversely be perceived, albeit typecast, passive,

demanding and dependent. No allowance is made for our patients' varying diverse needs which as aptly described by Beck et al (1988) as the 'five dimensions of self' hence taking into consideration the physical, emotional, intellectual, social and spiritual dimensions of an individual. Consequently, the shift from the 'mechanistic' medical perspective of nursing, to a holistic nursing model.

The need to organise care coherently stimulated the introduction of nursing models, thereby giving the impetus to more patient centred and holistic care. Hence the increased alluding to the 'appreciation' of the 'person' in relation to others. As claimed by Rose (1997), the process effectively provides the framework for a systematic and rationalised observation. It provides the individual nurse with both justification and a 'map' on how one is planning to proceed with the care. Thus effectively clarifying how the decision making process has evolved through mutual consent and the involvement of the multi-disciplinary team.

This framework will effectively support the functions common to all health carers which include:

- Maintenance of the patient, and significant others, as central in all services
- Preservation of the dignity and sense of personal control of the patient and significant others
- Communication with other health professionals to ensure co-ordination of services for the patient's advantage

FROM ASSESSMENT TO EVALUATION

In addition, this problem solving outlook will guide one in identifying actual patient problems within a nurse's remit, whilst identifying potential problems one can help to prevent. Following this one will develop a plan to address the patient's both potential and actual problems, hence determining what assistance the patient requires and who is in the best position to provide it. Finally selecting goals for and together with the patient determine whether they are being achieved.

Whilst this process fosters a scientific approach to solving problems encountered in clinical practice, the skills employed in its utilisation are closely related to the skills used by other professionals.

THE FIVE STEPS

Assessment

This first step serves as an opportunity to lay the foundation for achieving excellence in clinical practice (Charnow et al, 1993). The subsequent steps and quality of patient care that ensue depend on the strength of the nursing appraisal. The range of procedures that make up this phase, which include, patient observation, interviewing the patient and family members and significant others, gathering of health history data, assessing physiological systems and performing physical examination all require a thorough ability to communicate effectively with one's patient.

Diagnosis

The North American Nursing Diagnosis Association adopted the following definition as a nursing diagnosis: - 'A clinical judgement about individual, family or community responses to actual or potential health problems or life processes. It provides the basis for the selection of nursing interventions to achieve outcomes for which the nurse is accountable' (Nanda, 1990).

From the above one may notice that this definition includes three key points, namely that:

- When formulating a nursing diagnosis, one is making a judgement about the patient's response to health problems or life processes
- During the planning phase, the nurse selects a nursing intervention that was described earlier on (in the assessment phase)
- From thereon the nurse is accountable for achieving the outcomes derived from the diagnosis

Hence the evolution from nursing decisions, based solely on experience and intuition leading to the demarcation from the medical diagnosis: consequently the shift from just reacting to a disorder to the holistic focus of care.

Planning

This third step of the nursing process involves the creation of a plan of action that will direct one's patient care towards desired goals. This phase will aide the nurse in:

- establishing care priorities
- identifying expected outcomes
- formulating nursing intervention to attain expected outcomes
- documenting the plan in an appropriate format required from one's area of practice

The plan will provide a central source of information about the patient's problems, needs and goals. It practically gives direction by showing colleagues the goals established with one's patient/s and the instructions provided to achieve them. In an era of diminishing health care resources this provides one with a clear vision, where one plans to nurse the patient through effective and quality health care delivery. The properly constructed plan will include the following characteristics:

- be realistic by avoiding setting goals that are too difficult for the patient to achieve
- tailor made for one's patient's particular needs
- specific in its portrayal

Implementation

This phase will reflect the agreement reached with the patient, and significant others, and how this can be facilitated to reach desired outcomes.

Interventions may be classified to attain a clearer understanding of the practice involved. These classifications include *Physiological, Psychological and Socioeconomic.*

Furthermore these interventions may be said to be independent, dependent and interdependent.

Evaluation

In the last step of this process, one will judge the effectiveness of one's nursing care and gauge one's patient progress towards the pre- established expected outcomes.

One will evaluate whether the original assessment performed still applies and this mainly will reflect the quality of the plan drafted. It has to be emphasised that at this stage one may in fact go again through any of the steps of the nursing process. If following the

initial assessment, there was a change in one's patient condition, it is highly advisable that one reconsiders the assessment established, as the interventions that follow may not have the desired impact, with the ensuing negative impact on various resources and expectations. For this reason, evaluation is fragmented in stages with the main ones being concurrent, retrospective objective and subjective.

BASIC SUPPORTING MODELS

There exist various theorists which facilitate this decision making process, amongst whom Maslow's and Henderson's models still remain central to nursing even though the time that has elapsed since their inception.

Maslow's (1954) model focuses on the basic human needs, classified as lower and higher. Simply expressed these needs move up from lower to upper when the lower need has been gratified. Hence an individual will focus to satisfy the needs low on the hierarchy, at least to a minimal degree prior to moving on to the one higher up.

Henderson's (1964) model, through comparable to Maslow's, also focuses on basic human needs, suggests that there are fourteen patient needs with which the nurse should be concerned. Both these models seek to facilitate the role of the nurse in performing one's unique function in assisting, as Henderson (1964) affirmed, 'the individual sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would do unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible'.

Bibliography

Charnow, J.A., Ellis, R., Ginnona, T. A., Goldberg, E. K., Harold, E. C., Mcendrick J., et al. (1993). *Nursing Proicess in Clinical Practice,* Pennsylvania: Springhouse Corporation.

Luckmann, J., & Sorenson, K., C., (1980) *Medical – Surgical Nursing; a Psychphysiologic Apporoach*. London: Saunders Company.

Hinchliff, S., Norman, S., Schober, J., (1998). *Nursing Practice and Health Care.* London: Arnold.

Clinical Experience Documentation

In the following table record the student's clinical experience hours

DATE	CLINICAL HOURS	PRECEPTOR'S INITIALS	STUDENT'S INITIALS
TOTAL HOURS			

I verify that _____ has completed the above clinical experience hours under my supervision.

_____

Preceptor's signature Date

Clinical Experience Documentation

(Preceptee's Copy)

In the following table record the student's clinical experience hours

DATE	CLINICAL HOURS	PRECEPTOR'S INITIALS	STUDENT'S INITIALS
TOTAL HOURS			

I verify that _____ has completed the above clinical experience hours under my supervision.

_____

Preceptor's signature Date

INTERVIEW SCHEDULE

Name:	
Clinical Area:	
Date:	
Preceptor:	

Interviews	Date	Preceptor's signature	Preceptee's signature
Preliminary			
Intermediate			
Final			

INTERVIEW SCHEDULE

(Preceptee's Copy)

Name:	
Clinical Area:	
Date:	
Preceptor:	

Interviews	Date	Preceptor's signature	Preceptee's signature
Preliminary			
Intermediate			
Final			

PRELIMANARY INTERVIEW

DATE _____

To be conducted on the first meeting day between the designated preceptor and the student.

Orientation to include:

Individual needs during placement

Identify performance criteria related to learning outcomes

Continuous assessment of clinical outcomes

Comments by Student

_____

_____

_____

_____

Signature of Student _____

Comments by preceptor

_____

_____

_____

_____

Signature _____

PRELIMANARY INTERVIEW

(Preceptee's Copy)

DATE _____

To be conducted on the first meeting day between the designated preceptor and the student.

Orientation to include:

Individual needs during placement

Identify performance criteria related to learning outcomes

Continuous assessment of clinical outcomes

Comments by Student

_____

_____

_____

_____

Signature of Student _____

Comments by preceptor

_____

_____

_____

_____

Signature _____

INTERMEDIATE INTERVIEW

DATE _____

Discuss with the student

1. Achievement of stated learning outcomes
2. Identification of strengths and weaknesses / diagnostic feedback
3. negotiate further opportunities

Comments by student:

_____

_____

_____

_____

Signature _____

Comments by preceptor

_____

_____

_____

_____

Signature _____

Date and time of final interview _____

INTERMEDIATE INTERVIEW

(Preceptee's Copy)

DATE _____

Discuss with the student

4. Achievement of stated learning outcomes
5. Identification of strengths and weaknesses / diagnostic feedback
6. negotiate further opportunities

Comments by student:

_____

_____

_____

_____

Signature _____

Comments by preceptor

_____

_____

_____

_____

Signature _____

Date and time of final interview _____

FINAL INTERVIEW

DATE _____

Discuss with the student to allow any second attempts for each item.

1. Individual self-assessment
2. Achievement of stated learning outcomes
3. Identification of strengths and weaknesses / diagnostic feedback
4. Overall performance rated

Comments by Student:

Signature _____

Comments by Preceptor

Signature _____

FINAL INTERVIEW

(Preceptee's Copy)

DATE _____

Discuss with the student to allow any second attempts for each item.

5. Individual self-assessment
6. Achievement of stated learning outcomes
7. Identification of strengths and weaknesses / diagnostic feedback
8. Overall performance rated

Comments by Student:

_____

_____

_____

_____

Signature _____

Comments by Preceptor

_____

_____

_____

_____

Signature _____

Control of Infection

Objectives

1. Able to identify the correct procedure for hand-washing.
2. Able to identify the sources of cross infection and ways of preventing cross infection, including isolation.
3. Able to demonstrate aseptic technique.
4. Able to identify the correct procedure for handling waste.
5. Able to identify the correct procedure for handling and disposing of body fluids.
6. Able to discuss the policy for the use of antibiotics.
7. Able to obtain and correctly handle specimens.
8. Understand the basic principles of food hygiene and handling.
9. Able to assess skin integrity.
10. Understand the need for pressure area care.
11. Able to undertake pressure area risk assessment and act upon findings.

Development review: evidence, reflection, notes

Administration of Medicines

Objectives

1. Reads the BNF Standards for the Administration of Medicines.
2. Able to discuss the metabolism of drugs.
3. Able to list the routes of drug administration and identify when each might be used.
4. Able to list universal abbreviations for frequencies at which drugs may be administered, and what they mean.
5. Able to list the sources of information on drugs that you can access.
6. Understand your responsibility in regards to:
   - stat doses;
   - continuous infusions.
7. Able to complete the IV drug assessment.
8. Know the Hospital policy for storage and administration of drugs.
9. Review commonly prescribed drugs for your clinical area.
10. Able to discuss the actions to be taken if a drug is administered wrongly.
11. Able to discuss what to do if a patient has a reaction to a drug.
12. Able to describe the process and purpose of adverse incident reporting.

Development review: evidence, reflection, notes

Lifting and Handling

Objectives

1. Understand the body mechanics in lifting.
2. Understand the body positions for correct lifting.
3. Able to demonstrate the correct way of lifting.
4. Able to discuss the maximum weight a single individual can handle.
5. Able to demonstrate different lifting techniques on weight bearing and non-weight bearing patients.
6. Able to identify and describe the use of mechanical and non-mechanical aids for lifting or handling patients.

Development review: evidence, reflection, notes

IVI Management

Objectives

1. Correctly calculate medication dosages and IV rates for a series of given scenarios.
2. Demonstrate safe maintenance including proper dressing of peripheral IV cannula.
3. Demonstrate proper techniques in verifying ordered medications and IV fluid prior to administration (using the five Rights).
4. Demonstrate proper infection control procedures in IV therapy.
5. State three common complications of IV medication therapy.
6. Demonstrate proper technique in writing and administering medications for a series of given scenarios.
7. State procedure for reporting medication errors.
8. Demonstrate ability to use both syringe pumps and volumetric pumps.
9. Demonstrate proper technique for administering medications within the clinical setting.

Development review: evidence, reflection, notes

Catheter Care (Enteral Feeding Tube)

Objectives

1. Explain the reasons for enteral feeding and when it can be used.
2. Describe the steps taken to ensure enteral feeding can be used.
3. Demonstrate a knowledge of the complications.
4. Safely introduce a nasogastric tube.
5. Prepare enteral feeding of the required amount and strength.
6. Ensure patency of the nasogastric tube.
7. Ensure the patient's comfort at all times whilst the tube is in situ.

Development review: evidence, reflection, notes

Catheter Care (Urinary Catheter)

Objectives

1. Explain the indications for urinary catheterization.
2. Describe the steps taken to ensure catheter is in correct place.
3. Demonstrate a knowledge of the complications.
4. Safely introduce a urinary catheter.
5. Ensure patency of the urinary catheter.
6. Ensure the patient's comfort at all times whilst the catheter is indwelling.
7. Demonstrates correct maintenance and cleaning of the catheter.

Development review: evidence, reflection, notes

ACADEMIC EVALUATION

Date:

Name of preceptor:

Name of Student:

Point Discussed:

Outcome:

Date of Next Session

Signed by preceptor

Signed by student

CLINICAL SUPERVISION

Date:

Name of preceptor:

Name of Student:

Point Discussed:

Outcome:

Date of Next Session

Signed by preceptor

Signed by student