Intensive Care Services

John Hunter Hospital

Transition to Specialty Practice Program 2018

(Step 1 and 2)

Name: _____

NSW GOVERNMENT Health

Hunter New England Local Health District

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Welcome!

Congratulations on your appointment to the Transition to Specialty Practice Program (ICU) with Hunter New England Local Health District. The selection for the ICU stream was a highly competitive process. We hope you find your new position challenging and enjoyable, as this dynamic environment offers fantastic learning and career opportunities for motivated nurses.

The Intensive Care Services provides tertiary referral services to the Hunter New England region in NSW which encompasses a geographic area of over 130,000 square kilometres. This includes a number of specialities across various sites such as Trauma, Cardiothoracic, Neurosurgical, Coronary Care, High Dependency and Paediatrics. An inter-professional team ensures patients receive the best possible care for a broad range of conditions.

As a service, we strive to provide the best possible care, by constantly reviewing practice, engaging in reflection and in challenging our own assumptions. We encourage new team members to actively contribute to this culture by bringing innovative ideas to our attention. We also encourage standardisation as this has been shown to increase patient safety.

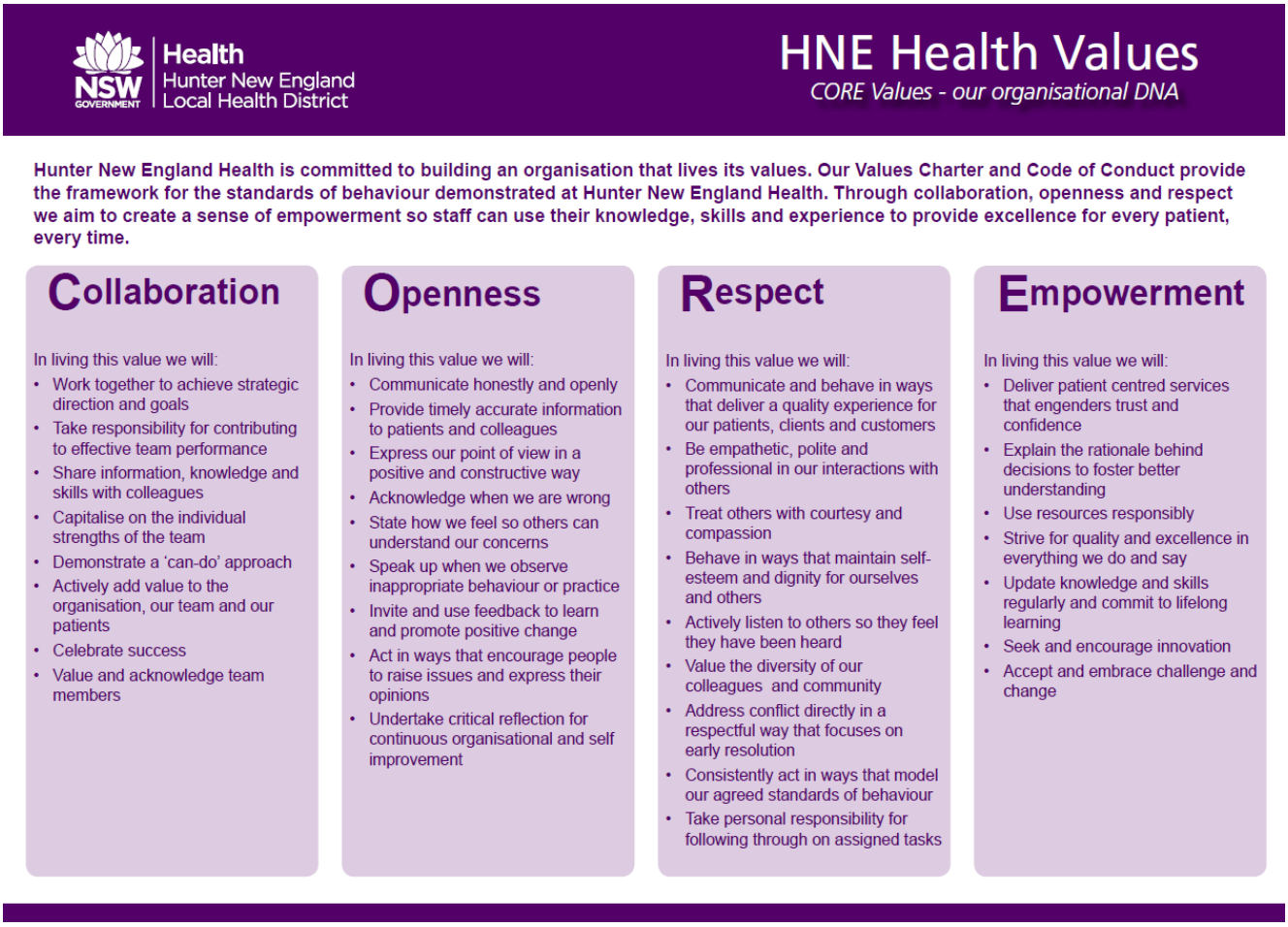
Our Nursing Vision & CORE Values

Hunter New England Health is a values-based organisation where staff behaviours and interactions with patients are based firmly on our agreed values.

We encourage collaboration, openness and respect in the workplace to create a sense of empowerment for our people to use their knowledge, skills and experience to provide excellence in patient care for every patient, every time.

Hunter New England Health is committed to building an organisation that lives its values.

In 2011, The NSW Ministry of Health adopted four CORE values for the NSW health system. They are;



The HNE Health Code of Conduct provides a framework for decisions and actions in the workplace and is based around the organisation's CORE values of Collaboration, Openness, Respect and Empowerment. Together, the Code and our values should guide your actions, decisions and work practice as an employee of Hunter New England Health.

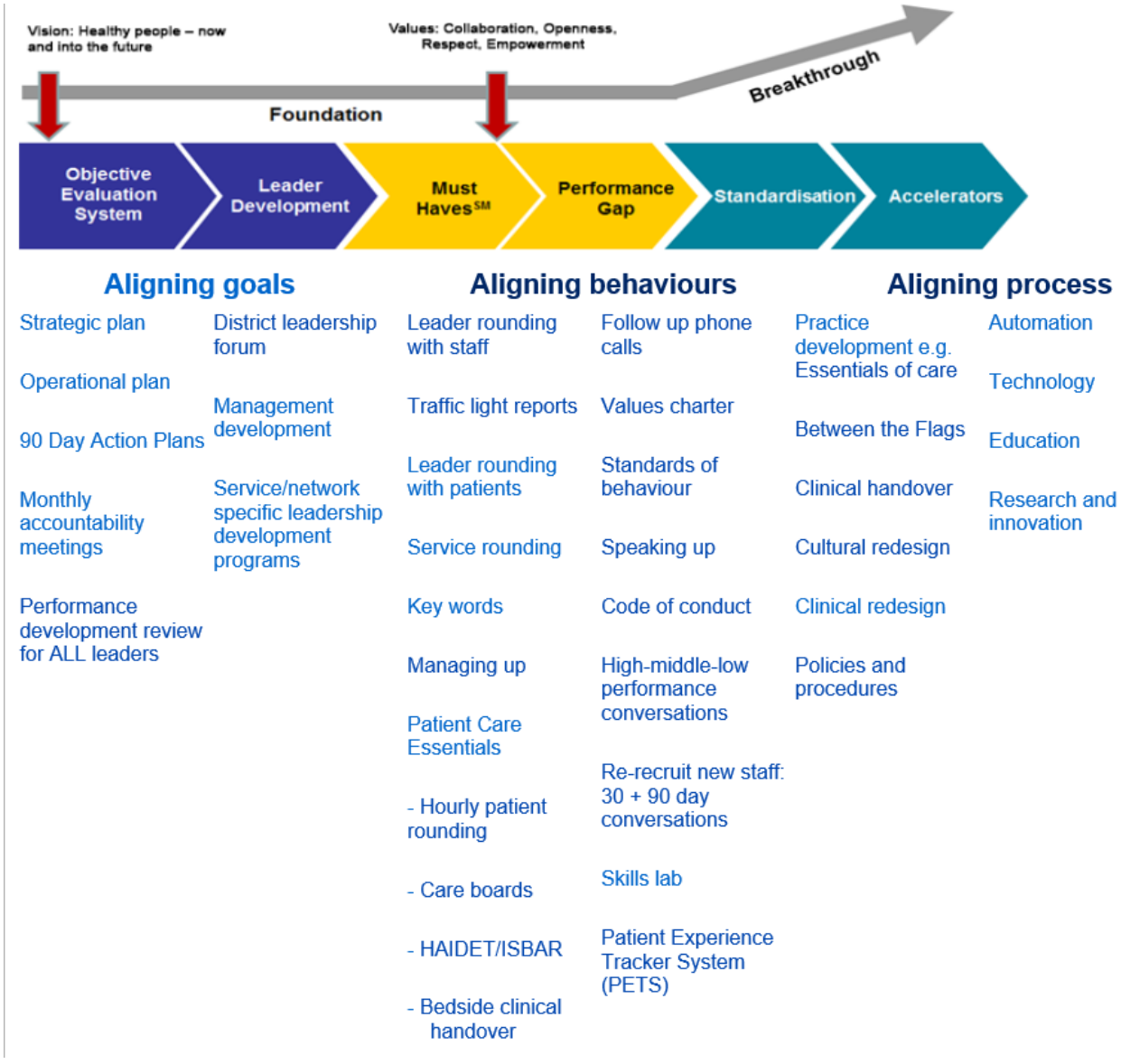
Our Commitment to Excellence

If you are new to Hunter New England Health you will need to become familiar with 'Excellence'. Please refer to the below visuals.

There is an excellence framework that supports aligning goals, aligning behaviour and aligning processes to improve patient care. You will hear more about patient and staff rounding, patient care boards, 90 day action plans and traffic like reports during your orientation. Within this framework, effective communication is driven by HAIDET and ISBAR.

Please visit the HNE intranet to learn more about Excellence and how these tools can assist in caring for patients and their families and ensuring a positive work environment at http://intranet.hne.health.nsw.gov.au/excellence2

EXCELLENCE
Every patient. Every time.



Excellence happens by building the capability of our leaders and our staff and making sure everyone, no matter what role they're in, is working in the best interests of patients and our organisation.

Through Excellence, teams adopt a series of proven tools and techniques that help them align goals, create greater accountability and consistency in what they do, and ultimately improve staff and patient experience.

- We want to acknowledge the valued work that people in our organisation do on a daily basis in a written document
- We want to minimise any variance in workplace behaviour
- We want to empower individuals to speak up about workplace behaviour that is a challenge or of concern
- We need to think about behaviours in our workplace that we value and appreciate
- We need to think about what behaviours we don't appreciate and be confident to speak up about them

John Hunter Hospital Workplace Principles

John Hunter Hospital Vision

John Hunter Hospital is committed to provide each patient with world class care, exceptional service and the compassion that we would want for ourselves and our loved ones.

- Delivery of our services is based on our planned, disciplined Excellence approach to doing the right thing for patients and their families, doing it consistently and doing it with respect. It is also about making John Hunter Hospital a great place to work.
- When you work with John Hunter it is important that you understand what is expected of you on a day-to-day basis.
- Our values charter in conjunction with the Code of Conduct and Standards of Behaviour provide you with more detailed information about the workplace behavior that is expected.

We expect that you will:

- Be responsible and accountable for maintaining effective workplace relationships, your contribution, to the team and your actions on a daily basis.
- Be truthful, open and trustworthy in your interactions with everyone.
- Communicate and behave in a courteous, polite and respectful manner with all people to promote a harmonious workplace.
- Do your job professionally, ethically and within the scope of practice of your role.
- Report inappropriate or unethical practice and speak up when things simply don't go right, even when you make a mistake yourself.
- Provide the best service possible to everyone at all times, striving for excellence in everything you do.
- Deliver your service in a caring, compassionate, empathic and supportive way.
- Be punctual, continuously develop yourself personally and professionally and see things through when you begin them.
- Be familiar with your team's Standards of Behaviour; actively use them and speak up about workplace issues early and directly with the person concerned.
- Escalate an issue at any stage where you perceive an inappropriate or ineffective response.

You can expect:

- A workplace that supports and demonstrates the behaviors listed above.
- Regular time to catch up with your manager including 30 and 90 day discussions, rounding and annual performance development review conversations.
- Cooperative and supportive team members and managers who provide excellent service.
- A safe and equitable workplace supported by relevant risk management approaches.
- Opportunities to learn and develop your skills.
- Your team member/s and/or your line manager to have a conversation with you when the above expectations are not met.
- All feedback to be provided in a courteous, polite and respectful manner.
- Your team member/s and/or line manager to "Speak Up" or have a "Straight Talk" conversation with you if your behaviour is inconsistent with team Standards of Behaviour, JHH Vision, HNE Health Values or the NSW Health Code of Conduct.
- Workplace conflicts to be resolved with a focus on restoring relationships, effective team functioning and service delivery.

Above & Below the Line Behaviours

Intensive Care Services staff have established agreed behaviours that staff would like to see more of and behaviours that staff want to see less of. For these to have effect and gain value we must peer manage behaviours below the line and reward behaviours above the line. This requires all staff to participate for the most effective outcome. These behaviors were reviewed in November 2017.

Staff Rounding

This is a short 5-10 minute discussion with your manager. Some questions you may be asked are:

- What is working well?
- Are there any individuals I should be recognising?
- Is there one area we should focus on to improve our service?
- If yes- Do you have any ideas?
- Do you have the tools and equipment you need to do your job?

These conversations are recorded on a database and provide valuable information to staff and also provide opportunity to recognise the efforts of specific people.

Our Values

Teamwork

Flexibility

Humour

Learning & Development

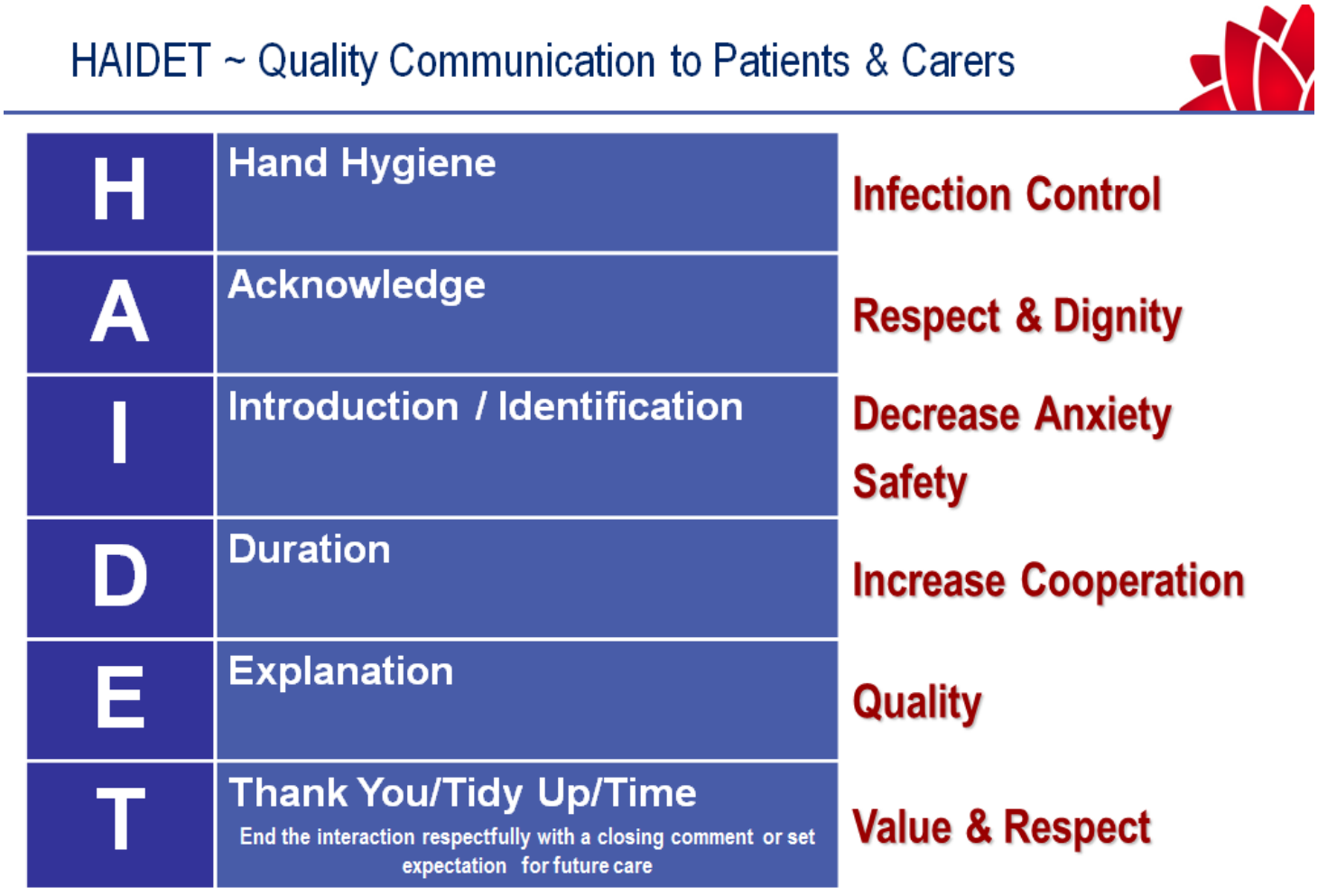
Intensive Care Services Agreed Behaviours			
Collaboration	**Openness**	**Respect**	**Empowerment**
Speak positively about Intensive Care Services	Promote honest open communication between all members of HC team.	Consideration of staff/patients/visitors	Encourage professional/practice development
Acknowledge/value opinions	Respectfully question breaches in policy/procedures	Introduce yourself to visitors and relatives and patients.	Encourage innovation
Reward individual success	Respectfully approach clinicians about standards of care	Being friendly and welcoming to everyone	Ask for assistance when required.
Support external relationships	Open disclosure	Maintain dignity and privacy of all patients and staff	Being able to say NO when unable to quarantine time to assist effectively ie checking DD's
Helping other colleagues when the unit is busy.	Clear communication and expectations	Professional responsibility eg punctuality, uniforms, telephone etiquette,	Model professional behaviours as per code of conduct.
Actively assist peoples when able.		Displaying positive body language Ie smiling, eye contact,	
Say hello thank you and please		Maintaining 2 visitor unit policy	
When asked to relieve to do so until that person returns		Direct visitors to the waiting room when not within the patient room.	

Intensive Care Services Behaviours we agree to speak up about			
Collaboration	**Openness**	**Respect**	**Empowerment**
To speak negatively about service and service delivery	Defiance to complying with service requests.	To talk over people, belittle or ignore colleagues or others (including relatives)	Use of social media to comment about workplace/people.
Be dismissive of people and situations	Complaining about people/workplace issues indiscriminately.	To raise voice during conversation or display negative body language	React negatively to constructive feedback.
Leaving work early and not assisting other staff to finalise work.	Defensive behavior when being openly questioned	Arriving late for work	Not asking for help/assistance when needed
Not answering monitor/equipment alarms.		Disregard patient/visitors anxiety, comfort and fears.	
Leaving cleaning duties to the ACCESS nurse		Referring to room number or associated injury instead of identifying by name.	
Poor organisation of breaks		Reading magazines (non work related) in the patient care environment during daylight or when relatives present.	
Not to leave ventilated patients unattended with no one in sight		use of mobile phones for personal reasons when engaged/allocated to patient care.	
		Not cleaning up after yourself	
		Use of mobile phones at the bedside	

HAIDET

Within the Excellence framework HAIDET has been added to improve communication with patients and relatives. This framework is described below and additional information can be found on the intranet.

H ~ Handwashing: Before interaction with patients and relatives we should attend to the 5 moments of hand hygiene to reduce the risk of transferring communicable diseases and pathogens.
A ~ Acknowledge: Eye contact with a smile allows you to connect with patients and carers. Addressing patients by name assists in identifying patients and shows respect and courtesy.
'Good morning Mrs. Nesbitt …..'
I ~ Introduce: Introduce yourself and your role to the patient and/or carer on your first contact.
'My name is ….. and I am your ….. I'll be caring for you today.'
D ~ Duration: Patients and carers feel less anxious if they are aware of what they are waiting for. When possible offer an expected timeframe, however ensure the timeframe is achievable and reasonable, over estimate, don't underestimate.
'We expect to have your test results by mid-afternoon' or 'Tomorrow around 11.00 am you will be having a …..'
E ~ Explanation: Inform the patient and/or carer in words they will understand. Explain what you will be doing and why; what they should expect; What is the proposed planned treatment or care.
Check to see if the patient has understood what has been said.
'Is there anything you are not clear on?' or 'Do you have any concerns about what I have just said?' or 'Can you explain to me in your words, what you understand is going to happen now.'
T ~ Tidy Up: Conducted environmental assessment – call bell with patient, equipment clear of bed etc
T ~ Thank You: End the interaction respectfully with a closing comment.
'Thank you for your time' or 'Before I go, do you have any questions? Please tell me – I have the time.'

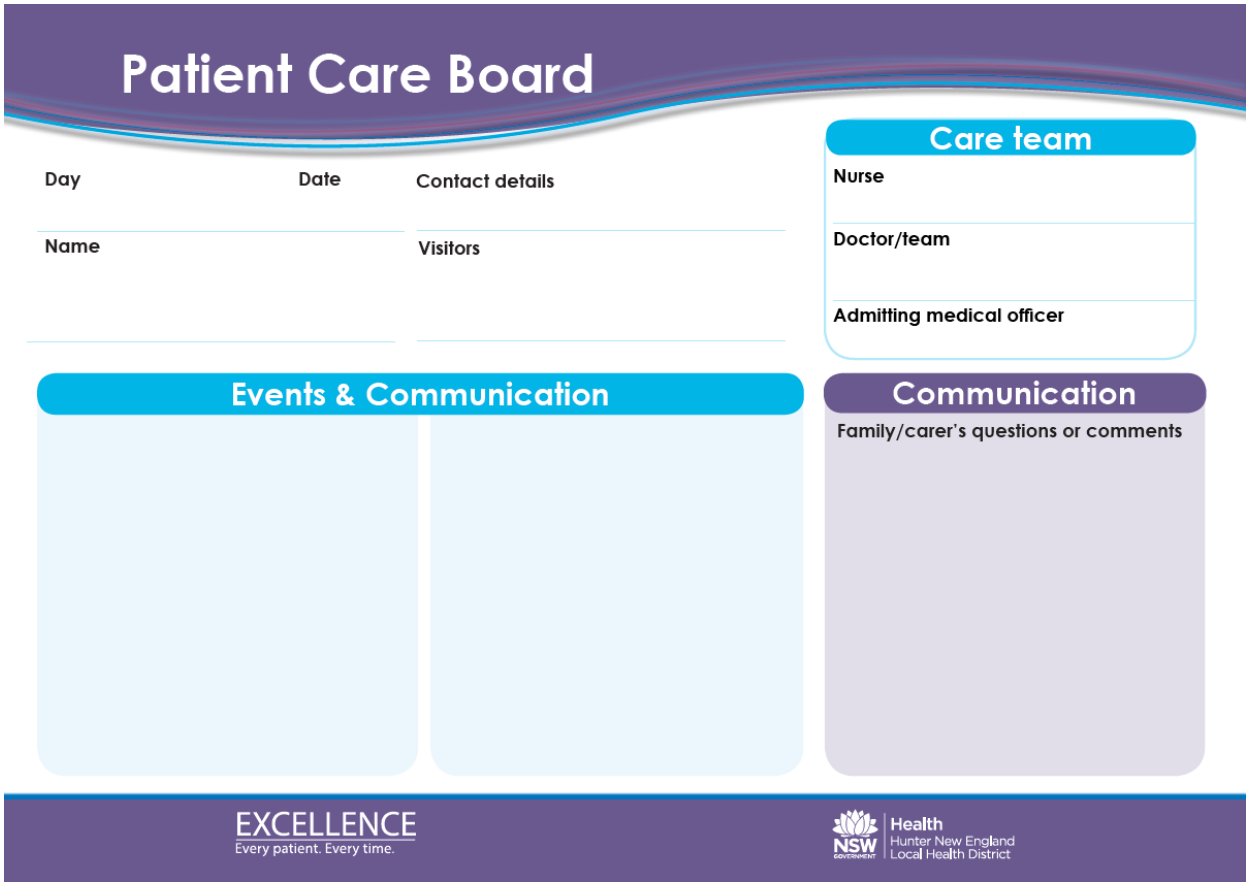


Patient Care Boards

The research tells us that 40-80% of medical information that health care practitioners communicate is forgotten immediately. Furthermore approximately half of the information remembered is incorrect (Kessels, 2003).

The use of Patient Care Boards improves communication between the patient and staff, encourages teamwork and efficiency, as well as demonstrating to patients and carers that everyone is working together to deliver the best individualised care for **Every Patient, Every Time.**

These care boards are completed by the nurse Every shift and are introduced to the patient and families (NOK) as a communication tool



http://intranet.hne.health.nsw.gov.au/excellence2

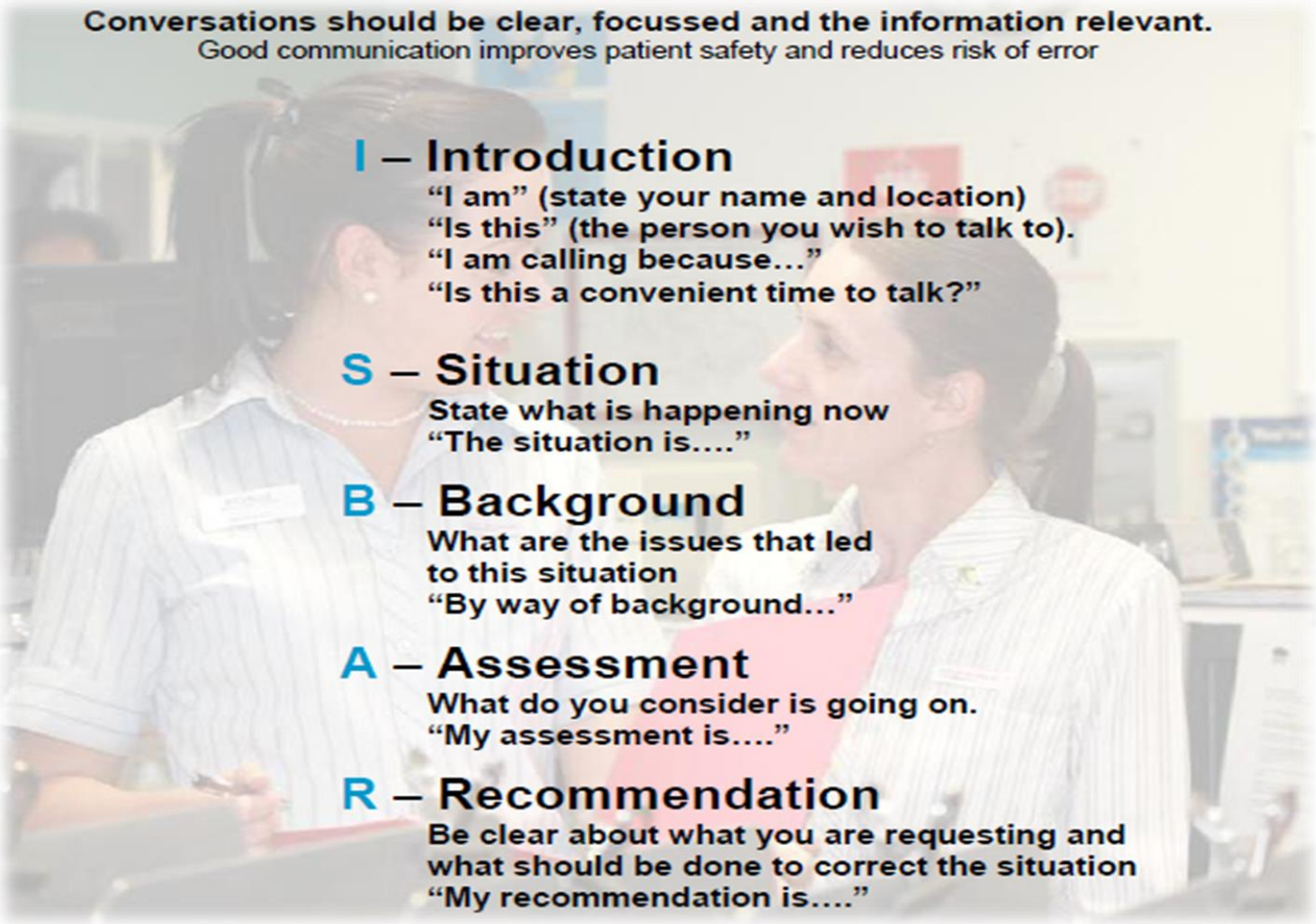
ISBAR

Critical Care Services are delivered in an increasingly complex clinical environment. Care of the patient is provided by a complex multidisciplinary team consisting of doctors, nurses and allied health. The individuals in this team have very different training, levels of experience and priorities of care. The members of this team also change shift by shift and day by day. A crucial component of successful co-ordination of this team and the provision of high quality and safe patient care is effective communication. Breakdown in communication has been described as a preventable factor in diagnostic errors and has been linked to delays in referrals and appropriate care, increasing morbidity and mortality.

Twice the numbers of adverse events have been attributed to communication than to inadequate skill levels of clinicians.

Structured communication tools are increasingly recognised as valuable in improving communication and patient safety.

ISBAR (an acronym for Introduction, Situation, Background, Assessment, Recommendation) is a framework for structured communication. It prompts us to introduce ourselves, state the current situation, give relevant background, state our assessment and our recommendation in any situation. The ISBAR acronym provides a framework to structure communication in a consistent and reliable way and makes expectations explicit.



ISBAR helps prioritise information for both parties; it decreases the chance of forgetting relevant information, helps to decrease assumptions or misunderstandings, by making the reason for the clinical communication obvious at the outset and encourages us to state the obvious.

During your employment within the Intensive Care Services you will be expected to use the ISBAR tool to structure your

- urgent calls for assistance
- requests for a medical review of a patient
- your daily handover at the end of each shift
- clinical handover when discharging a patient to the ward setting

Daily clinical handover at the end of each shift serves several important functions, including

- exchange of information
- socialisation
- organisation
- education

It provides information to oncoming shift about events of previous shift. The challenge for clinical handover is to communicate relevant and up-to-date information that is problem focussed, useful for planning and not time consuming

The information expected to be covered includes

- the patient's name and age
- the reason for admission
- the patient's past medical history
- treatments the patient has received
- your current patient assessment
- the plan of care for the patient

This information can all be presented in the ISBAR format, however the important tips below need to be observed

1. Preparation is vital – asses the patient, read the notes
2. Make sure you are clear and objective
3. Write down your relevant information
4. Gather relevant notes including continuing notes, test result and most recent observations

Finally remember that clinical handover is a learnt behaviour, it does not come naturally. Observe how others (nursing and medicine) handover. Utilise strategies you observe that are helpful, listen to other clinical handovers of patients you have already cared for and finally don't be afraid to ask for help.

Reverse ISBAR

As half of the incidents reported using the IIMS system are related to communication it is crucially important for the safety of our patients to ensure that the communication is carried out using the ISBAR principle. If not, then we can use the reverse ISBAR system of:

I - Can you please tell me who you are?
S - What is your major concern?
B - Why is the patient in hospital?
A - What are the vital signs? What do you think the priority problem is?
R - What would you like me to do?

The Two Challenge Rule

Sometimes we need to assert our concerns regarding safety and civility and there are many ways of doing this. As part of the Excellence Programme called Speaking Up, Hunter New England Health promotes the use of the 'CUS' acronym:

C: I am **C**oncerned
"I am concerned about..."
U: I am **U**ncomfortable
"I feel uncomfortable about..."
S: This is a **S**afety issue
"For the safety of the patient we need to… now"

Safety & Quality Improvement in Intensive Care

Hunter New England Health (HNE Health) is committed to providing a healthy and safe workplace for all employees, clients and visitors. It is the responsibility of all health care professionals within the multidisciplinary team to minimise the actual and potential clinical risks that exist within our environment. Adverse events have significant costs to patients, families and the health care system. Central to the management of identifying, analysing and minimising patient risk is notification utilising the IIMS database system.

Every health care professional is involved in contributing to the continuous process of improving the quality of the patient journey. Some strategies you may be involved in include morbidity and mortality meetings, root cause analysis, performance improvement/quality meetings, in-services and IIMS. The intensive care Performance Improvement Coordinators can assist with all strategies and also coordinate accreditation, NSW Health, HNE Health or Clinical Excellence Commission quality programmes, or local improvement projects.

In addition the ICU Liaison Service operates 24/7 and is undertaken by the intensive care Liaison Clinical Nurse Consultant Monday to Friday during hours and experienced intensive care nurses staff after hours.
The primary focus of the service is to review patients discharged from ICU over a 72 hour period and attends all rapid response calls across the campus.
Within the intensive care the Liaison Nurse is responsible for the management of the 'care of the chronically critically ill' or long term patient and also reviews patients prior to discharge to ensure that the patient is safe to leave the unit. If at any time you have concerned about sending a patient out to the ward whether in the red zone or not you can contact the Liaison Service on **55841** for consultation.

How do I report an actual or potential adverse event?

The Incident Information Management System (IIMS) is an anonymous reporting system which is available for all health care workers twenty four hours a day. All incidents or near misses should be reported through IIMS.

IIMS reporting can be completed at any computer within the Hunter New England Local Health District. You can locate the IIMS icon either from the desktop or on the Hunter New England Local Health District intranet main page. If you are having any difficulties completing any of the fields ask an experienced member of staff, an Educator or Manager.

Clinical Handover: Written Documentation

Documentation should be sufficiently detailed to allow care delivery to be tracked, monitored and evaluated. When caring for any patient at least once per shift you are expected to make a written entry in the patient notes, however time, relevant changes and additional information can be added at any time. Entries should reflect the patient's needs, care provided to the patient, and clinical decision making relating to changes in care delivered. They should also be written contemptuously, which means as soon as the events occur. Notes written in retrospect should be acknowledged as such.

All documentation is considered legally binding and must include objective rather than subjective comments and be time relevant as possible. So others may interpret your documentation please use only approved abbreviation and symbols.

Ideally your daily assessment entry should be written using the ISBAR format.

There is no need to transcribe any documentation that is provided elsewhere. The documentation should reflect findings from your assessments, your interpretation of them and what action was taken. You may find it useful to group elements of the assessment and interventions into body systems to enhance the exchange of information.

To add structure to your Nursing Assessment you may find a body systems approach beneficial.
An example of what might be documented for a day entry might consist of the following:

Example 1

I – **Introduction** – *(Time, place and person needs to be provided for context within the notes)*
22/10/2015 Time: 1420 hrs: Nursing

S – Situation ICU Morning Assessment. Care assumed from 0700 hours

B – Background *(Without reiterating the patient's history you may like to acknowledge your awareness of it or include new information)* History noted. ICU day four MET Call from F3 due to acute Respiratory deterioration post CABG, new Intercostal Catheter for Pleural Effusion

A – Assessment Neuro: RASS initially 3 mildly agitated Morphine/Midazolam infusions increased to optimise post sedation vacation RASS now -4 Moving all limbs to painful stimuli only. **CVS**: Febrile to 39.2 RMO aware sputum, urine and blood cultures taken. ST with occasional ectopics, Potassium now within normal range post IV stat order, ECG attended and visualised by RMO; no further orders. MAP>65, ART line patent; arm board and dressing insitu. x1 IVC removed as no longer patent and Day 3. Right IJ CVC all lumens patent: dressing remains insitu, BGL maintained within range as per unit IV Actrapid protocol. **RESP**: Air entry asymmetrical left greater than right with diminished breath sounds in right base. Remains intubated and ventilated on SIMV(PRVC) RR12x 650mls PEEP 7 Fi02 50%. Purulent secretions obtained from ETT suction, Specimen sent 29/10/14 Observed to have a weak cough. Intercostal Catheter draining reasonable amount of serous fluid. No swing/bubble. **Renal**: IDC patent U/O >0.5 mls/kg/hr except for 2 hours; RMO Keilgal informed 250ml N/Saline bolus given with observed increase in diuresis. **GIT** Abdo soft non-tender, Bowel sounds present, BNO 3 days, aperients prescribed and administered. NGT feeds at goal rate, no aspirate performed due to fine bore tube. **Integument**: Pressure areas intact. TEDS and sequential calf compression devices insitu. Elbow wound redressed as leaking; granulating well, dry dressing reinforced with gauze bandage for protection. **Additional:** Complaints related to patient comfort addressed with repositioning, given update on patients current status.

R - Recommendations. Hourly ET suction due to increased volume of secretions.

Sign name and then print and include designation e.g. RN EEN etc

Example 2

I – Introduction - 28/01/2015 Time: 0530 hrs: Night duty summary

S – Situation New Trauma admission from ED via OT at 0100 hours. Condition now stable.

B – Background MBA with TBI and # Left hip and right leg.

A – Assessment Neuro: GCS E3VTM5 Sedation ceased at 0300 hours patient now rouses easily to voice, no reports of pain with use of IV Fentanyl at 30mcg/hr . Equal strength in all limbs. RASS score unchanged. **CVS**: Afebrile, SR, NIBP low to systolic 90. RMO aware. Fluid bolus given with increase in blood pressure. IV access only x2 IVC's. **RESP**: Minimal secretions obtained from hourly ETT suction. Patient tolerating PSV PS12 PEEP 5 FiO2 35%. ABG's reflect adequate gas exchange on current settings. **RENAL**: U/O greater than 0.5 mls/kg/hr. **GIT**: OGT insitu with minimal aspirates. Has remained NBT, Abdo soft non-tender. BNO since pre-admission. **Integument**: Some grazes on ear and large haematoma, lips cracked oral mucosa now clean and intact. Log rolled 3rd hourly. Pressure areas intact. TEDS and Heparin s/c given. **Additional**: No enquiries. Partner arrive at 0130hours, given update from Dr Keilgal.

R – Recommendations – Referral to Social Work please regarding documentation for insurance company and employer for Work Cover to complete admission requirements. Formal C-spine assessment required.

Sign name and then print and include designation e.g. RN EEN

Other references that may assist in writing appropriate documentation include;

http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0008/88343/HNELHD_Pol_14_06_Minimum_Standards_of_Patient_Care_for_Adult_Inpatients.pdf

http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0006/152259/Clinical_Abbreviations_in_Health_Records_GNS_CACS_16_003.pdf

https://www.safetyandquality.gov.au/wp-content/uploads/2017/01/Recommendations-for-terminology-abbreviations-and-symbols-used-in-medicines-December-2016.pdf

Learning Culture

Nurses are fortunate to be able to positively affect people's lives as well as to make lifelong colleagues and friends in the course of their day. In addition, the critical care environment provides fertile ground for personal and professional development. We offer various learning opportunities including; in-service, workshops, journal club, insitu simulation and case presentations.

As other nurses will have made significant investments in your development, we feel that there is a responsibility to reciprocate this gift. For this reason, it is an expectation that all nurses of all skill levels contribute to the development of other nurses. This concept reflects an emphasis on professional practice development and a culture of learning. This is underpinned by the *Professional Development Pathway.* The pathway caters for all levels of nursing expertise and can be individualised and modified to recognise prior learning.
Interprofessional teaching and learning sessions are conducted every Tuesday and Thursday in at 1400hrs. You are encouraged to structure your shift in order to make yourself available to attend these sessions.

Transition to Specialty Practice (ICU) Program Outline

The transition to Specialty Practice Program (ICU) aims to meet the needs of all stakeholders within the critical care environment and provide the participants within the intensive care environment a standardised program to:

- Develop the confidence and competence of the intensive care nurse within a supportive clinical environment
- Enhance professional adjustment of the nurse new to intensive care practice, and their assimilation into the workplace
- Improve retention in the nursing workforce
- Provide quality care and outcomes for their patients
- Develop critical thinking practices, engage in reflection and respond appropriately within the clinical environment
- Develop core foundational skills and knowledge to enable safe delivery of care
- Use current processes' and professional development opportunities already available within the area health service to provide the novice intensive care nurse a comprehensive but flexible program that supports their transition from novice to advanced beginner
- Provide varied learning opportunities during which the participant can access, share and validate knowledge

This program also incorporates the *NSW Transition to Practice Intensive Care Nursing Program*

Program Objectives

As minimum participants who complete the program will have an understanding of the following:

- Anatomy and physiology
- Psychosocial aspects, including cultural and spiritual beliefs
- Pathophysiology
- Technology applications
- Pharmacology
- Caring for the carer including debriefing, stress management and peer support
- Comprehensive clinical assessment (including diagnostic and laboratory results)
- Patient and family education
- Illness and alterations of vital body functions
- Legal and ethical issues
- Plans of care and nursing interventions
- Professional nursing roles in critical care including clinical teaching tragedies, team leadership and management issues
- Medical indications and prescriptions with resulting nursing care responsibilities
- Use of current research findings to deliver evidence based interprofessional care
- Global critical care perspectives
- The participants will be supported by the following to achieve these aims:
- Clinical placements
- Competency based practice
- Study days

The Nurse Educator of Intensive Care Services, Leila Kuzmiuk is the coordinator of this program and your first contact. The Intensive Care Education teams are responsible for supporting your clinical development and competence in the critical care environment.
Leila.Kuzmiuk@hnehealth.nsw.gov.au DECT (492) 23571

The aims and objectives of the program align to the following National Safety and Quality Health Standards (2017):

Participants who complete the Transition to Specialty Practice Program (ICU) will have developed skills and competence essential to intensive care nursing including:

- Patient assessment and safety
- Invasive devices (introductory)
- Invasive mechanical ventilation (introductory)
- Intra-hospital transport
- Non-invasive positive pressure ventilation
- Safe management of chest drains
- External ventricular drain management
- Safe management of a patient with a tracheostomy
- Safe spinal log roll
- Cough assist
- Adult advanced life support
- Paediatric basic life support

National Standard 1 ***Clinical Governance***	**Clinical performance and effectiveness**	
	Safety and Quality Training	1.19 1.20
	Performance Management	1.22
	Credentialing and scope of clinical practice	1.23 1.24
	Safety and quality roles and responsibilities	1.25 1.26
	Evidenced-based care	1.27
	Variation in clinical practice and health outcomes	1.28
National Standard 2 ***Partnering with Consumers***	**Clinical governance and quality improvement systems to support partnering with consumers**	
	Integrating clinical governance	2.1
	Partnering with patients in their own care	
	Healthcare rights and informed consent	2.4
	Sharing decisions and planning care	2.6 2.7

	Health literacy	
	Communication that supports effective partnerships	2.8 2.10
	Partnering with consumers in organisational design and governance	
	Partnerships in healthcare governance planning, design, measurement and evaluation	2.14
National Standard 3 ***Preventing and Controlling Healthcare-Associated Infection***	**Clinical governance and quality improvement to prevent and control healthcare-associated infections and support antimicrobial stewardship**	
	Integrating clinical governance	3.1
	Applying quality improvement systems	3.2
	Partnering with consumers	3.3
	Infection prevention and control systems	
	Standard and transmission-based systems	3.6
	Hand hygiene	3.8
	Aseptic technique	3.9
	Invasive medical devices	3.10
	Clean environment	3.11 3.12
National Standard 4 ***Medication Safety***	**Clinical governance and quality improvement to support medication management**	
	Integrating clinical governance	4.1
	Applying quality improvement systems	4.2
	Medicines scope of clinical practice	4.4
	Documentation of patient information	
	Adverse drug reactions	4.8 4.9
	Medication management processes	
	Information and decision support tools for medicines	4.13
	Safe and secure storage and distribution of medicines	4.14
	High-risk medicines	4.15
National Standard 5 ***Comprehensive Care***	**Clinical governance and quality improvement to support comprehensive care**	
	Integrating clinical governance	5.1
	Applying quality improvement systems	5.2
	Partnering with consumers	5.3
	Designing systems to deliver comprehensive care	5.4
	Collaboration and teamwork	5.5 5.6
	Developing the comprehensive care plan	
	Planning for comprehensive care	5.7
	Screening of risk	5.10
	Clinical assessment	5.11

	Developing the comprehensive care plan	5.12 5.13
	Delivering comprehensive care	
	Using the comprehensive care plan	5.14
	Comprehensive care at the end of life	5.18
	Minimising patient harm	
	Preventing and managing pressure injuries	5.22 5.23
	Preventing falls and harm from falls	5.24 5.26
	Nutrition and hydration	5.28
	Preventing delirium and managing cognitive impairment	5.29 5.30
	Predicting, preventing and managing aggression and violence	5.34
	Minimising restrictive practices: restraint	5.35
National Standard 6 ***Communicating for safety***	**Clinical governance and quality improvement to support effective communication**	
	Integrating clinical governance	6.1
	Applying quality improvement systems	6.2
	Partnering with consumers	6.3
	Correct identification and procedure matching	
	Correct identification an procedure matching	6.5
	Communication at clinical handover	
	Clinical handover	6.7 6.8
	Communication of critical information	
	Communicating critical information	6.9 6.10
	Documentation of information	
	Documentation of information	6.11
National Standard 7 ***Blood Management***	**Clinical governance and quality improvement to support blood management**	
	Integrating clinical governance	7.1
	Prescribing and clinical use of blood and blood products	
	Optimising and conserving patient's own blood	7.4
	Documenting	7.5
	Prescribing and administering blood and blood products	7.6
	Reporting adverse events	7.7
National Standard 8 ***Recognising & Responding to Acute Deterioration***	**Clinical governance and quality improvement to support recognition and response systems**	
	Integrating clinical governance	8.1
	Partnering with consumers	8.3

	Detecting and recognising acute deterioration and escalating care	
	Recognising acute deterioration	8.4 8.5
	Escalating care	8.6 8.9
	Responding to acute deterioration	
	Responding to deterioration	8.10 8.11 8.13

Professional Development Pathway

The pathway outlines a structure for professional development and has been designed for clinicians at all levels. It is necessary to complete each step of the pathway prior to progressing to the next.
Please provide documented evidence for assessment to the education team for recognition of prior learning.

Step One: Demonstrating safe practice (mandatory)

The first part of the *Professional Development Pathway* focuses on transition to the specialty and orientation to the critical care environment and consists of *Demonstrating Safe Practice* and *Developing Clinical Skill*.

It ensures communication of *the things you need to know* and provides you with skills to ensure safe practice at an introductory level. Its focus is to familiarise you with a new environment and ensure your nursing practice aligns with local standards and policies.

On completion of step 1 you will be able to be a resource person and an assessor for undergraduate student nurses. You will set learning goals, identify resources and demonstrate your ability to safely care for patients.

Step one is usually completed within the equivalent of three months of starting employment within the intensive care services.

To ensure progression you will be required to:

- Meet legislative requirements/ HNE required education (Appendix 1)
- Complete a specific number of the ICU introductory competencies
- Achieve a satisfactory level of performance at the equivalent of three months; as evidenced by a PDR with your NUM

Step Two: Developing clinical skill (mandatory)

The second part of the *Professional Development Pathway* builds on step one and ensures further development of knowledge and skill within a specialty area.
On completion of this stage you should be able to act as a resource person for those at step one. The requirements for completion of this step include:

- Complete the remainder of the ICU introductory competencies
- Development of your professional portfolio (Appendix III)
- Advanced life support accreditation
- Achieve a satisfactory level of performance at the equivalent of twelve months; as evidenced by a PDR with your NUM

In order to achieve these requirements it is advisable that you identify a mentor from within your specialty with whom you are able to discuss your nursing practice constructively. When you have identified a mentor you must approach them and arrange to meet regularly to discuss your progress. It is your responsibility to take the initiative to meet and discuss your progress.

Step Three: Towards specialist practice

The focus of step three is the development and integration of knowledge and skill at a more advanced level. On completion, you will use your advanced clinical skills to make comprehensive and accurate patient assessments, analyse clinical data and provide complex care for patients with multiple system failure.

Additionally you will be seen as a resource for all staff entering the intensive care environment. You will be equipped to contribute to quality improvement, development of policy and guidelines, provide formal and informal education and fulfil the requirements of the ACCESS role.
The progression options for this step are as follows:

- Graduate certificate in critical care or equivalent
- A number of ICU advanced clinical competencies and practices
- Contribute to one clinical practice improvement project
- Retrieval nurse role

Step Four: Demonstrating professional leadership

Step four focuses on the development of the professional aspects of practice. It provides you with the skills to effectively lead and support the team whilst coordinating the management of patients. The progression options for this step include:

- Attend a preceptor or mentor workshop/course
- Complete ICU team leader program
- Obtain Clinical Nurse Specialist status

You now have the opportunity to be able to relieve in the following positions within the intensive care services

- Clinical Nurse Educator
- Nurse Educator
- Nursing Unit Manager
- Clinical Nurse Consultant
- Liaison Nurse
- Performance improvement coordinator (quality)
- Research coordinator
- Data Manager
- Equipment Nurse

Orientation

Orientation is an essential element of the first step of the Professional Development Pathway- *Demonstrating Safe Practice* and *Developing Clinical Skill*. For some of you this may involve two days of Hospital Orientation that provides standardised information about the organisation before commencing within the intensive care.
Following the Hospital Orientation, you will receive one day of *Educator Assisted Familiarisation* that consists of an induction to the Intensive Care environment with the Education team. *Assisted Bedside Orientation* follows when you will work in a supernumerary capacity. This means that you will work in partnership with another Registered Nurse (preferably your preceptor) to care for your allocated patient. It is important to realise that *Educator Assisted Familiarisation* and *Assisted Bedside Orientation* are only the introduction of your orientation period.
This manual will assist you to complete Step 1 & 2 of the *Professional Development Pathway.* In addition, the manual also provides a record of your achievements, which you require at Performance Development Reviews with your NUM.

It is essential that you bring this manual to work with you, or leave it in your locker, as you will need to utilise this manual on a daily basis.

This will enable your preceptor or resource person to clearly identify your goals and therefore assist you to complete these goals.

Educator Assisted Familiarisation

As discussed earlier, you will spend one day working and learning with the ICU Education team. The *Educator Assisted Familiarisation* day aims to provide an awareness of your new surroundings, staff and equipment and prepare you for caring for a patient within the critical care environment. At this time you will be given a short tour of the intensive care and become familiarised with commonly used ICU equipment. A more detailed summary of the structure of these days is provided on the following pages.

Intensive Care Transition to Specialty Practice Program Orientation Program

Day One: Monday 5th February 2018

Venue/Time		Prompts for discussion	Person responsible	Venue
Familiarisation to ICU	0800-0900 hrs	Welcome, meet & greet education team, CNC, NUM's & NM Familiarisation Game Allocation of following resources ICU TRN program manual ICU pre commencement survey (online) ICU flowchart Photos Allocation of protective eye wear ICU access cards Induction checklist forms, Arterial Blood gas forms Missing Patient Management guideline	Nursing and management teams from JHH and CMN	AICPM room 3987
	0900-0930 hrs	Tour of intensive care services & other relevant departments including fire & safety	Nursing Education Team	Intensive Care Unit
	0930-1000 hrs	Fire Safety (practical only)	Fire Officer	AICPM room 3987
	1000-1030hrs	**Morning Tea**		
	1030-1100hrs	ICU equipment, resources, trials and managing broken equipment	Equipment Nurse	Intensive Care Unit
	1100-1145 hrs	Induction checklist completed: Staff roles and responsibilities for patient safety and quality Rostering , staff allocation & annual leave, missing patient management	H.R.NUM	AICPM room 3987
	1145-1215 hrs	Clinical trials in Intensive Care	Clinical Trials Coordinator	AICPM room 3987
	1215-1245 hrs	Quality in Clinical Practice Intensive Care Unit Liaison Service	Quality Improvement coordinator Liaison CNC	AICPM room 3987
Mandatory	1245-1315 hrs	**Lunch**		
	1315-1415 hrs	Introduction to ICU Program, TRN manual and preceptorship	Nursing Education Team	AICPM room 3987
	1415-1445 hrs	Medication calculation test	Nursing Education Team	AICPM room 3987
	1445-1545 hrs	Cytotoxic Awareness training (level 2) Donning & Doffing	Nursing Education Team	Intensive Care Unit

	1545-1615hrs	PMVA training	Nursing Education Team	RNC Conference Room 1
	1615-1630 hrs	Reflection, wrap up & home	Nursing Education Team	RNC Conference Room 1

The program set out above is a guide and the Education team may vary the content and order according to the individual requirements of the nurses' and the availability of venues for instruction

Day two: Tuesday 6th February 2018

Time		Prompts for discussion	Person responsible	Venue
Respiratory system	0800-0930 hrs	Review anatomy & physiology Mechanisms of breathing Role of O2, CO2, pulse oximetry Respiratory failure Oxygen delivery devices	Nursing Education Team	AICPM room 3987
	0930-1000 hrs	**Morning Tea**		
	1000-1200 hrs	Presentation & simulation of respiratory assessment of self-ventilating patient including documentation Perform respiratory assessment on patient in unit Present your experience & assessment findings to the group	Nursing Education Team & Physiotherapy	AICPM room 3987 & Intensive Care Unit
	1200-1300 hrs	Presentation on principles of mechanical ventilation including non-invasive & invasive terminology and ETT vs mask assessment	Nursing Education Team	AICPM room 3987
	1300-1330 hrs	**Lunch**		
	1330-1430 hrs	Demonstration & ventilator assembly & circuit checks for NIPPV & IPPV	Nursing Education Team	Intensive Care Unit & AICPM room 3987
	1430-1515 hrs	Extend respiratory assessment to include invasively ventilated patient with ETT Present your experience & assessment findings to the group	Nursing Education Team	Intensive Care Unit & AICPM room 3987
	1515-1545 hrs	Orientation to ICU intranet policies & guidelines	Intensive Care Clinical Nurse Consultant	ICU Tutorial room 3102
Resources	1545-1615hrs	Communication with the patient & families	Intensive Care Services Social Worker	ICU Tutorial room 3102
	1615-1630 hrs	Reflection, wrap up & home	Nursing Education Team	ICU Tutorial room 3102

The program set out above is a guide and the Education team may vary the content and order according to the individual requirements of the nurses' and the availability of venues for instruction

Day three: Wednesday 7th February 2018

Time		Prompts for discussion	Person responsible	Venue
Cardiovascular system	0800-0900 hrs	Review anatomy of cardiac system including, • electrical conduction, • rhythm interpretation • commonly seen arrhythmias	Nursing Education Team	RNC North Block Conference room 2186
	0900-1000hrs	Review physiology of cardiac system including • blood flow • cardiac cycle • Starling law • preload • afterload • contractility	Nursing Education Team	RNC North Block Conference room 2186
	1000-1030 hrs	**Morning Tea**		
	1030-1130 hrs	Invasive haemodynamic monitoring Demonstration & exercise of transducer assembly including monitor & documentation	Nursing Education Team	Intensive Care Unit
Familiarisation to ICU	1130-1230 hrs	Library Services	Librarian	RNC North Block Conference room 2186
	1230-1300 hrs	Infection Control	Infection Control CNC	RNC North Block Conference room 2186
	1300-1400 hrs	**Welcome Party Lunch** **Introduction to TRN's, preceptors and ICU staff**	Education and Management Team, preceptors & nursing staff	Intensive Care Tea Room
Cardiovascular system	1400-1600 hrs	Presentation & simulation of cardiovascular assessment including documentation Perform cardiovascular assessment on patient in unit Present your experience & assessment findings to the group	Nursing Education Team	AICPM room 3987
	1600-1630 hrs	Reflection, wrap up & home	Nursing Education Team	AICPM room 3987

The program set out above is a guide and the Education team may vary the content and order according to the individual requirements of the nurses' and the availability of venues for instruction

Day four: Thursday 8th February 2018

Time		Prompts for discussion	Person responsible	Venue
Cardiovascular system	0800-0900 hrs	Presentation on arterial blood gas analysis	Nursing Education Team	RNC Conference Room 1
	0900-1000 hrs	Simulation of performing arterial blood gas sampling Obtain ABG sample from patient in unit & arterial blood gas analysis Credentialing of ABG machine	Nursing Education Team	Intensive Care Unit & RNC Conference Room 1
	1000-1030 hrs	**Morning tea**		
	1030-1230 hrs	Commence introductory medication resource identifying all resources available Each TRN is to present one of the following medications to the group • Fentanyl • Insulin • Potassium • Noradrenaline • Morphine • Midazolam • Propofol • Adrenaline • Dobutamine • Vasopressin • SNP • GTN • Metaraminol	Nursing Education Team	RNC Conference Room 1 & Intensive Care Unit
	1230-1300 hrs	**Lunch**		
Resources	1300-1400 hrs	Medication Administration Policy Five rights of drug administration Pharmacy Drug search & imprest POTS	Intensive Care Services Pharmacist	RNC Conference Room 1
Neuro system	1400-1600 hrs	Review anatomy & physiology of gastro intestinal & renal systems Presentation & simulation of gastro intestinal & renal assessment including documentation Perform gastro intestinal & renal assessment on patient in unit Present your experience & assessment findings to the group	Nursing Education Team	RNC Conference Room 1& Intensive Care Unit
	1600-1630 hrs	Reflection, wrap up & home	Nursing Education Team	RNC Conference Room 1

The program set out above is a guide and the Education team may vary the content and order according to the individual requirements of the nurses' and the availability of venues for instruction

Day five: Friday 19th February 2018

Time		Prompts for discussion	Person responsible	Venue
Familiarisation	0800-1000hrs	Review anatomy & physiology of neurological system Presentation & simulation of neurological assessment including documentation Perform neurological assessment on patient in unit Present your experience & assessment findings to the group	Nursing Education Team	RNC Conference Room 1 & Intensive Care Unit
	1000-1030 hrs	**Morning tea**		
GIT & Renal systems	1030-1200 hrs	Review anatomy & physiology of integumentary system Lecture and simulation of integumentary assessment including • waterlow score • documentation • pressure relieving devices • mouth care score and interventions Perform integumentary and mouth care assessment on patient in unit Present your experience & assessment findings to the group	Nursing Education Team	RNC Conference Room 1 & Intensive Care Unit
	1200-1230 hrs	**Lunch**		
Integumentary system	1230-1400 hrs	Presentation & simulation of bed space assembly & daily routine including • equipment safety checks • orientation to monitor • invasive monitoring • other bed space equipment bedspace hazards • data print outs emergency arrest trolley & emergency procedures	Nursing Education Team	RNC Conference Room 1 & Intensive Care Unit
	1400-1500 hrs	Staff ID badges	Nursing Education Team	E Block Room 6028
	1500-1600 hrs	The TRN experience	Past TRN participants	RNC Conference Room 1
	1600-1630 hrs	Reflection, wrap up & home	Nursing Education Team	RNC Conference Room 1

Ensuring adequate supervision and support

Intensive care units in tertiary referral hospitals employ large numbers of staff. The John Hunter Hospital is no exception to this rule with over 200 nurses (casual and permanent) working within the service. It therefore takes some time to develop working relationships, or even meet many of the nurses. It is possible for new nurses to get lost in the system. In these cases they may fail to develop in the way they had hoped-this program has been specifically designed with this in mind.

Tips to ensure you are adequately resourced

1. Introduce yourself to the people working in the bed spaces around your area.
2. Introduce yourself to the team leader at the beginning of every shift and let them know your level of experience.
3. Clarify the major issues for your patient's management at the beginning of your shift e.g.: ask, '…what do I need to watch for in a patient who has…?'
4. Ask your preceptor or resource person to check over your charts to identify anything that needs to be considered.
5. Request allocation of specific patients ahead of time (usually the day before) by discussing with the Team Leader. This will help to ensure you are allocated patients who are appropriate for your learning needs. (NB: it may not always be possible to grant requests).
6. Plan your resources ahead. If you enjoy working with a particular preceptor or resource person, check the allocation sheets to see if they are working on any of your other shifts. Discuss with them the possibility of working together again. So other people know your intention put an asterisk next to both your names in the allocation sheet and write 'work together'.
7. Different people may suggest various methods of completing a task. This can be confusing and frustrating, but it is important to remember that people have the best intentions. Where information is conflicting, ask about the underlying principles so you can provide safe care. Also check if there is a policy or guideline so you can ensure you are working by the preferred method.
8. The Team Leader, Educators, CNC and Managers can arrange alternative support if your resource person is busy and you find yourself struggling.
9. If you are feeling stressed, unsafe, or unhappy at work, discuss this with your Managers, Educators or the CNC. Remember these issues are our problem as well as yours and we are here to help you manage them. There are often small things that can be done to significantly lighten your load – come and talk to us.

Asking for feedback

It is often challenging to gauge where you are up to or if you are doing the right thing. Even though you will participate with 30 & 90 day conversations and progress meetings with the management and education teams we encourage you to seek feedback each shift from your preceptors and all healthcare professionals that you are working alongside with.

1. Be receptive and welcome ALL feedback because another healthcare professional has taken the time to give you feedback so you can learn and grow. Feedback comes from a space of *Putting the Patient First*

2. Inform your colleagues that you are on the Transition to Specialty Practice Program (ICU) and remember to tell them you welcome feedback please so you can learn and develop your knowledge and skills

3. When delivering clinical handover ask the nurse if you missed any important information or that they would of done differently

4. Ask your colleagues how they would do things so you can learn new skills.

5. Ask the nurse on the next shift that you have handed over to let you know if you did not complete something or if there was something you missed (this might involve sending them an email or following up with them on later shift).
6. Make the most of **EVERY** learning opportunity that is presented to you

7. When you have been supervised completing a new skill or been involved in a deteriorating patient ask for specific feedback on your performance from others that were involved

Your responsibilities

Employment in any organisation relies on a functioning partnership, and as you know, all partnerships involve responsibilities. Your responsibilities are outlined in your job description (if you have not received a copy of this, ask your Managers to provide you with one). You are also required to practice within the Australian Registered Nurse Standards for Practice & the Australian College of Critical Care Nurses Competency Standards for Specialist Critical Care Nurses.

Hunter New England Local Health District has the responsibility of providing you with adequate guidance and support in order for you to conduct your role safely. Obviously, this relies on both parties communicating issues in a timely fashion.

For this reason, completion of hospital mandatory assessments and all the requirements of Step one & two of the *Professional Development Pathway* are mandatory for nurses commencing within the intensive care service.

Your initial progress and goal setting will be reviewed with a member of the nursing education or management teams during 30 and 90 day conversations. At this time you will have the opportunity to set goals and complete your education learning plan.

You will also complete program evaluations online over the twelve moths.

Bedside Assisted Orientation

Bedside assisted orientation provides you with the opportunity to care for patients while being supported on a one to one basis in a supernumerary capacity. You should feel free to ask all the questions you like in order to build on your confidence.

Over these days you will be allocated one patient to provide complete care for whilst under supervision; however at this stage you are not responsible for the patient. A more detailed summary of the structure of these days is provided on the following pages.

You may not find the opportunity to be exposed to all the content over these days. Do not be concerned as an Educator, Preceptor or Resource person can provide this information at a later date.

Bedside assisted orientation day one

On completion of this activity at the bedside you will have an understanding of bedside emergency equipment, planning care and communication. This activity is intended to be completed day 1 at the bedside. This content will also prepare you to complete the *Patient Assessment & Safety* and *Introductory Invasive Haemodynamic Monitoring* competencies; therefore it is beneficial for you to be aware of the performance criteria required.

The table below provides prompts for you and your resource person towards achieving the daily goals. It is essential that each area is signed by your allocated resource person. An educator will follow up with you to ensure this has been complete and address any areas not covered.

Skill sets		Prompts for discussion	Resource person
Patient safety	Emergency checks	Check resus bag available & easily accessible (include PEEP valve check if present)	
		Check flow meter operational	
		Discuss contents of bedside emergency bag	
		High wall suction operational (NB: Low wall suction inappropriate for emergency purposes)	
		Discuss bedside Tracheostomy tube spares (spare tube and inner cannula)	
	Airway	Airway security, position of ETT at teeth Cuff pressure	
	Breathing	Inspect rise & fall of chest/auscultate for equal air entry Check ventilator settings against prescription Set ventilator alarms appropriately	
	Circulation	Discuss levelling and zeroing of transducers Check infusions against orders Identify infusions and follow lines to patient Identify emergency IV port Assess line security and labelling Correct CVP monitoring line Discontinuation of infusions Checking placement (waveform and X-ray)	
	General	Checks placement of NGT Maintaining patient supervision and visibility Discuss appropriate alarm settings for each monitored parameter (consider medical orders) Discuss safety of alarm volume Consider falls risk/ restraints/ bed rails Adheres to the 5 rights of medication admin Rationale for infusions: mcg/kg/min for vasoactive medications & mcg/kg/hr for pain/sedation medication & associated documentation Completes IV administration competency	
Assessment and	Physical assessment	Overview of systems approach to physical assessment: neuro, CVS, resp, GIT, renal, skin	

	GCS	Explore the concepts and standards for assessment of GCS	
	Essential care	Identifies plan of care for the shift Attends dressings Mouth care/ eye care/ pressure ulcer risk/ positioning and muscle stretching/DVT prophylaxis/ hygiene Psychosocial and spiritual care	
	Environment	Damp dusting/Hand hygiene/Bedspace tidy Pressure area care rounds/ X-ray rounds responsibilities Manual handling risks and trip hazards	
Communication	Documentation	Observe clinical handover from shift to shift Integrated note writing & ICU Flow chart MCAT score/Waterlow score/Agitation Sedation score Delirium score/Pain score/Falls risk PAST/patient printout/day one admission Competes Patient Care Board Updates Patient Journey Board	
	Relieving others	Negotiates meal breaks Communicates issues at Medical rounds Provides observation for ventilated and non-ventilated patients and ongoing mgt for patient Negotiates attendance at in-service	

Bedside assisted orientation day two

On completion of this activity at the bedside you will have an understanding of bedside emergency equipment, planning care and communication. This activity is intended to be completed day 2 at the bedside. This content will also prepare you to complete the *Patient Assessment & Safety* and *Introductory Invasive Haemodynamic Monitoring* competencies; therefore it is beneficial for you to be aware of the performance criteria required.

The table below provides prompts for you and your resource person towards achieving the daily goals. It is essential that each area is signed by your allocated resource person. An educator will follow up with you to ensure this has been complete and address any areas not covered.

Skill sets		Prompts for discussion	Resource person
Patient safety	In addition to the *patient safety* skill sets from day one also focus on the following:		
	Tube security	Supervision of the patient with an artificial airway Demonstrates tube security methods Identifies importance of changing tapes daily	
	ETT position	Checks and documents position at teeth X-ray confirmation of lines and tubes by doctor Discusses appropriate actions for tube position variance	
Assessment and planning care	In addition to the *assessment and planning care* skill sets from day one also focus on the following:		
	Respiratory assessment	Explore the concepts of respiratory physical assessment (incl. signs and symptoms of respiratory distress)	
	Respiratory interventions	Based on your assessment, discuss appropriate interventions including, positioning, suctioning, nebulisers, humidification, mobilisation and pain relief	
Concepts in practice	Cuff management	Indications for ETT/ trache tubes with cuffs Limitations/complications of cuffed tubes Cuff pressure assessment Cuff related injuries Cuff emergencies	
	Patency and suctioning	Tube patency and causes of blockages Suctioning technique	
	Tracheostomy care	Inner cannula management Stoma dressings	
	Oxygenation and ventilation	Obtaining and interpreting SpO_2 & $etCO_2$ waveforms Ventilation: Factors affecting oxygenation and carbon dioxide elimination	
	Potential complications of ventilation	Barotrauma and tension pneumothorax Decreased cardiac output Absorption atelectasis and oxygen toxicity Ventilator associated pneumonia Respiratory muscle atrophy	

Communication	Ventilation observations	Documentation on charts in ICU	
	Documentation	Accurately documents assessment findings Complete integrated notes Completes Patient Care Board	
	Clinical Hand over	Clinical hand over with assistance	

Bedside assisted orientation day three

On completion of this activity at the bedside you will have an understanding of bedside emergency equipment, planning care and communication. This activity is intended to be completed day 3 at the bedside. This content will also prepare you to complete the *Patient Assessment & Safety* and *Introductory Invasive Haemodynamic Monitoring* competencies; therefore it is beneficial for you to be aware of the performance criteria required.

The table below provides prompts for you and your resource person towards achieving the daily goals. It is essential that each area is signed by your allocated resource person. An educator will follow up with you to ensure this has been complete and address any areas not covered.

Skill sets		Prompts for discussion	Resource Person
Patient safety	In addition to the *patient safety* skill sets from day one & two also focus on the following:		
	Arterial lines	Safety precautions Line security & labelling	
	Central lines	Correct CVP monitoring line Discontinuation of infusions Checking placement (waveform and X-ray) Line security & labelling	
	Medications	Pharmacy drug search Drug imprest list & POTS MedChart	
Concepts in practice	Arterial lines	Indications for Arterial line Insertion sites Waveforms Waveform accuracy/ dynamic response test (fast flush test for under and overshooting) Troubleshooting Drawing blood samples via arterial lines Dressings/ set changes	
	Central lines	Indications for CVC Insertion sites Waveform accuracy troubleshooting Waveforms in relation to the cardiac cycle Dressings/ line set changes	
Assessment and planning care	In addition to the *assessment and planning care* skill sets from day two also focus on the following:		
	Hydration assessment	Discuss clinical assessment of hydration status Discuss accurate measurement of CVP Discuss assessment of hydration via invasive devices listed above Discuss optimisation of hydration status in relation to inotropic and vasoactive medications	
Communication	In addition to the *communication* skill sets in the previous activities also focus on the following:		
	Documentation	Accurately documents assessment findings Completes integrated notes Completes Patient Care Board	
	Clinical Hand over	Clinical Hand over with minimal assistance	

Bedside assisted orientation

This is an extra activity to complete at the bedside. You may find the opportunity to include this content on the previous three days. If not an Educator, Manager, Preceptor or Resource person can provide this information at a later date.

On completion of this activity at the bedside you will have an understanding of bedside emergency equipment, planning care and communication. This activity is intended to be completed day 4 at the bedside. This content will also prepare you to complete the *Patient Assessment & Safety* and *Introductory Invasive Haemodynamic Monitoring* competencies; therefore it is beneficial for you to be aware of the performance criteria required.
The table below provides prompts for you and your resource person towards achieving the daily goals. It is essential that each area is signed by your allocated resource person. An educator will follow up with you to ensure this has been complete and address any areas not covered.

Skill sets		Prompts for discussion	Resource Person
In addition to the skills listed from day one, two & three consider the following			
Assessment and planning care	Preparing for the admission of an ICU patient	Liaises with team leader about admission details Appropriately prepares space for admission Anticipates patient care requirements Utilises ICU admission pack Prioritises initial care and intervenes appropriately Individualises and rationalises monitoring/ observations required for patient, or seeks direction	
	Transport of critical ill patient	Coordinates transport and correctly states responsibilities Anticipates and prepares for patient needs during transport Gathers and checks appropriate equipment and drugs for transport Completes transport 'checklist' Ensures patient comfort/safety Provides appropriate assessment and management during transport	
	Discharge	Liaises with NUM/ TL Prepares patient for D/C Completes documentation and ensures updated ward charts available Completed Electronic Patient Care Journey Board Provides clinical handover to ward staff Cleaning of bedspace area & equipment	

Bedside assisted orientation day four & five

On day four and five of *bedside assisted orientation* you will be allocated one patient to provide complete care for whilst under supervision, however at this stage you are not responsible for the patient. This is your opportunity to utilise what you have learnt from the supernumerary period during *Educator assisted familiarisation* and *Bedside assisted orientation* in preparation for caring for a patient independently.

Introductory medication resource

This is a mandatory open book medication administration safety test. The aim is to assist the Registered Nurse to increase their understanding and knowledge of the administration practices of the most common continuously infused medications utilised within this Intensive Care environment.

All participants will be expected to complete this resource within two weeks of commencement.

Adrenaline
What is the standard infusion strength for adrenaline?
What type of administration set and device is always used for adrenaline infusions?
What fluids may be used for adrenaline infusions? Which fluid is commonly prescribed?
What are the three main effects of intravenous adrenaline.
What route and form of access should be used to infuse adrenaline?
What other medications can be infused with adrenaline via a three way tap?
Name the potential adverse/side effects associated with adrenaline infusions?

Noradrenaline
What is the standard infusion strength for noradrenaline?
What type of administration set and device is always used for noradrenaline infusions?
What fluids may be used for noradrenaline infusions? Which fluid is commonly prescribed?

What is the main effect of intravenous noradrenaline.

What route and form of access should be used to infuse noradrenaline?

What other medications can be infused with noradrenaline via a three way tap?

Name the potential adverse/side effects associated with noradrenaline infusions?

Dobutamine

What is the standard infusion strength for dobutamine?

What type of administration set and device is always used for dobutamine infusions?

What fluids may be used for dobutamine infusions? Which fluid is commonly prescribed?

What are the main effects of intravenous dobutamine?

What route and form of access should be used to infuse dobutamine?

Name the potential adverse/side effects associated with dobutamine infusions?

Vasopressin

What is the standard infusion strength for vasopressin?

What type of administration set and device is always used for vasopressin infusions?

What is the standard infusion rate for vasopressin infusion?

What fluids may be used for vasopressin infusions? Which fluid is commonly prescribed?

What are the three main effects of intravenous vasopressin.

What route and form of access should be used to infuse vasopressin?

What other medications can be infused with vasopressin via a three way tap?

Name the potential adverse/side effects associated with vasopressin infusions?

Morphine

What is the standard infusion strength for morphine?

What type of administration set and device may be used for morphine infusions?

What fluids may be used for morphine infusions? Which fluid is commonly prescribed?

What are the main effects of intravenous morphine.

What drug is used to temporarily reverse the effects of morphine?

Name the potential adverse/side effects associated with morphine infusions?

Midazolam
What is the standard infusion strength for midazolam?
What type of administration set and device is always used for midazolam infusions?
What fluids may be used for midazolam infusions? Which fluid is commonly prescribed?
What are the main effects of intravenous midazolam.
What drug is used to reverse the effects of midazolam?
Name the potential adverse/side effects associated with midazolam infusions?

Fentanyl
What is the standard infusion strength for fentanyl?
What type administration set and device may be used for fentanyl infusions?
What fluid may be used for a fentanyl infusion? Which fluid is commonly prescribed?
What are the main effects of intravenous fentanyl.
Name the potential adverse/side effects associated with fentanyl infusions?

Actrapid Insulin
What is the standard infusion strength for insulin?
What type of administration set and device is always used for insulin infusions?
What are the main effects of intravenous insulin.
What fluid may be used for an insulin infusion? Which fluid is commonly prescribed?
How often should blood glucose levels be checked when infusing insulin?
Name the potential adverse/side effects associated with insulin infusions?

Nimodipine
What is the standard infusion strength and infusion regimen for nimodipine?
What type of administration set and device is always used for nimodipine infusions?
State the regimen for commencing intravenous nimodipine.
What are the main effects of intravenous nimodipine.
What route and form of access should be used to infuse nimodipine?
Name the potential adverse/side effects associated with nimodipine infusions?

Propofol
What type of administration set and device is always used for propofol infusions?
How often should propofol and the administration set be changed?
What are the three main effects of intravenous propofol.
What other medications can be infused with propofol via a three way tap?
What route and form of access should be used to infuse propofol?
Name the potential adverse/side effects associated with propofol infusions?

Glyceryl Trinitrate (GTN)
What infusion strengths may be used for GTN infusion?
What type administration set and devices may be used for GTN infusions?
What fluids may be used for GTN infusions? Which fluid is commonly prescribed?
What are the main effects of intravenous GTN.
What route and form of access should be used to infuse GTN?
What special precaution should be observed when preparing a GTN infusion?
Name the potential adverse/side effects associated with GTN infusions?

Potassium Chloride
What infusion concentrations strengths may be used for potassium chloride infusion administered via a central venous device?
What infusion concentration strengths may be used for potassium chloride infusion administered via a peripheral cannula?
What type of giving sets and administration devices may be used for potassium chloride infusions?
What fluids may be used for potassium chloride infusions?
What is the main effect of intravenous Potassium Chloride?
Name the potential adverse/side effects associated with Potassium Chloride infusions?

Metaraminol
What is the standard infusion strength for metaraminol?
What is the standard IV bolus injection strength?
What type of administration set and device is always used for metaraminol infusions?
What are the main effects of intravenous metaraminol.
What route and form of access should be used to infuse metaraminol?
What other medications can be infused with metaraminol via a three way tap?

Name the potential adverse/side effects associated with metaraminol infusions?

General
What safety precautions must be followed when infusing vasoactive drugs or high osmolar solutions drugs?
What alarm parameters should be set when infusing vasoactive drugs?
When disconnecting infusions from a line what must be done to the lumen/intravenous catheter?
What safety precautions must be followed when 'double pumping' vasoactive drugs?
What resources are available to guide health professionals on the administration of intravenous medications at both the John Hunter & Calvary Mater Intensive Care Services?

Congratulations!

Congratulations on completing the requirements of *Educator* and *Bedside Assisted Orientation* over previous days.
Prior to caring for a patient independently take the time to review what you have completed and consider any outstanding issues for completion. An educator will meet with you to discuss your responses.

How am I going?
Has the Intensive Care Services expectations of you been realistic?
In what areas have you significantly increased your knowledge?
What individuals have you identified as being especially supportive?
How are you coping with your transition to the new workplace?
Were there areas of knowledge and skills that were not covered during *Bedside Assisted Orientation*?

You will be asked to start caring for patients on your own from this point in time.

Setting an Education Learning Plan

Towards the end of your first month you will have the opportunity to set an individualised education learning plan with one of your Educators or Preceptors. Additionally, at three months you will have the opportunity to discuss your achievements and the completion of these goals will be reviewed at your three month equivalent Performance Development Review with a manager. Your 30 & 90 day conversations will also be part of this.

Goals	Date achieved
Individualised goal # 1 Strategies for achievement:	
Individualised goal # 2 Strategies for achievement:	
Individualised goal # 3 Strategies for achievement:	

Educator/Preceptor Name	Sign	Date

You may find it useful to apply the SMARTA principle with setting goals
Specific
Measurable
Achievable
Realistic
Timely
Aligned

Discussion notes

TRN Speciality Practice Program Study Days

Adjunct to the *Educator Assisted Familiarisation* and *Bedside Assisted Orientation* the Transition to Registered Nurse orientation program includes four study days throughout the year. It is compulsory that participants attend all four of these days.

You can expect to receive presentations; practical hands on sessions; simulation and information from a variety of different nurses. The study days will also support you gain knowledge and training towards completing intensive care introductory competencies. In order to accommodate different learner's needs and levels of experience, the session structures outlined below are a guide only and are open to adaptation at the discretion of the person delivering each session.

TRN Specialty Practice Program Study Days 2018		
Respiratory/Ventilation	JHH	Monday 12th March
Cardiac/ Haemodynamic	CMN	Wednesday 18th April
Neurological	JHH	Wednesday 16th May
Advanced Life Support	JHH	Monday 3rd December

It is your responsibility to ensure that you are rostered to attend all of these study days

Respiratory/Ventilation Study Day

The aim of this day is to explore the support and management of patients suffering respiratory dysfunction within the critical care environment. Particular attention will be given to invasive ventilation, management strategies and nursing care of the ventilated patient.

Prerequisites

It is recommended that the participant:

- Revisits fundamental anatomy and physiology
- Read the JHH ICU Invasive mechanical ventilation management (Adults) learning package
- Read the JHH ICU power point presentations on V60 & Trilogy ventilators
- Read the Atrium Managing chest drainage education books
- Read the Pleural Drain Management, Dressing and Removal_Adults HNELHD GandP 15_15
- Read the HNE Intubation resource package
- Read the Management of Adult Inpatients with Tracheostomy HNELHD CG 15_19
- Read the Airway Suctioning for Mechanically Ventilated Adult Patients HNELHD CG 15_07
- Read the Suctioning the Non-Ventilated Patient HNELHD CG 15_16
- Read the Tracheostomy Maintenance and Care – Inpatient HNELHD CG 15_12
- Current evidence based journal articles & resources will be emailed to you

Objectives

- Demonstrate an understanding of principles of ventilation including modes and strategies employed for respiratory failure
- Demonstrate an understanding of the indications and management for intubation and airway management
- Demonstrate an understanding of the function and management of chest drains
- Demonstrates an understanding of the management and care of a patient with an artificial airway i.e. tracheostomy, endotracheal tube

- Formulate a respiratory focused care plan which can be applied in the clinical setting

Cardiac/Haemodynamic Study Day

Compromise of the cardiovascular system will often require admission to the critical care environment. This study day will enable the participant to analyse and interpret rhythm strips, develop an understanding of the haemodynamic consequences of shock and become familiar with the pharmacological agents utilised.

Prerequisites

- Revisit fundamental anatomy and physiology
- Read the JHH ICU Introductory haemodynamic monitoring learning package
- Read the Arterial line: insertion & management of pressure monitoring for patient greater than 25 kgs JHH_JHCH_BH_0034 (currently updating in 2018)
- Read the Arterial line dressing patient>25 kgs JHH_JHCH_BH_0035 (currently updating in 2018)
- Read the Arterial line and blood collection patient > 25kgs JHH_JHCH_BH_0036 (currently updating in 2018)
- Read the CVAD Intravenous Administration Set Change HNELHD GandP 16_19
- Read the Withdrawing Blood from a Central Venous Access Device (CVAD) HNELHD GandP 16_20
- Read the Central Venous Access Device dressing HNELHD GandP 16_18
- Read the Totally Implantable Vascualr Accesss Device (TIVAD)/Port-a-Cath® Access Management HNELHD GandP 13_11
- Read the Double Pumping Syringe Drivers- Vasocative Medications JHH_0238
- Current evidence based journal articles & resources will be emailed to you

Objectives

- Demonstrate an understanding of the pathophysiology and haemodynamics
- Demonstrate an understanding of acute coronary syndrome, septic and cardiogenic shock
- Recognise haemodynamic consequences of shock and its management
- Familiarisation with commonly utilised pharmacological agents and their safe administration

Neurological Study Day

The aim of this day is to explore common neurological presentations to the critical care environment; the related physiology and the nursing management of the neurologically impaired adult. Particular attention will be given to the nursing management of the traumatic brain injured patient.

Prerequisites

- Revisit fundamental anatomy and physiology
- Read the JHH ICU neurological learning package
- Read the Severe Traumatic Brain Injury-Initial Resuscitation and Management HNELHD_CG 17_05
- Read the External Ventricular Drainage System in Intensive Care JHH_027
- Read Extr ventricular Drain-CSF Specimen JHH_0236
- Read the Management of Aneurysmal Subarachnoid Haemorrhage JHH_0181
- Read the End of Life Care: Organ and Tissue Donation after Brain Death HNELHD CG 15_14
- Read the JHH ICU traumatic brain injury resource
- Read the Spinal Injury Management HNELHD GandP 16_17
- Current evidence based journal articles & resources will be emailed to you

Objectives

- Identify traumatic and non-traumatic neurological presentations
- Demonstrate an understanding of CSF production, Munro-Kellie doctrine and the relationship of ICP
- Familiarisation with management of a patient with an external ventricular drainage device
- Familiarisation with the management of a traumatic brain injured patient
- Familiarisation with the management of a patient with a Aneurysmal Subarachnoid Haemorrhage
- Familiarisation with identifying a potential brain and tissue donor and the pathways for organ donation

Advanced Life Support

This study day will enable the participant to demonstrate competence in the management of life threatening situations and also provide an opportunity to gain Adult Advanced Life Support and Paediatric Basic Life Support accreditation. The curriculum of this program is endorsed by the Hunter New England Local Health District.
You may also elect to pursue Paediatric Advanced Life Support Accreditation.

Prerequisites

- Identification of life threatening arrhythmias
- Basic life support accreditation (Adult)
- Review online learning resources for ALS found on HNE Intranet ALS site Edmore Training Portal and My Health Learning online
- Complete the Adult/Paed ALS Multiple Choice Exam prior to the study day and submit Certificate/s to Education Team as evidence. Found online via Edmore: www.hneh.edmore.com.au
- Complete My Health Learning on line
    - Advanced Life Support Theory (Module 1) Adult training
    - Advanced Life Support Theory (Module 2) Adult training

Objectives

- Advanced airway management
- Life threatening arrhythmia analysis
- Arrhythmia management
- ARC ALS algorithms
- Management of resuscitation equipment
- Documentation

Assessments and competencies

The ICU introductory competencies as part of Step 1 & 2 of *Professional Development Pathway* have been designed to ensure the minimum requirements for safe practice. It is encouraged that you identify and seek out learning opportunities to gain exposure to clinical scenarios and to practice skills you are developing. For example, talk to the Team Leader, ACCESS nurse and Education Team about your current goals when on shift and ask to be included in unit activities as appropriate.

It is a good idea to ensure that you are well prepared prior to attempting any competency. Preparation ensures that you make the most of the learning opportunities provided and is a courtesy to those providing you with support and assessment. Copies of these competencies are provided over the following pages and can also be found on the JHH ICU intranet.

John Hunter Hospital

Who can assess you?
Any members of the education team, clinical nurse specialists & experienced ICU nurses

What assessment documentation is required per competency?
Assessor Guideline

- available on the CNS share-drive (team leader only able to access) & from Education Teams
- to be retained by the assessor (candidate not to keep)
- must be forwarded to the Education Team as evidence of competency attainment

Unit of Competency Descriptor

- located in this TRN Manual & on JHH ICU Intranet
- signed by your assessor
- this is your record of competence

Calvary Mater Newcastle Hospital

Who can assess you?
Any members of the education team, clinical nurse specialists & experienced ICU nurses. There is a list of these assessors displayed on the Education notice board behind the Nurses' desk.

What assessment documentation is required per competency?

Assessor Guideline

- available from the Educator for the assessors
- to be retained by the assessor (candidate not to keep)
- must be forwarded to the Education Team JHH ICU as evidence of competency attainment

Unit of Competency Descriptor

- located in this TRN Manual & the Educator
- signed by your assessor
- this is your record of competence

The table below outlines the schedule of the requirements of the program for completion. Your progress of these mandatory requirements will be reviewed at one, three, six and twelve months.

Assessment Schedule		
Prior to Commencement		Completed
Basic life support Competency (Adult)	Required Clinical Competencies	
Nasogastric Insertion Competency	Required Clinical Competencies	
Indwelling Catheter Insertion Competency	Required Clinical Competencies	
HNE Patient controlled analgesia learning package	Required Clinical Competencies	
My Health Learning required training modules	Required Clinical Competencies	
MRI Safety online	ICU requirement	
Central Venous Access Devices: The fundamentals online	Required Clinical Competencies	
Manual handling competency	Required Clinical Competencies	
Due by 9th February		
ICU medication calculation test	ICU requirement	
Cytotoxic awareness (level 2)- includes donning & doffing competency	Required Clinical Competencies	
HAIDET Competency	Required Clinical Competencies	
Hourly Rounding competency	Required Clinical Competencies	
Patient Care Boards competency	Required Clinical Competencies	
Prevention, Management , Violence & Aggression	Required Clinical Competencies & ICU requirement	
Due by 16th February		
IV medication administration competency	ICU requirement	
ICU medication resource	ICU requirement	
3.1 Module 1:Introduction Activity 1	NSW Transition to Practice Intensive Care Nursing Program	
3.2 Module 2: Safety Activity 2,3,4,5,6,8,9,10	NSW Transition to Practice Intensive Care Nursing Program	
Due by 12th March		
3.3 Module 3:Patient Assessment Activity 11,13,14,15,16	NSW Transition to Practice Intensive Care Nursing Program	
3.4 Module 4: Respiratory Activity 18,19,20	NSW Transition to Practice Intensive Care Nursing Program	
Pre requisites for Respiratory/Ventilation Study Day	ICU requirement	
Due by 16th March		
Patient assessment and safety Competency	ICU Introductory Competencies	

Due by 30th March		
3.4 Module 4: Respiratory Activity 27,28,29	NSW Transition to Practice Intensive Care Nursing Program	
Due by 18th April		
3.5 Module 5: Cardiac and Haemodynamic Activity 35,36,37,40,41,42,43,44	NSW Transition to Practice Intensive Care Nursing Program	
Pre requisites activities for Cardiac/Haemodynamic Study Day	ICU requirement	
Due by 20th April		
3.2 Module 2: Safety Activity 7	NSW Transition to Practice Intensive Care Nursing Program	
3.4 Module 4: Respiratory Activity 30,31,32,33	NSW Transition to Practice Intensive Care Nursing Program	
Due by 11th May		
3.6 Module 6: Neurological Activity 45,46,47,48,50	NSW Transition to Practice Intensive Care Nursing Program	
Due by 16th May		
Introductory invasive devices Competency	ICU Introductory Competencies	
Introductory invasive mechanical ventilation Competency	ICU Introductory Competencies	
Cough assist Competency	ICU Introductory Competencies	
Pre requisites activities for Neurological Study Day	ICU requirement	
Epidural competency	Required Clinical Competencies	
Due by 1st June		
3.6 Module 6: Neurological Activity 49	NSW Transition to Practice Intensive Care Nursing Program	
3.10 Module 10: Consequences of Critical Illness Activity 61,62,63	NSW Transition to Practice Intensive Care Nursing Program	
Due by 6th July		
Intra-hospital transport Competency	ICU Introductory Competencies	
Due by 24th August		
3.3 Module 3:Patient Assessment Activity 17	NSW Transition to Practice Intensive Care Nursing Program	
3.4 Module 4: Respiratory Activity 22,23	NSW Transition to Practice Intensive Care Nursing Program	
3.4 Module 4: Respiratory Activity 24,25,26	NSW Transition to Practice Intensive Care Nursing Program	
3.4 Module 4: Respiratory Activity 34	NSW Transition to Practice Intensive Care Nursing Program	
3.7 Module 7: Gastrointestinal Activity 54,55,56	NSW Transition to Practice Intensive Care Nursing Program	

3.8 Module 8:Renal Activity 57,58	NSW Transition to Practice Intensive Care Nursing Program	
3.9 Module 9: Obstetrics Activity 60	NSW Transition to Practice Intensive Care Nursing Program	
Due by 26th October		
Case Presentation	ICU requirement	
Due by 3rd December		
Pre requisites activities for Advanced Life Support Study Day	ICU requirement	
Due by 17th December		
Non-invasive positive pressure ventilation Competency	ICU Introductory Competencies	
Management of a patient with a tracheostomy Competency	ICU Introductory Competencies	
Spinal log roll Competency	ICU Introductory Competencies	
Management of chest drains Competency	ICU Introductory Competencies	
External ventricular drain management Competency	ICU Introductory Competencies	
Advanced Life Support accreditation	Required Clinical Competencies	
Paediatric Basic Life Support	Required Clinical Competencies	
Professional Portfolio	APHRA & ICU requirement	

Clinical Rotations

As part of the Transition to Specialty Practice Program (ICU), you will rotate to two clinical areas over the next twelve months. They include the Intensive Care Services at John Hunter Hospital and the Calvary Mater Newcastle. The following pages will provide you with some information prior to your clinical rotations.

Calvary Mater Newcastle

Calvary Mater Newcastle is owned and operated by The Little Company of Mary Healthcare. A 150+ bed facility, the Calvary Mater Newcastle offers district and tertiary emergency clinical toxicology, coronary care, drug and alcohol, general medicine, general surgery, haematology, radiation oncology, medical oncology and palliative care in accordance with the HNELHD service agreement. The Mater is also co-located with Hunter New England mental health services, providing emergency triage and admission for patients requiring psychiatry services.
All these specialties are supported by the Intensive Care Unit (ICU).
The research facility at the Mater has academic and teaching affiliations with the University of Newcastle and conducts world class research into breast cancer, melanoma and haematological disorders.

The ICU is a multidisciplinary unit with six ICU beds. The unit treats approximately five hundred critically ill patients each year with a case mix of oncology patients experiencing neutrapenic sepsis; post chemotherapy treatment; haematology bone marrow malignancies and thrombolytic disorders; clinical toxicology; medical and also general surgery. The ICU also provides a Rapid Response Service (RRT), TPN and IV access/line service for the remainder of the hospital.

Multidisciplinary Staff

Nurse Unit Manager	Leanne Bradford	40143760 DECT 50316 Leanne.Bradford@calvarymater.org.au
Clinical Nurse Educator	Cathie Wheeler	40143756 Catherine.Wheeler@calvarymater.org.au
Administrative Assistant	Shaveena Balakrishnan (Mon/Tues)	 40143755
ICU CSO	Amanda Dean	40143694
ICU Technicians	Bob Adams; Glen Melia	40143756
ICU Medical Director	Dr Katrina Ellem	40143761
ICU Staff Specialist	Dr Alan Rashid	
ICU Staff Specialist	Dr Tim Stanley	
ICU Staff Specialist	Dr Ursula Beckmann	
ICU Staff Specialist	Dr Peter Saul	
Locum Intensivist	Dr Guyon Scott	
Locum Intensivist	Dr Nevin Kollannoor	
Locum Intensivist	Dr Rob Thomas	
Locum Intensivist	Dr Vinodh Thodur	
Locum Intensivist	Dr Kylie McArdle	

Nursing Roster

There are a number of nursing shifts. Below are the codes and associated times:

M	0700-1530hrs
M6	0700-1345hrs
TD	0700-1930hrs
TN	1900-0730hrs
E	1330-2200hrs
E6	1515-2200hrs
EN	2130-0730hrs
"On Call"	2200-0700hrs

What is an 'On Call' Shift

You will be required to do some 'on call' shifts throughout the roster. These are usually allocated on your evening shift, so in the event that additional nursing staff is required for night duty, you are required to stay or will be called in. You will receive an 'on call' allowance, plus the hours worked are paid as overtime.

What do I do if I am sick?

If you are unable to attend a rostered shift due to illness or other reasons, please contact the NUM or team leader on **40143765** as soon as possible. This will allow the team leader to organise staffing and patient allocation.

How do I get paid?

For all Calvary Mater Newcastle employees:
The Mater pay period is the week **opposite** to the John Hunter Hospital.

Whist on clinical rotation at the JHH **you need to have your timesheet signed by the JHH NUM II and email your timesheet to Leanne Bradford on 40143487, no later than the Thursday before your pay.**

For all John Hunter Hospital employees:

Whilst on clinical rotation at the Calvary Mater Newcastle, you will need to **email your timesheet to the JHH NUM II on 49214799**.

Please do not fax. Please send by the Friday. If any changes occur to your timesheet over the weekend, then email the NUM II. If timesheets are not received by the Monday you're your pay will not be processed accurately.

Annual leave & Roster requests

All annual leave and specific roster requests are to be emailed to Leanne Bradford **in advance** at:
Leanne.Bradford@calvarymater.org.au

Accessing emails

Whist on placement at the John Hunter, Calvary Mater employees will be able to access their work email portal externally at
https://webmail.calvarymater.org.au/CookieAuth.dll?GetLogon?curl=Z2Fowa&reason=0&formdir=1

Uniforms

As a Calvary Mater employee you will not be issued with uniforms as you are given a uniform allowance included in your fortnightly pay. You will need to purchase your own uniforms. You can choose any outlet to purchase them. Locally Hunter Scrubs have our logo that can be embroidered.

How do I pay for parking?

If you have payroll deductions for parking at the John Hunter Hospital, The Calvary mater offers reciprocal arrangements. You will be issued with a swipe card from the security department. Please contact the CNE to organise this for you.

The John Hunter Hospital does not offer reciprocal arrangements. You will need to contact the car park office to arrange a temporary access card charged at weekly rates.

Working in ICU at the Mater: What can I expect?

Your clinical rotation at the Mater will provide you with an opportunity to experience the spectrum of classification of intensive care.

Even though the Mater is only six beds, patient acuity and complexity can still be high with fluctuating levels of high patient activity-particularly over the winter months. Our Unit also provides continuous renal replacement therapy (CRRT) to complex patients and 25% of our total admissions are via the HNE Retrieval Service.

Due to the relatively small size of the Mater ICU, this placement will also provide you with the opportunity to work closely with senior Intensivists and RNs who willingly make themselves available for teaching at the bedside which for transition nurses will effectively enhance the consolidation of your learning in the program.

Periods of low activity on your placement at the Mater also provides you with the opportunity to concentrate on completing competencies, pursuing personal research interests or generally embrace the opportunity to go that ‘extra mile’ in terms of the provision of nursing care to your patients. The challenges of providing care to psychiatric patients will further develop your critical care skill set and you will no doubt have many rewarding clinical encounters with patients and their families to take back with you to John Hunter Hospital.

John Hunter Hospital

The John Hunter Intensive Care Services is a 27 bed tertiary referral unit for the Hunter Region and the North Coast. The unit offers tertiary referral services in Trauma, Paediatrics, Medicine, Surgery, Obstetrics, Nephrology (including dialysis and renal transplantation) and Cardiothoracic Surgery.

Telephone numbers and contacts

All telephone numbers and contacts are available on the desktop phone directory located on the main workstations in all zones or via the HNE intranet staff directory.

- Emergency number (internal): 7700
- How to page: Dial 13955 and follow the prompts
- Hospital switchboard: 99
- ICU main unit number: (492)14254

The ICU Management & Education Team

The management of the ICU is supported by a Nurse Manager and two Nurse Unit Managers and are as follows:

Nurse Manager	Heather Chislett	67629 (Speed dial)
NUM II	Natalie Gilmour	(498) 23494
NUM II	Neralee Horwood	(492) 55310
Clinical Nurse Consultant	Kelvin Smith	(498) 55283
Clinical Nurse Consultant- ICU Liaison	Jenny Hall	(498) 55841
Nurse Educator	Leila Kuzmiuk	(492) 23571
Clinical Nurse Educator	Kelli McAlpine	(492) 23946
Clinical Nurse Educator	Vacant	(492) 23572
Clinical Nurse Educator	Part time (secondment)	(492) 14999

Apart from the Management and Education Team, the ICU currently has over 30 Clinical Nurse Specialists (CNS's) who serve a number of roles including the "Team Leader" role on a shift to shift basis. The nurse in charge is the first point of contact regarding issues on a shift by shift basis. They can be contacted on Dect **55314**

Rostering

The Intensive Care utilises skill mix rostering system that also support the flexibility to request shifts. Throughout the Transition to Specialty Practice Program (ICU) you will be rostered on an eight/ten – hour rotating roster to ensure you can access support staff while you complete the program requirements.

Staff will only be considered eligible for a twelve hour rotating roster after successful completion of

- Step 1 and 2 of the *Professional Development Pathway* for Intensive care nurses
- Advanced Life Support accreditation
- Eighteen months intensive care clinical experience

You are required to make an appointment with a manager to discuss your progression and options

Shift Code	Hours
M	0700-1530hrs

M6	0700-1330hrs
7M	0700-1930hrs
L	1300-2130hrs
L6	1500-2130hrs
D9	100-1930hrs
BE	2115-0715hrs
7N	1930-0730hrs

Sick Leave

During business hours, please contact the "Team Leader" (Dect (498) **55314**) who will transfer your call to a manager. After hours, please contact the "Team Leader" (Dect(498) 55314) who will transfer your call to After Hours Nurse Manager as per policy.

FACS/Personnel Careers Leave

Please refer to the above process. If leave is utilised after hours you must follow up with a manager the next business day to confirm appropriate leave balance and complete a leave application form

Annual Leave

Please see management for Annual Leave Bookings.

JHH ICU Medical Staff

The ICU medical team is led by a Medical Director with 12-13 Staff Specialists employed in the unit. The Staff Specialists are supported by ICU fellows, registrars, and residents.
During the day ICU 1 and ICU 2 medical teams support the clinical environment. Each team consists of an Intensivist, Registrar and JMO. An ICU 3 Intensivist (referred to as the 'outside' doctor) covers all aspects of the Rapid Response Team (RRT) and retrieval calls including patient management, advice and review for admissions to ICU 24/7. Out of hours only one Intensivist on call covers the clinical environment for both the ICU 1 & 2 teams.
In the PICU there is a separate medical team which consists of an Intensivist, Registrar and JMO during hours. After hours the team consists of an Intensivist and JMO only. This team responds to all Paediatric RRT calls 24/7.
The Intensive Care Staff Specialists are as follows:

ICU Medical Director	Dr Ken Havill
ICU Staff Specialist	Dr Jorge Brieva
ICU Staff Specialist	Dr Srikanth Tummala
ICU Staff Specialist	Dr Eduardo Martinez
ICU Staff Specialist	Dr Ray Asimus
ICU Staff Specialist	Dr Rob O'Connor
ICU Staff Specialist	Dr Martin Rowley
ICU Staff Specialist	Dr Martina Zib
ICU Staff Specialist	Dr Rakshit Panwar
ICU Staff Specialist	Dr Lee-Tam Teo
ICU Staff Specialist	Dr Cynthia Bierl
ICU Staff Specialist	Dr Sheena Gune
ICU Staff Specialist	Dr Himanshu Aneja
ICU Staff Specialist	Dr Ben Moran
ICU Staff Specialist	Dr Torg Westerlund
ICU Post Grad Fellow	Dr Ameet Parekh
ICU Post Grad Fellow	Dr Jeram Hyde

Clinical Rotations Roster

	Orientation 05/02/18-16/02/18	Rotation 1 19/02/18-29/04/18 12/02/17-16/02/18 CMN employees)	Rotation 2 30/04/18-08/07/18	Rotation 3 09/07/18-16/09/18	Rotation 4 17/09/18-25/11/18	Rotation 5 26/11/18-03/02/19
Marc Hodgson Jodi Curtis	CMN employees will do their second week of orientation at CMN Intensive Care Unit	CMN	JHH	JHH	JHH	JHH
Sarah Dalton Elizabeth Bailey		JHH	CMN	JHH	JHH	JHH
Samantha Douglas Rachael Buckley		JHH	JHH	CMN	JHH	JHH
Michaela Bacon Ashley Hopkins		JHH	JHH	JHH	CMN	JHH
Samantha Keir Gemma Hartgers		JHH	JHH	JHH	JHH	CMN

Feedback

It is important for both parties involved that structured feedback is provided. You will find over the following pages a progress evaluation form.
It is mandatory that the clinical rotation progress evaluation forms are completed by the manager, educator/preceptor and participant towards the end of each rotation.
These will be reviewed by the educators, preceptors and managers at the beginning of each clinical rotation and at your scheduled performance development review with your manager to discuss your clinical progress and identify clinical goal setting

Clinical Rotation Progress Evaluation

Clinical Area: _____

Dates of rotation: _____

Please comment on the participant progress to date. Include clinical knowledge and skill development, identification of strengths and areas for development, communication and teamwork skills and adherence to policy legislation and local guidelines and procedures.

Educator/Preceptor:

_____
_____
_____
_____
_____
_____
_____
_____
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Leave taken (include FACS, Sick, Annual,
Other):_____
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Clinical Rotation Progress Evaluation

Clinical Area: _____

Dates of rotation: _____

Please comment on the participant progress to date. Include clinical knowledge and skill development, identification of strengths and areas for development, communication and teamwork skills and adherence to policy legislation and local guidelines and procedures.

Educator/Preceptor:

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Leave taken (include FACS, Sick, Annual,
Other):_____
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Clinical Rotation Progress Evaluation

Clinical Area: _____

Dates of rotation: _____

Please comment on the participant progress to date. Include clinical knowledge and skill development, identification of strengths and areas for development, communication and teamwork skills and adherence to policy legislation and local guidelines and procedures.

Educator/Preceptor:

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Name: _____ Signature: _____

Manager:_____
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Leave taken (include FACS, Sick, Annual,
Other):_____
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Name: _____ Signature: _____

TRN participant::_____
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Assessment Items

Assessment

Case Presentation
Due Date: **By 26th October**

Choose a patient you have cared for within **your current** clinical placement

Verbally present this patient case study as an in-service to your nursing colleagues at your current clinical placement.

Identify one clinical management aspect and relate the management strategies to the current evidence based literature.
For example: HFOV as a ventilation strategy for respiratory failure; patient centred care for the oncology patient; end of life care for palliation; High flow oxygen delivery for prevention of intubation, PRVC vs SIMV/PS for respiratory failure, adrenaline vs noradrenaline for distributive shock.

Your presentation style will not be assessed.

The presentation should include:

- A clear concise introduction of the person central to the case study
- Pathophysiology underlying the patient's condition and priorities of care
- Presentation of all aspects of care throughout the intensive care phase is discussed including rationales for care and patient history
- Medical and nursing management
- Ethical considerations
- Maintains the patients perspective and consideration of psychosocial needs and implications for care
- Discussion of intensive care delivery with a nursing care focuses whilst incorporating the role of technology and nursing implications
- Discusses the interaction of health care professionals towards a patient centred approach to the delivery of health care

ALL presentations MUST be saved onto a USB and be compatible with the HNE Windows Operating System. HNE does not support Apple Mac

We recommend that you do a trial run prior to your presentation.

Step 1 ICU Competencies

The following competencies are part of *Developing Safe Practice* and mandatory to complete. If you have considerable Intensive Care Nursing experience you may receive recognition of prior learning. Please make an appointment with a member of the education team to discuss your previous learning, experience and/or professional portfolio.

UNIT OF COMPETENCY

Patient assessment and Safety

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to perform a baseline patient assessment and plan care for an adult intensive care patient. This competency is a beginner level competency.

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA (Critical Aspects)**
1. Demonstrates adherence to Work, Health Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Follows HNE guidelines and procedures for work health safety & infection
2. Demonstrates an understanding of safe preparation prior to performing patient assessment	2.1 Identifies and locates equipment required for performing assessment 2.2 Reviews patient documentation to identify current trends in observations and clinical condition 2.3 Draws curtains and ensures patient privacy and dignity 2.4 Considers communication difficulties and their solution 2.5 Includes family in assessment process
3. Demonstrates accurate checking of bedside emergency equipment	3.1 Performs systematic check of all bedside emergency equipment 3.2 Identifies location and patency of emergency IV access 3.3 Demonstrates knowledge of emergency unit trolley contents and defibrillator
4. Utilises a framework for patient assessment	4.1 Performs an initial observation of patient condition utilising Airway, Breathing, Circulation 4.2 Identifies a systematic approach for patient assessment 4.3 Proceeds to assess the body systems in order of priority 4.4 Communicates any abnormalities to medical and nursing staff
5. Demonstrates a safe and accurate assessment of the respiratory system	5.1 Assesses patency of airway 5.2 Assesses respiratory rate and work of breathing 5.3 Auscultates chest and identifies breath sounds 5.4 Palpates chest and identifies abnormalities 5.5 Checks artificial airway ensuring correct cuff pressure and airway security 5.6 Positions patient with head elevation of at least 45 degrees unless medically contraindicated

6. Demonstrates a safe and accurate assessment of the cardiovascular system	6.1 Interprets cardiac rhythm and any deviation from normal sinus rhythm 6.2 Assesses all invasive lines for position, compatibility of infusions, line and fluid changes and volume of vasoactive infusions 6.3 Ensures cardiovascular pressure monitoring devices are levelled and zeroed 6.4 Auscultates and interprets heart sounds 6.5 Assesses blood pressure 6.6 Assesses position, security and appropriate dressings for all invasive catheters 6.7 Assesses quality of peripheral circulation 6.8 Ensures DVT prophylaxis has commenced 6.9 Interprets recent pathology blood results
7. Demonstrates a safe and accurate assessment of the neurological system	7.1 Performs assessment utilising the Glasgow Coma Scale to assess patient consciousness 7.2 Assesses pupillary reaction 7.3 Assesses patients ability to swallow and their cough reflex 7.4 Assess deficiencies in limb motor strength 7.5 Assesses pain, sedation and delirium score
8. Demonstrates a safe and accurate assessment of the renal system	8.1 Assesses urine output 8.2 Interprets renal function laboratory blood results 8.3 Assesses urine colour 8.4 Performs and interprets urinalysis results 8.5 Assesses IDC insertion site
9. Demonstrates a safe and accurate assessment of the endocrine and gastrointestinal system	9.1 Visually inspects abdomen 9.2 Auscultates for bowel sounds 9.3 Palpates abdomen and identifies abnormalities 9.4 Reviews bowel activity and bowel regimen 9.5 Assesses patient nutritional requirements 9.6 Performs blood glucose level
10. Demonstrates a safe and accurate assessment of the integumentary system	10.1 Assesses skin condition 10.2 Inspects integrity around invasive devices 10.3 Calculates pressure injury risk assessment score following skin assessment 10.4 Assesses appropriate mattress insitu 10.5 Assesses patient hygiene requirements. 10.6 Assesses mouth integrity and calculates and records MCAT score 10.7 Assesses wound management
11. Demonstrates legal documentation	11.1 Accurately documents all assessment findings 11.2 Documents any difficulties and their resolution in the ICU clinical integrated notes 11.3 Updates the ICU care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • ICU & HNELHD guidelines and procedures • Infection Control precautions • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

UNIT OF COMPETENCY

Introductory Management of Invasive Devices

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely manage an adult intensive care patient with invasive haemodynamic monitoring.
Pre requisites include completion of 'CVAD Fundamentals' online module via HETI OR EviQ three CVAD online modules via HNELHD PPG.
This competency is a beginner level competency and a prerequisite to the Hunter New England Intensive Care Services advanced haemodynamic competencies.

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work Health and Safety and infection control requirements	1.1 Performs hands hygiene according to 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Follows correct ICU and HNE guidelines and procedures for CVAD's, haemodynamic monitoring and security of catheters
2. Demonstrates correct assembly and maintenance of the pressure transducer system	2.1 Demonstrates correct assembly of the pressure transducer system 2.2 Demonstrates correct procedure for levelling and zeroing the pressure transducer system 2.3 Demonstrates setting of appropriate alarms limits for patients condition on the monitor
3. Demonstrates an understanding of the arterial and central venous catheter waveforms	3.1 Identifies the correct landmarks of the arterial catheter waveform 3.2 Identifies the correct landmarks of the central venous catheter waveform 3.3 Demonstrates how to accurately assess haemodynamic observations on the monitor
4. Demonstrates an understanding of potential complications and their prevention	4.1 Checks medical haemodynamic parameters correspond to the monitor alarm limits 4.2 Observes and assesses the insertion sites for signs of bleeding & infection 4.3 Checks security of dressings 4.4 Performs dressing change 4.5 Checks and ensures that there is no air present in the administration line 4.6 Identifies when pressure transducer system, IV administration sets & IV administration adjuncts change due 4.7 Performs line change 4.8 Checks and observes peripheral circulation 4.9 Clearly labels all lines 4.10 Uses aseptic or non-touch technique when manipulating the pressure transducer system 4.11 Utilises scrub the hub when accessing pressure transducer & administration sets 4.12 Adheres to CLAB Guidelines
5. Maintains and responds to alterations in the patients haemodynamic status	5.1 Appropriately responds to alarms 5.2 Observes the patient's haemodynamic parameters and takes action to resolve abnormalities

	5.3	Seeks assistance from medical and nursing staff where appropriate
6. Demonstrates correct CVAD removal	6.1 6.2 6.3 6.4 6.5 6.6 6.7	Completes Level 1 procedure safety check list Assesses for risk of vascular air embolism pre removal Ceases infusions and engages clamps prior to removal Positions patient correctly in bed Removes CVAD according to HNE guidelines & procedures Inspects entire length of catheter for damage & ensures tip is intact Assesses for vascular air embolism post removal
7. Demonstrates legal documentation	7.1 7.2 7.3 7.4	Accurately documents parameters on the patient's observation chart Accurately documents CVAD information on the ICU flow chart and/or CVAD care plan Documents any difficulties and their resolution in clinical integrated notes Updates the ICU care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • ICU & HNELHD guidelines and procedures • Infection Control precautions • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

UNIT OF COMPETENCY

Introductory Invasive Mechanical Ventilation

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely care for an adult intensive care patient requiring invasive mechanical ventilation. This competency is a beginner level competency and a prerequisite to the John Hunter Hospital Intensive Care Services advanced haemodynamic competencies.

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly
2. Demonstrates correct assembly and set up of invasive mechanical ventilation therapy	2.1 Identifies and locates the correct equipment 2.2 Correctly assembles ventilator equipment 2.3 Performs pre-use check 2.4 Correctly assembles etCO2 monitoring
3. Demonstrates understanding of artificial airway security and patency	3.1 Identifies correct position of endotracheal tube 3.2 Ensures the tube is secure 3.7 Correctly assesses and documents cuff pressure 3.8 Assesses skin condition and requests appropriate assistance to change tube position if required 3.9 Checks ventilator circuit connections are secure 3.10 Demonstrates correct suctioning technique
4. Demonstrates an understanding of the assessment and maintenance of adequate mechanical ventilation	4.1 Correctly auscultates and assesses bilateral chest wall movement/air entry. 4.2 Assesses oxygenation 4.3 Assesses carbon dioxide clearance 4.4 Demonstrates an understanding of the patient's ventilation mode and adjuncts to ventilation 4.5 Identifies clinical resources for assistance with managing patient's ventilation
5. Demonstrates use of correct ventilator settings and alarm limits	5.1 Checks medical ventilation order corresponds to the ventilator settings 5.2 Checks and sets alarms appropriate for patient's condition 5.3 Checks ventilator is plugged into mains power 5.4 Appropriately responds to alarms
6 Demonstrates an understanding to safely manage the patient receiving invasive mechanical ventilation to avoid complications	6.1 Demonstrates safe patient supervision at all times 6.2 Monitors patient respiratory and haemodynamic status throughout therapy 6.3 Demonstrates nursing actions to prevent ventilator associated pneumonia (VAP) 6.4 Notifies medical and nursing staff of alterations in patient's condition

7	Demonstrates an understanding of the patient's psychosocial needs	7.1 7.2 7.3	Promotes an environment that minimises the patient's risk of sensory deprivation Promotes sleep patterns and diversional activities Ensures patient and family receives information and explanations
8	Demonstrates legal documentation	8.1 8.2 8.3	Accurately documents ventilation and respiratory parameters on the patient's observation chart Documents any difficulties and their resolution in the clinical integrated notes Updates the ICU care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • ICU & HNELHD guidelines and procedures • Infection Control precautions • OH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:** **Details of Feedback from Candidate:** **Assessor's Signature:** **Date:** **Candidate's Signature:** **Date:**

UNIT OF COMPETENCY

Cough Assist Competency

(REGISTERED NURSE & PHYSIOTHERAPISTS)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse or Physiotherapist to safely care for an adult intensive care patient requiring the cough assist device. This competency is a beginner level competency.

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly
2. Demonstrates an understanding of indications for cough assist	2.1 Identifies rationale for cough assist therapy 2.2 Assesses patient for contraindications for cough assist 2.3 Demonstrates an understanding of the patient's ventilation , and adjuncts to ventilation
3. Demonstrates correct assembly and set up of the cough assist device	3.1 Identifies and locates the correct equipment 3.2 Correctly assembles the device and circuit 3.3 Identifies how to check setting applied by physiotherapist
4 Demonstrates correct application of device to patient	4.1 Provides explanation of procedure to patient and gains informed consent 4.2 Correctly applies cough assist and interface to patient 4.3 Monitors patient and device throughout procedure 4.6 Adheres to HNELHD Cough Assist Device procedure at all times
5 Demonstrates an understanding to safely manage the patient with cough assist device and avoid complications	5.1 Correctly auscultates and assesses bilateral chest wall movement/air entry 5.2 Correctly assesses cough strength and effectiveness 5.3 Assesses suctioning requirements 5.4 Identifies respiratory problems relating to secretion clearance 5.5 Notifies appropriate medical and physiotherapist staff of alterations in patient's condition
6 Demonstrates evaluation of effectiveness of device	6.1 Conducts reassessment of respiratory parameters 6.2 Assesses secretion removal 6.3 Interprets any changes and improvement in patient observations
7 Demonstrates legal documentation	7.1 Accurately documents ventilation and respiratory parameters on the patient's observation chart 7.2 Documents any difficulties and their resolution in the clinical integrated notes 7.3 Updates the ICU care plan each shift

<table>
<tr><th>EVIDENCE GUIDE</th><th>ASSESSMENT DECISION</th></tr>
<tr><td>Context for assessment:
This unit of competency must be
assessed in the intensive care environment</td><td>☐ Competent ☐ Not Yet Competent

Action/Further Training Required:</td></tr>
<tr><td rowspan="4">Underpinning knowledge is required
of the following:

• ICU & HNELHD guidelines and procedures
• Infection Control precautions
• WH&S Standards
• Relevant anatomy and physiology
• Use of Cough Assist Device JHH_JHCH_BH 0247
• HNE Excellence tools</td><td>Details of Feedback to Candidate:</td></tr>
<tr><td>Details of Feedback from Candidate:</td></tr>
<tr><td>Assessor’s Signature:

Date:</td></tr>
<tr><td>Candidate’s Signature:

Date:</td></tr>
</table>

Where to from here?

Congratulations on completing Step 1 of the Intensive Care Services *Professional Development Pathway.* You can now start the process of building on your clinical knowledge and skills within the Intensive care environment.

Step 1 and Step 2 of the *Professional Development Pathway* is mandatory for all Intensive Care Nurses at the John Hunter Hospital.

If you have considerable Intensive Care Nursing experience you may receive recognition of prior learning. Please make an appointment with a member of the education team to discuss your previous learning, experience and/or professional portfolio.

Step 2: Developing Clinical Skill

Complete the remainder of the ICU introductory competencies

There are a total of ten (10) ICU introductory competencies. They are outlined over the following pages and located on the ICU intranet (under the heading of 'Education Resources')
If you have not already done so, you need to achieve competence in the remainder of the ICU introductory competencies.
If you have already achieved competence then you can move onto developing your professional portfolio.

Development of your professional portfolio

A professional portfolio is an excellent method of storing evidence of professional responsibilities, commitments, plans, expectations and outcomes. It is a detailed professional record which is particularly useful for planning career pathway, working towards clinical nurse specialist and preparing for interviews. It is now a mandatory requirement for national registration for all nurses.

Your professional portfolio belongs to you and as a result no portfolio is alike. You may consider the following items may be included in a portfolio:

- Record of employment, education and both professional and personal development
- Performance based on analysis of previous and current practice
- Evidence of competence in chosen speciality and role
- Learning based on skill and knowledge acquisition
- Future goals and career direction\individual reflective processes

A suggested format for a professional portfolio is provided in Appendix 1. Suggested frameworks to guide you with reflective processes are included in Appendix II and III. Please approach any member from the management or education teams or your colleagues for advice and direction.

Achieve a satisfactory level of performance at the equivalent of twelve months; as evidenced by a PDR with your NUM

It is your responsibility to make an appointment with a member of the management team to conduct your twelve month performance development review.
It is advised that you complete the performance development tool and an education plan prior to attending your appointment. The performance development documents can be obtained from the management team or via the HNE intranet; site index; A to Z of HR information; 'Performance development review'. The hyperlink to this site is also located on the ICU intranet (under heading 'professional development'). If you require a copy of your job/position description this can be obtained from the management team.
We have included an education plan below for you and the organisation's nursing vision and statement as this may assist you when completing your performance development tool. You may also invite a member of the education team to be present

Step 2 ICU Competencies

The following competencies are part of *Developing Clinical Skill* and mandatory to complete. If you have considerable Intensive Care Nursing experience you may receive recognition of prior learning. Please make an appointment with a member of the education team to discuss your previous learning, experience and/or professional portfolio.

UNIT OF COMPETENCY

Intra-hospital Transport

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely transport an adult intensive care patient from the Intensive Care Services. This competency is a beginner level competency.

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Follows correct ICU and HNE guidelines and procedures for transporting an intensive care patient
2. Demonstrates safe preparation of the patient for transport	2.1 Communicates effectively with all members of the interprofessional and multidisciplinary team 2.2 Commences preparation with adequate time allocated for potential complications 2.3 Assesses patients respiratory and haemodynamic status 2.4 Identifies any special requirements for nature of transport 2.5 Gathers and checks appropriate equipment, drugs and utilises transport checklist for transport 2.6 Anticipates and prepares for patient needs during transport 2.7 Demonstrates setting of appropriate alarms for patients condition
3. Demonstrates safe management of patient during transport	3.1 Coordinates transport and correctly states responsibilities 3.2 Demonstrates safe patient supervision at all times 3.3 Ensures patient comfort and safety 3.4 Provides continuous assessment with a focus on Airway, Breathing Circulation and management throughout transport
4. Maintains and responds to alterations in the patients respiratory and haemodynamic status	4.1 Appropriately responds to alarms 4.2 Observes the patients respiratory and haemodynamic parameters and takes action to resolve abnormalities 4.3 Seeks assistance from medical and nursing staff where appropriate
5. Demonstrates legal documentation	5.1 Accurately documents parameters on the patients observation chart 5.2 Documents any difficulties and their resolution in clinical integrated notes 5.3 Documents type and time of intra-hospital transport on ICU flowchart

<table>
<tr><th>EVIDENCE GUIDE</th><th>ASSESSMENT DECISION</th></tr>
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assessed in the intensive care environment</td><td>☐ Competent ☐ Not Yet Competent

Action/Further Training Required:</td></tr>
<tr><td rowspan="4">Underpinning knowledge is required
of the following:

• JHH ICU & HNELHD guidelines and procedures
• Infection Control precautions
• WH&S Standards
• Relevant anatomy and physiology
• HNE Excellence tools</td><td>Details of Feedback to Candidate:</td></tr>
<tr><td>Details of Feedback from Candidate:</td></tr>
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<tr><td>Candidate’s Signature:

Date:</td></tr>
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UNIT OF COMPETENCY

Introductory Non-invasive Positive Pressure Ventilation

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely manage an adult intensive care patient requiring non-invasive positive pressure ventilation. This competency is a beginner level competency

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Decontaminates hands according to 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly
2. Demonstrates understanding of indications for use of non-invasive therapy	2.1 Identifies rationale for non-invasive therapy 2.2 Assesses patient for contraindications for use of non-invasive therapy 2.3 Consults with medical officer regarding appropriate mode of non-invasive ventilation 2.4 Demonstrates an understanding of the patients ventilation mode
3. Demonstrates correct assembly and set up of non-invasive therapy equipment	3.1 Identifies and locates equipment 3.2 Correctly assembles ventilator circuit 3.3 Performs pre-use check if required 3.4 Enters ventilator settings and sets appropriate alarm limits 3.5 Identifies clinical resources for assistance with managing patients ventilation
4. Demonstrates an understanding to safely manage the patient receiving non-invasive therapy to avoid complications	4.1 Monitors patient respiratory and haemodynamic status throughout therapy 4.2 Interprets data displayed on interface of ventilator 4.3 Maintains patient ventilation when not receiving non-invasive therapy 4.4 Assesses skin integrity of patient's face 4.5 Identifies effectiveness of therapy 4.6 Identifies complications associated with non-invasive therapy
5. Demonstrates use of correct ventilator settings and alarm limits	5.1 Checks medical ventilation order corresponds to the ventilator settings 5.2 Checks and sets alarms appropriate for patient's condition 5.3 Appropriately responds to alarms
6. Demonstrates an understanding of the psychosocial and comfort needs	6.1 Utilises resources to maintain patient comfort and safety 6.2 Promotes an environment that minimises patient risk of sensory deprivation 6.3 Promotes sleep patterns and diversional activities 6.4 Ensures patient and family receives information and explanations
7. Demonstrates legal documentation	7.1 Accurately documents ventilation and respiratory parameters on the patients observation chart 7.2 Documents any difficulties and their resolution in the clinical integrated notes 7.3 Updates the ICU care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • JHH ICU & HNELHD guidelines and procedures • Infection Control precautions • Principles of Asepsis • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

UNIT OF COMPETENCY

Safe management of a patient with a Tracheostomy

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely care for an adult intensive care patient with a tracheostomy tube. This is a beginner level competency

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Follows correct ICU, HNE, ACI guidelines and procedures for tracheostomy management.
2. Demonstrates an understanding of the safety equipment required	2.1 Ensures essential safety equipment is available at the bed space 2.2 Locates tracheostomy safety equipment
3. Demonstrates safe tracheostomy management	3.1 Checks tracheostomy security 3.2 Assesses patency of tracheostomy tube 3.3 Describes and performs tracheostomy suction correctly 3.4 Performs dressing using aseptic technique checking stoma for inflammation 3.5 Performs inner cannula change using aseptic technique and cleans and stores inner cannula using correct procedure. 3.6 Demonstrates understanding of signs, symptoms and consequences of a blocked or displaced tracheostomy
4. Demonstrates an understanding of both active and passive humidification	4.1 Assesses patients requirements for humidification 4.2 Demonstrates correct use of HME 4.3 Demonstrates correct use of humidified oxygen set up for tracheostomy
5. Demonstrates effective communication with the patient and family	5.1 Provides relevant information to the patient and family members 5.2 Identifies potential communication strategies to enhance understanding 5.3 Assesses patient level of consciousness and cognitive function 5.4 Demonstrates correct use of a speaking valve 5.5 Demonstrates correct management of the cuff
6. Demonstrates legal documentation	6.1 Accurately documents interventions on the patients observation chart 6.2 Documents any difficulties and their resolution in clinical integrated notes 6.3 Updates the nursing care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • ICU & HNELHD guidelines and procedures • Infection Control precautions • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

UNIT OF COMPETENCY

Management of Chest Drains

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely manage an adult intensive care patient with chest drains. This competency is a beginner level competency

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Follows correct ICU and HNE guidelines and procedures for changing of chest drainage system
2. Demonstrates safe management of chest drainage	2.1 Assesses insertion site(s) 2.2 Assesses air entry 2.3 Assesses chest drain tubing for patency 2.4 Checks chest drain security 2.5 Identifies level of drainage on chest drainage system at beginning of shift 2.6 Assesses pain score
3. Demonstrates correct chest drain system assembly	3.1 Checks equipment is assembled and connected correctly 3.2 Positions chest drainage system bottle correctly 3.3 Demonstrates safe chest drainage system change
4. Demonstrates an understanding and application of level of suction	4.1 Identifies differences between high vs low wall suction 4.2 Checks appropriate level of suction for this patient 4.3 Checks suction equipment is operational
5. Demonstrates correct chest drain removal	5.1 Adheres to principles of infection control at all times 5.2 Removes drain according to HNE & ICU guideline 5.3 Identifies indications for clamping chest drains for removal
6. Demonstrates legal documentation	6.1 Accurately documents swing, air and drainage correctly 6.2 Documents chest drainage system changes in ICU care plan 6.3 Documents any difficulties and their resolution in clinical integrated notes

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • ICU & HNELHD guidelines and procedures • Infection Control precautions • Principles of Asepsis • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

UNIT OF COMPETENCY

Safe Spinal Log Roll

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely co-ordinate a spinal log roll for an adult intensive care patient. This competency is a beginner level competency

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Performs hand hygiene according to the 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Demonstrates correct moving safely techniques
2. Demonstrates an understanding of the spinal injury and potential risks during manual handling	2.1 Reviews clinical integrated notes for any limitations 2.2 Reviews the 'spinal management checklist' sticker 2.3 Assesses patient respiratory and haemodynamic status 2.4 Assesses sedation score 2.5 Assesses pain score
3. Performs log roll according to ICU procedure	3.1 Prepares equipment and resources 3.2 Organises health care workers appropriately 3.3 Identifies responsibilities as co-ordinator of the log roll
4. Demonstrates strategies to prevent pressure injury	4.1 Assesses skin integrity 4.2 Demonstrates correct cervical collar care 4.3 Demonstrates adherence to HNE Policy Compliance Procedure, Pressure Injuries: Prediction, Prevention and Management
5. Demonstrates legal documentation	5.1 Accurately documents all clinical assessment findings 5.2 Documents any difficulties and their resolution in the clinical integrated notes 5.3 Updates the ICU care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • JHH ICU & HNELHD guidelines and procedures • Infection Control precautions • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

UNIT OF COMPETENCY

External Ventricular Drain Management

(REGISTERED NURSE)

DESCRIPTOR: This assessment is concerned with the ability of the Registered Nurse to safely manage an adult intensive care patient with an external ventricular drain (EVD). This competency is a beginner level competency. This can be assessed as two separate areas of competence

- External Ventricular Drain Management (sections 1-3, 6)
- Performing Cerebrospinal Fluid sampling (section 5-6)

Candidate: _____ Assessor: _____

ELEMENTS (Expected Performance)	**PERFORMANCE CRITERIA** (Critical Aspects)
1. Demonstrates adherence to Work, Health and Safety and infection control requirements	1.1 Decontaminates hands according to 5 moments of hand hygiene 1.2 Dons personal protective equipment 1.3 Ensures bed at correct level and bedspace free from hazards 1.4 Disposes of equipment and waste correctly 1.5 Follows correct ICU guidelines and procedures for external ventricular drain systems
2. Demonstrates correct assembly and maintenance of the EVD system	2.1 Demonstrates an understanding of the indications for an EVD 2.2 Reviews the clinical integrated notes 2.3 Demonstrates EVD system assembled correctly 2.4 Demonstrates the correct procedure for levelling and zeroing an EVD
3. Demonstrates safe management of a patient with an EVD	3.1 Performs patient neurological assessment 3.2 Responds to neurological assessment and implements appropriate plan for patient 3.3 Correctly assesses and documents intracranial pressure and cerebral perfusion pressure 3.4 Ensures security of the catheter and drainage system
4. Demonstrates an understanding of the potential complications and their prevention	4.1 Identifies correct characteristics of the intracranial pressure waveform 4.2 Observes the patients neurological and haemodynamic parameters 4.3 Observes for clinical signs and symptoms of potential complications 4.4 Notifies medical and nursing staff of alterations and seeks assistance where appropriate
5. Demonstrates correct procedure for CSF collection	5.1 Identifies indications for CSF sampling 5.2 Follows ICU procedure for sampling CSF 5.3 Observes potential complications from CSF sampling procedure
6. Demonstrates legal documentation	6.1 Accurately documents parameters on the patient observation chart 6.2 Documents any difficulties and their resolution in the clinical notes 6.3 Updates the ICU care plan each shift

EVIDENCE GUIDE	ASSESSMENT DECISION
Context for assessment: This unit of competency must be assessed in the intensive care environment	☐ **Competent** ☐ **Not Yet Competent** **Action/Further Training Required:**
Underpinning knowledge is required of the following: • JHH ICU & HNELHD guidelines and procedures • Infection Control precautions • Principles of Asepsis • WH&S Standards • Relevant anatomy and physiology • HNE Excellence tools	**Details of Feedback to Candidate:**
	Details of Feedback from Candidate:
	Assessor's Signature: **Date:**
	Candidate's Signature: **Date:**

Where to from here?

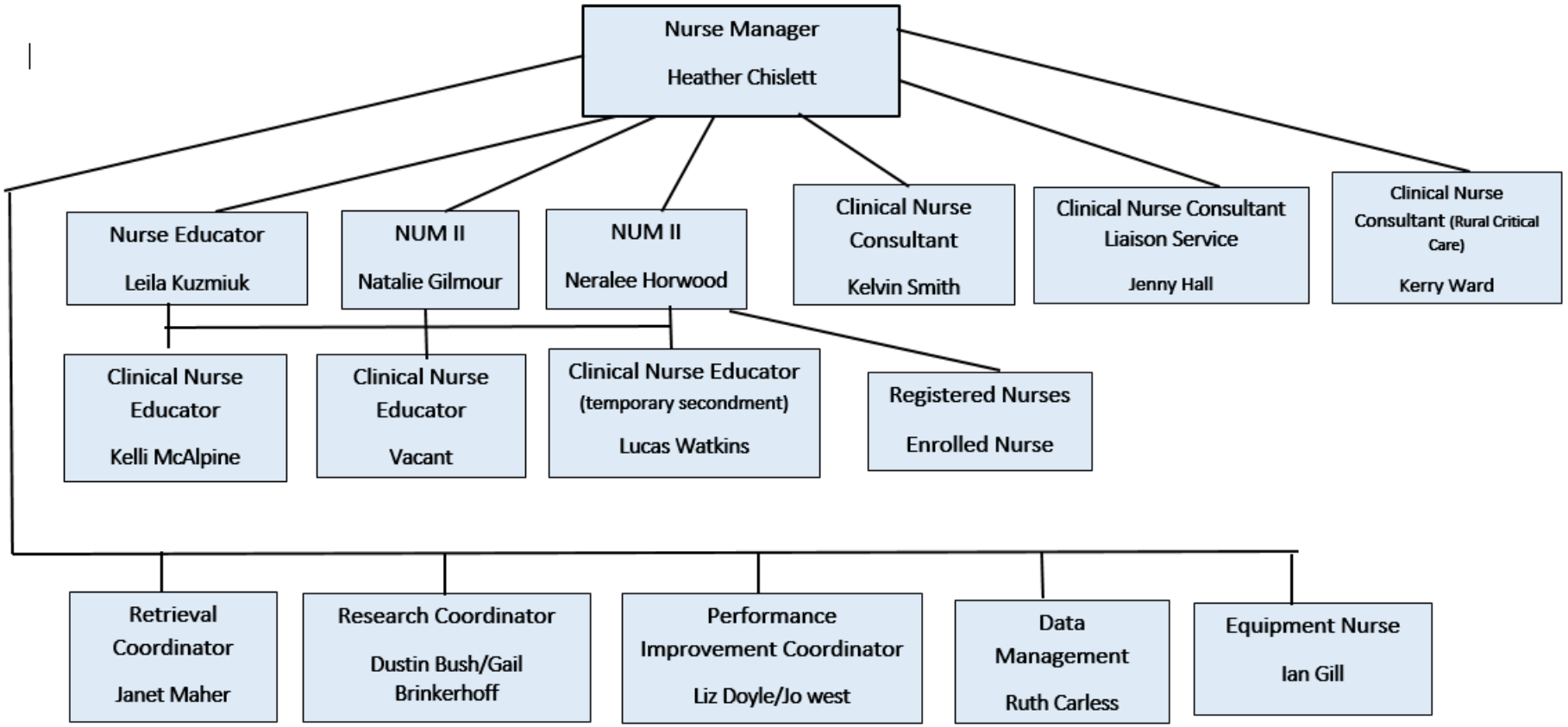
If you are asking this question, congratulations on coming this far! Assuming you have fulfilled the requirements and have successfully completed the formal performance development review, you are now ready to progress to Step three: *Towards specialist practice.* A copy of step three is located on the intensive care intranet or you can obtain one from the education team.

References and learning resources

This list provided is a starting point. You may find other texts and information packages which are more useful.

- Some useful textbooks include the following
    - Aitken, L., Marshall, A,. & Chaboyer, W. (2015).ACCCN's Critical Care Nursing. (3rd ed), Elsevier Australia
    - Bersten, A.D. & Soni, N. (2013) Oh's Intensive Care Manual. (7th ed). Elsevier Australia
    - Conover, M.B. (2003). Understanding electrocardiography. (6th ed.) St Louis:Mosby
    - Darovic, G.O.(2002) Haemodynamic monitoring ;Invasive and Noninvasive Clinical Application. (3rd ed.) Philadelphia, PA: WB Saunders Company.
    - Davies, L. (2004). Cardiovascular Nursing Secrets. St Louis, Missouri: Mosby Elsevier
    - Hasan, Ashfaq., (2010) Understanding Mechanical Ventilation: A practical Handbook. London, Springer-Verlag
    - Hickey, J.V. (2009). The Clinical Practice of Neurological and Neurosurgical Nursing. (6th ed.) Philadelphia: Lippincott Williams & Wilkins
    - Morton, P.G., Fontaine, D., Hudak, C.M. & Gallo, B.M. (2004). Critical Care Nursing: a Holistic Approach. (8th ed) Lippincott Williams & Wilkins
    - Pierce, L., (2007) Management of the Mechanically Ventilated Patient. 2nd Ed. Saunders Elsevier
    - Totara, G.J. & Derrickson, B. (2009). Principles of Anatomy and Physiology. (12th ed.) John Wiley & Sons, Inc
    - Urden, L.D., Stacey, K.M. & Lough, M.E. (2005) Thelan's Critical Care Nursing. (5th ed) Elsevier Health Sciences
    - www.radiologymasterclass.co.uk/tutorials
    - http://joel1122334.wix.com/arterialbloodgases
    - Hunter New England Health Nursing & Midwifery Learning Resources Directory http://lp.hne.health.nsw.gov.au
    - Ferrer, M.,Torres, A. (2015). Noninvasive ventilation for acute respiratory failure. *Current opinion in Critical Care* DOI:10.1 097/MC 00 000 0000 000 0173
    - Singer, B., & Corbridge, T.(2009). Basic Invasive Mechanical Ventilation. *The Southern Medical Association* 102,(12), pp1238-1245
- The following critical care journals can be found via CIAP
    - AACN Advanced Critical Care
    - American Journal of Critical Care
    - Australian critical Care
    - Critical Care Clinics
    - Critical Care Medicine
    - Critical Care Nurse
    - Critical Care Nursing Clinics of North America
    - Critical care Nursing Quarterly
    - Current Opinion in Critical Care
    - Dimension in Critical Care Nursing
    - Intensive Care Medicine
    - Intensive and Critical Care Nursing
    - Nurse Critical Care
    - Nursing in Critical Care
- Other useful databases include Pubmed and Up to Date.

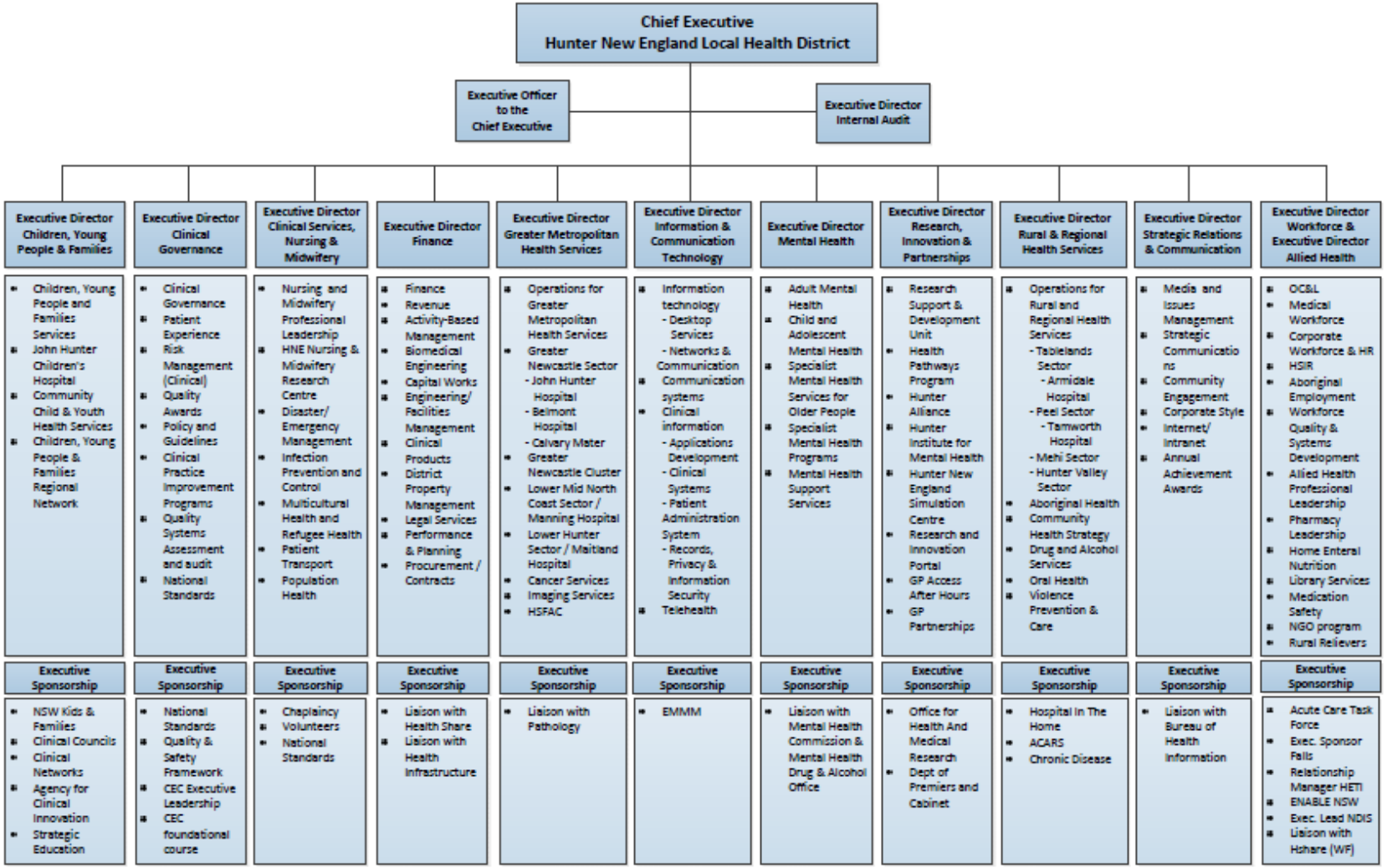
John Hunter Intensive Care Nursing Structure



Hunter New England Local Health District

Organisational Chart (Including Executive Portfolios)

Health
Hunter New England
Local Health District



Last Updated: October 2015

Acknowledgements

This manual was developed by Leila Kuzmiuk, Nurse Educator with contributions from the Education team, Intensive Care Services, John Hunter Hospital and, Intensive Care Services, John Hunter Hospital. Reviewed December 2012, January 2014, January 2015, January 2016, December 2016, December 2017

We want to acknowledge the following publication for their permission and contribution towards the development of the Hunter New England Health, Orientation Manual (Step 1) 2011.

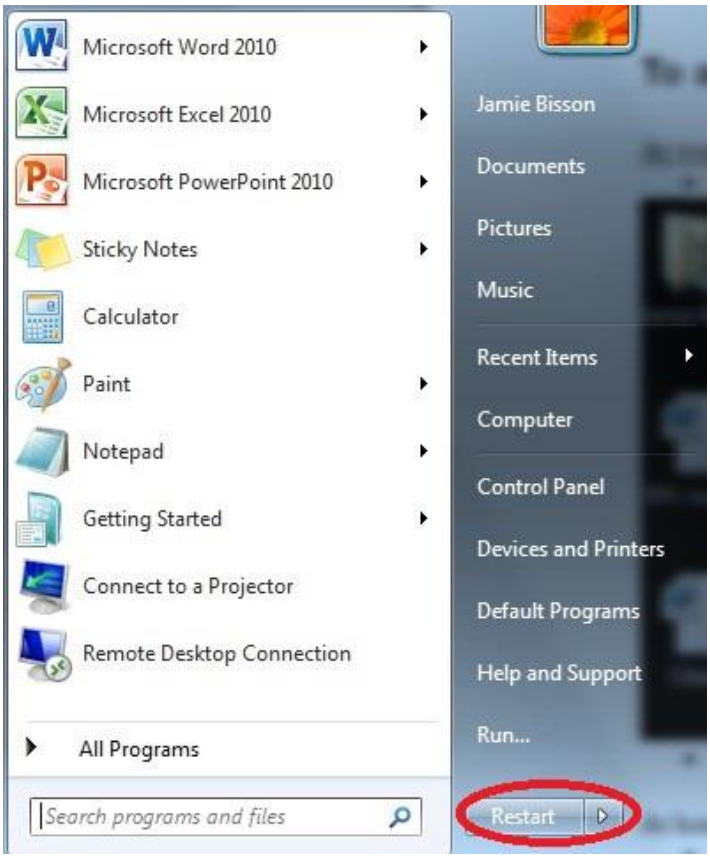
- Elliott, R., Kuzmiuk, L., O'Leary, G., Spiers, B., Thomson, G & Tinker, M. (2009) Royal North Shore Hospital, Department of Intensive Care, Intensive Care Manual, New Graduate Program

Appendix I: Network Applications

Network Username and Access

Your temporary passwords will be supplied by the Nursing Unit Managers at the commencement of employment with the Intensive Care Services.
To activate your password you must;

- Restart a computer in the unit



- Logon using your username (your ID Number) and your temporary/initial password
- A prompt will then ask you to change your password to one of your choice and will then start-up
- If you have any difficulties with this process ring I.T. services on 13800 select option 3, then option 2.

Access Microsoft outlook

At work when logged in as yourself

- Click on the Microsoft Outlook icon

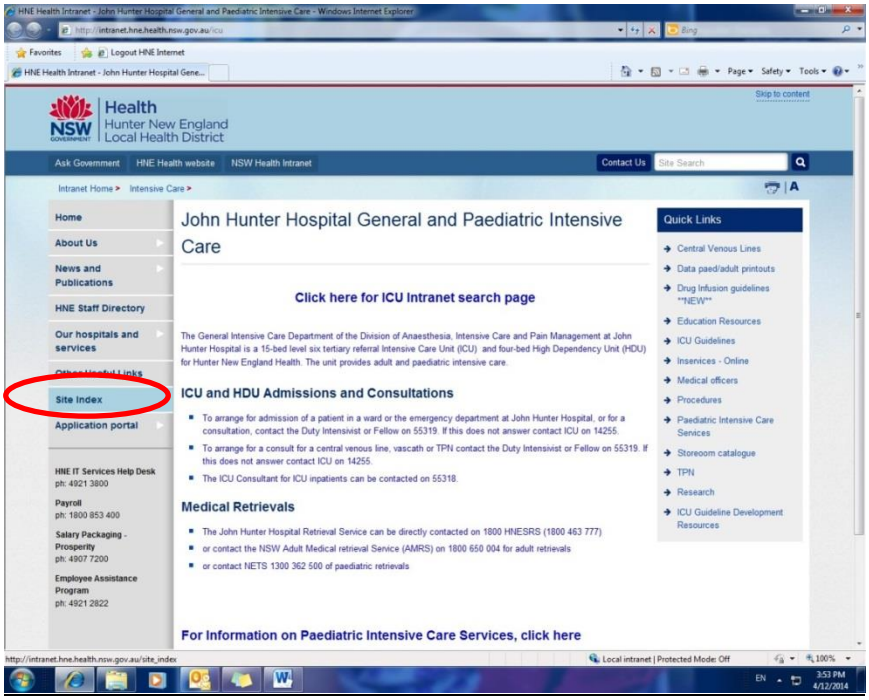
If you are logged on as the ward User ID (jhicudr)

- You can log in two ways, either enter into the address bar of the internet explorer address bar https://webmail.hnehealth.nsw.gov.au, or click on the following icon:

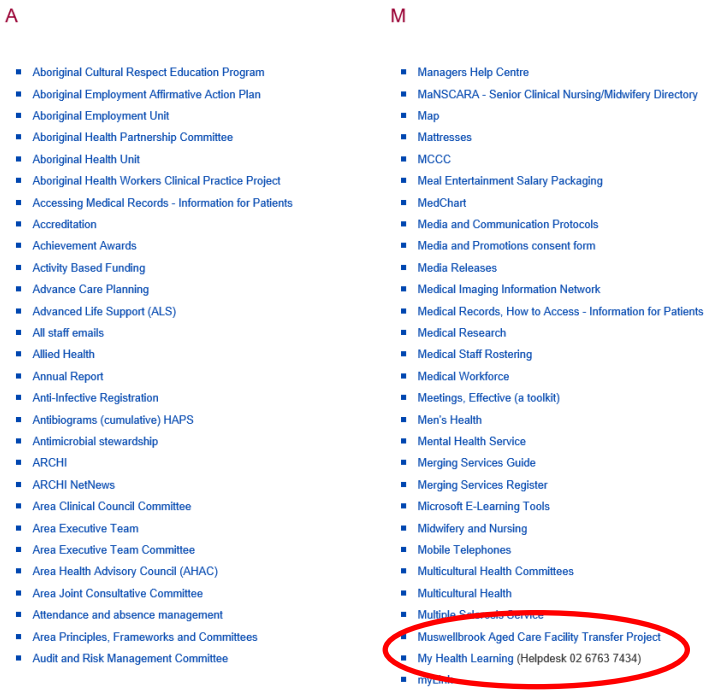
- Log-on using your username and password

Accessing My Health Learning – At work

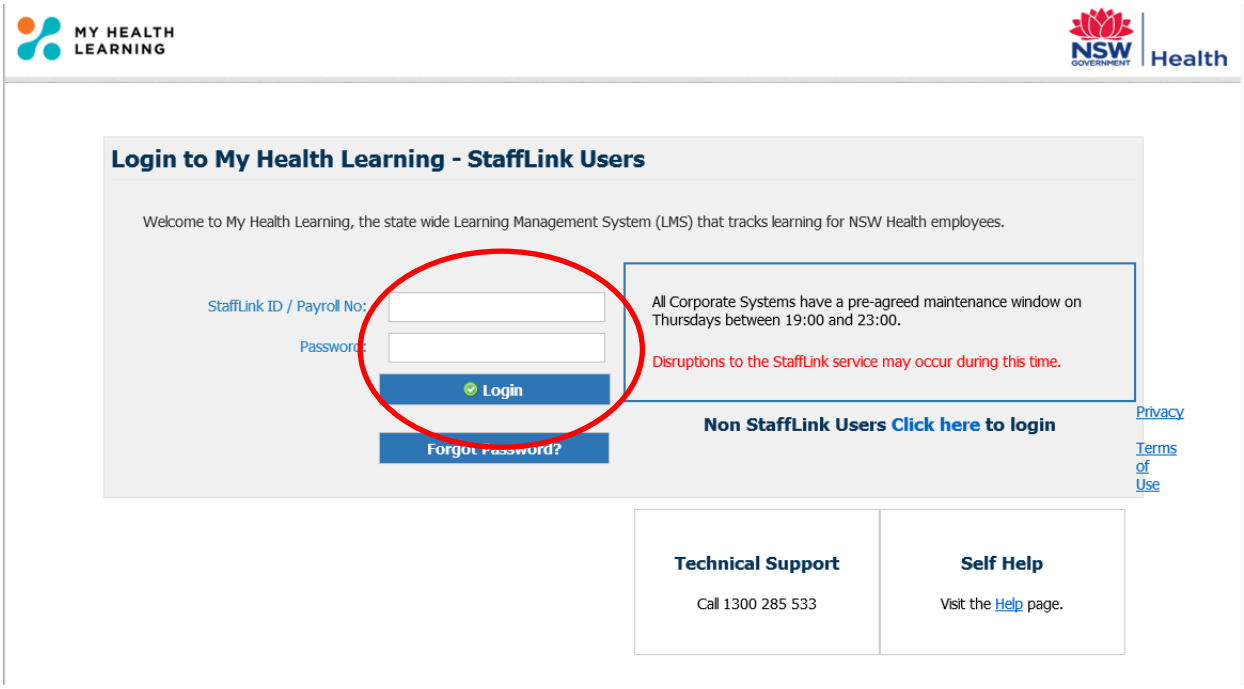
- From either the ICU intranet page or HNE intranet page – go to site index



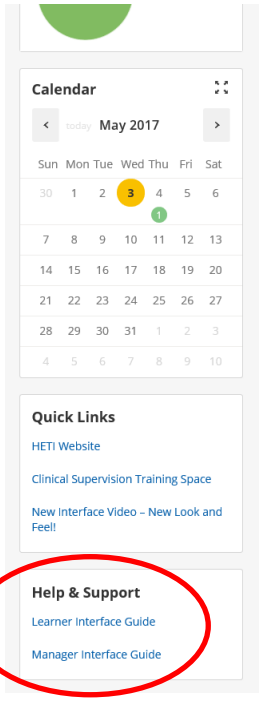
- On the site index, scroll down until you find 'My Health Learning" and click on it



- In order to login enter your user name and password (NB. This is the same as your Stafflink ID and password). If you have any difficulties logging in please note the section on this page "Helpdesk"



- To access your required training ensure you are in "learner" mode. This home screen outlines the training that you are required to complete. If you are unfamiliar with how to use 'My Health Learning', please access the "Learner Interface Guide" under the Help & Support section

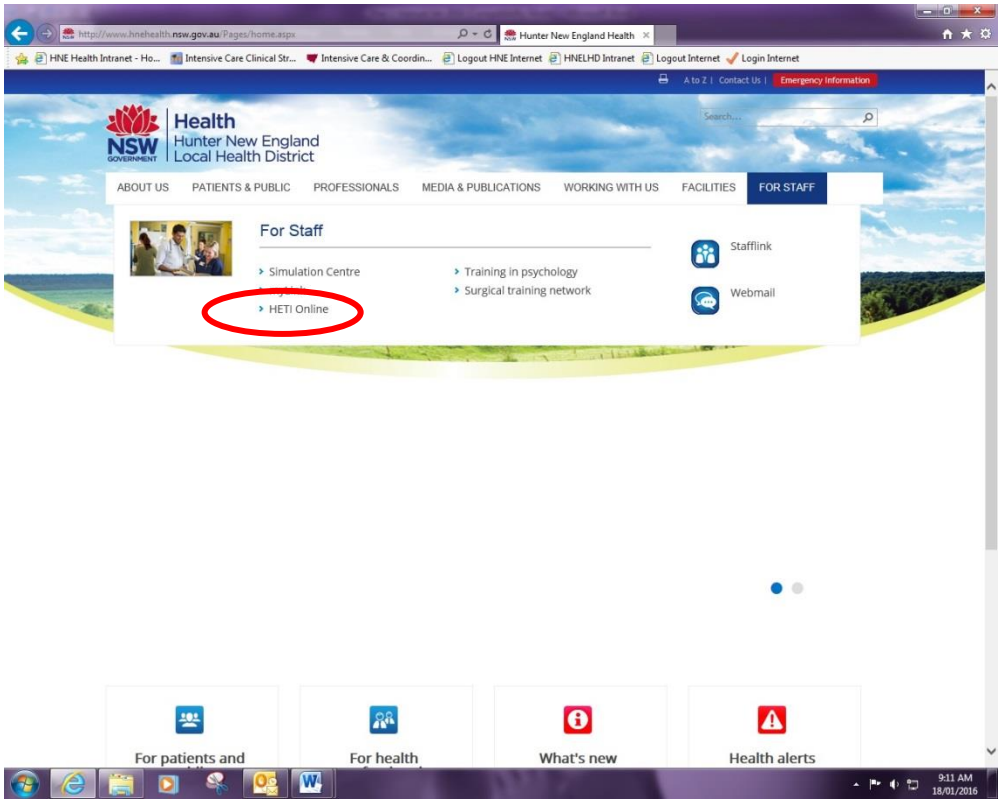


Accessing My Health Learning – At home

- It is possible to access My Health Learning from your home computer. In order to access this training you must first go to the external HNE webpage http://www.hnehealth.nsw.gov.au/Pages/home.aspx

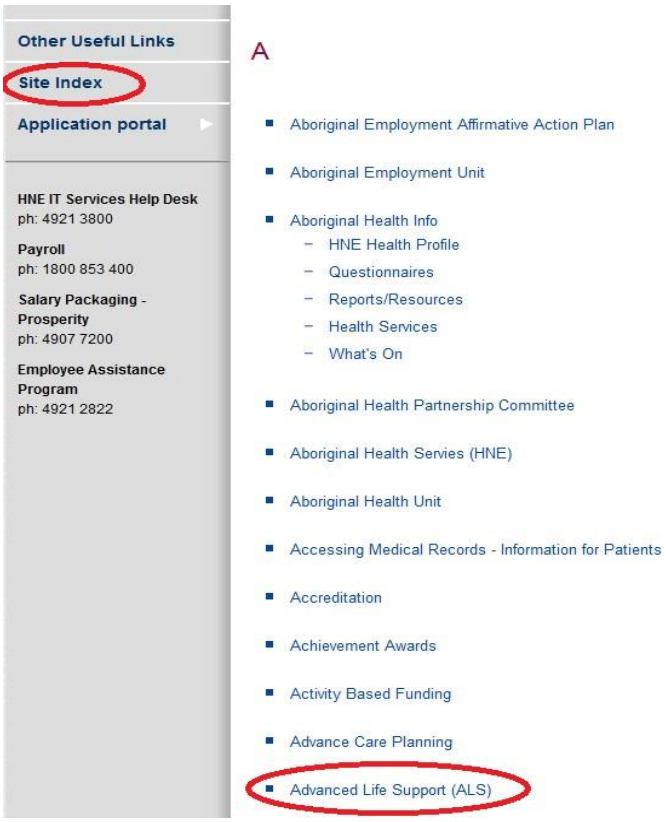
- Once on this site please go to the tab labelled “For staff”

- From here go to “HETI Online”. This will bring up the HETI login page where you can sign in to complete your training

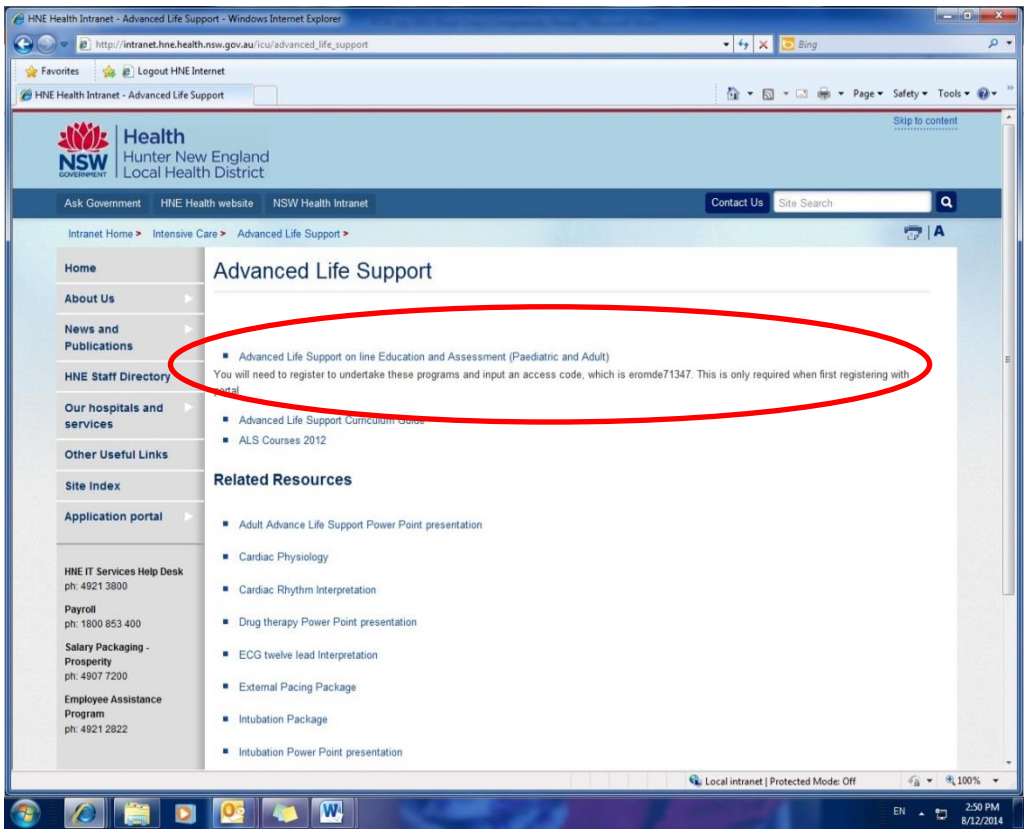


Advanced Life Support

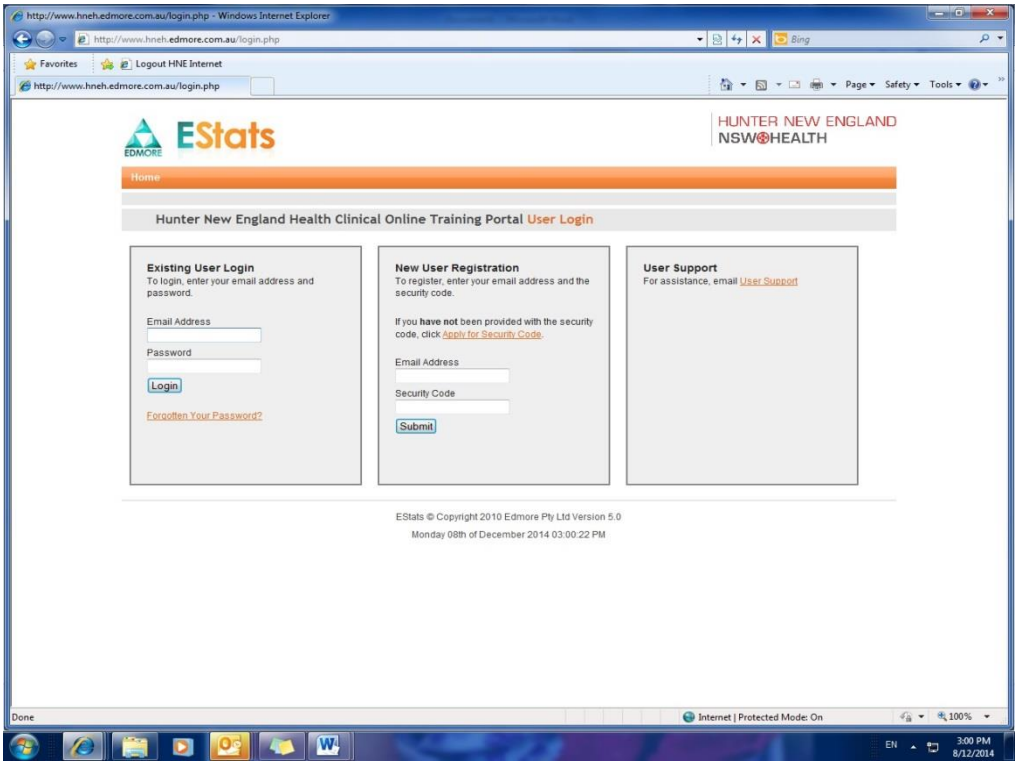
- To complete Advanced Life Support (ALS) you first need to successfully complete the on-line assessment. You can access this through the HNE Edmore site. This can be accessed via going to the "Site Index" of the Intranet and clicking on "Advanced Life Support"



This will bring up the link to the ALS site. Please note the instructions and access code underneath this link that you will require when registering with this site for the first time.



- You will then be taken to the HNE Health Edmore site where you can log in with your email address and password. You will need to register for the first time on an HNE computer prior to gaining access from home. Ensure that your browser at home is updated to the latest version.

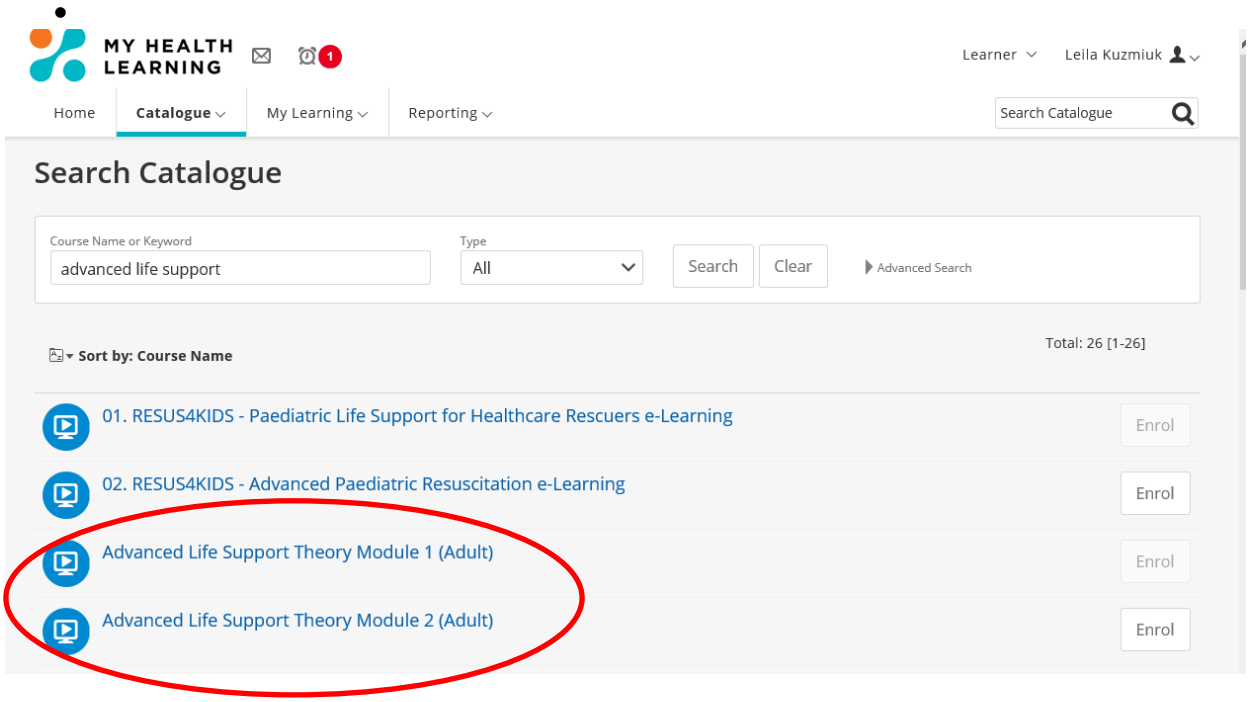


- Please print out your certificate/s and provide a copy to the ICU education team, or your ALS assessor, prior to completing your practical assessment

- The HNE edmore site can also be accessed on your home computer by entering the address http://hneh.edmore.com.au/login.php

- **My Health Learning ALS MODULES**: In addition to the above training, My Health Learning also have two modules that may be completed in order to complement your learning. This course is called “Advanced Life Support 1”. In order to access this training go to the My Health Learning home page as outlined earlier.

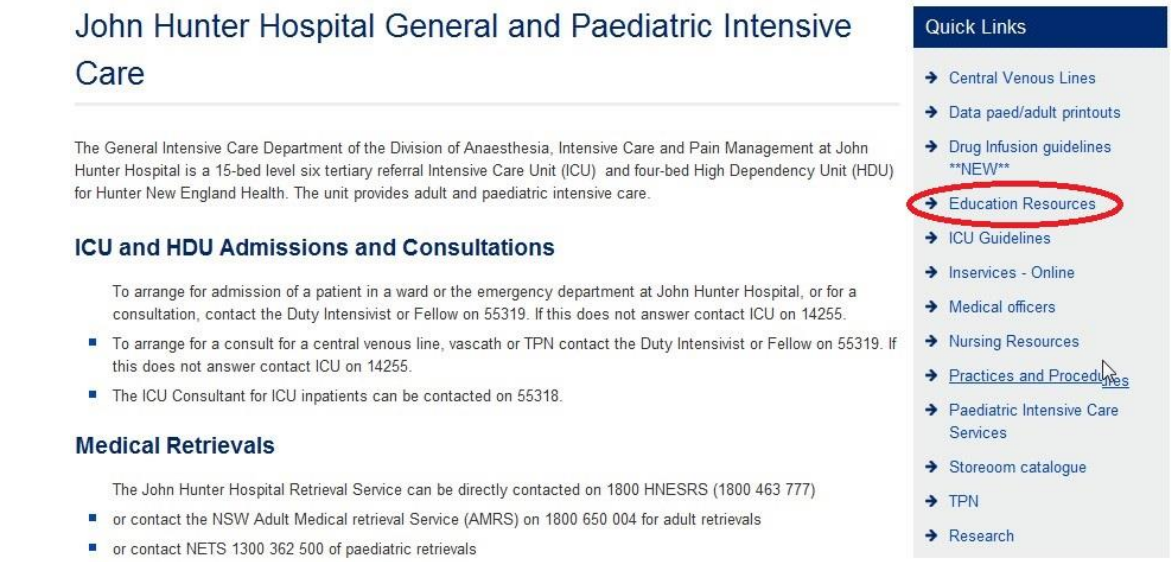
- In the search catalogue enter the term “Advanced life Support” and click the search button



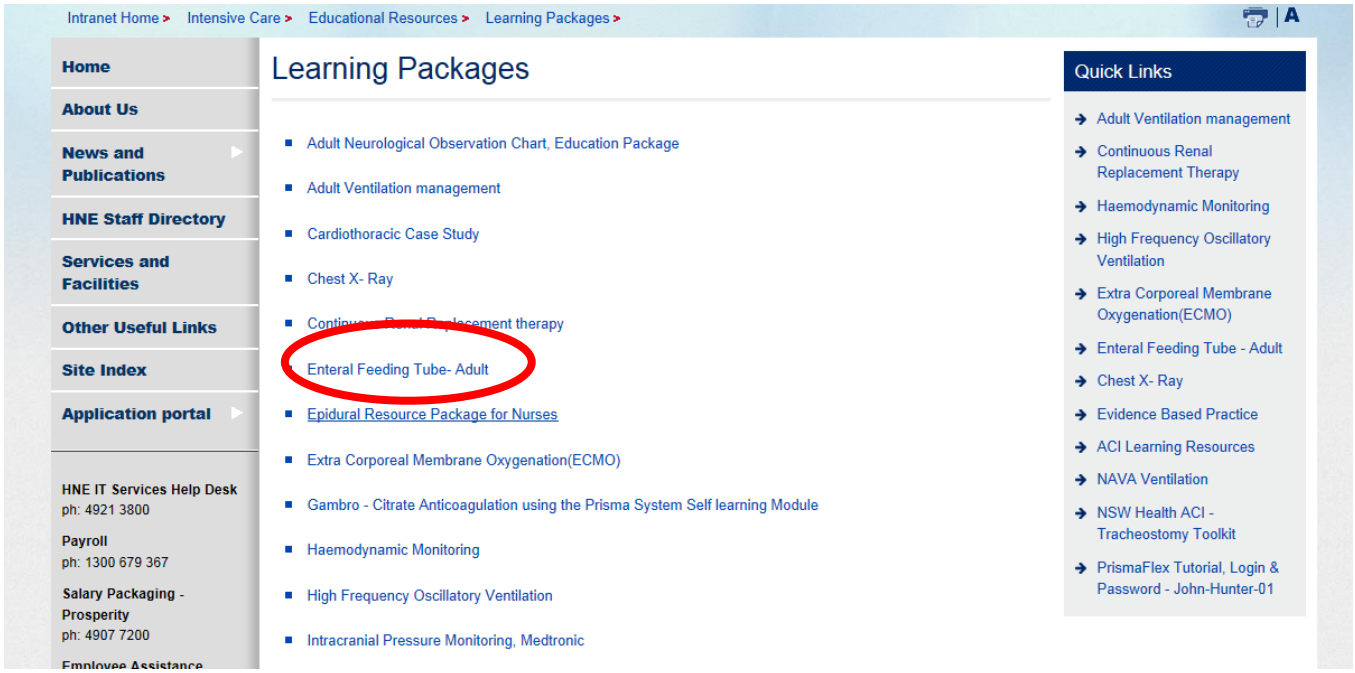
Once the search is complete you can click on the link “Advanced Life Support 1” or “Advanced Life Support 2” in order to access the training

Nasogastric tube insertion self-directed learning package and competency

- Within our ICU Intranet, which is not accessible from home you will find this learning package and competency. These are found in the "Education Resources" section



- Then click on "Learning Packages"
- Finally click on "Enteral Feeding Tube - Adults"



- From this link you will be able to find the learning package and the competency

Appendix II: Setting SMARTA Goals

SMART goal setting brings structure and accountability into achieving your goals and objectives. Instead of vague resolutions, SMART goal setting creates a verifiable pathway towards a certain objective with clearly identified milestones and an actionable plan

Specific

What exactly do you want to achieve? The more specific your description, the easier it is to plan how to achieve your goal. Specificity clarifies the difference between 'I want to understand the respiratory system' and 'I want to learn how to listen to breath sounds

Measurable

Measurable goals means that you identify exactly what it is you will see, hear and feel when you reach your goal. It means breaking your goal down into measurable elements which require concrete evidence. Measurable goals can also go a long way in refining exactly what it is that you want. Defining the physical manifestations of your goal or objective makes it clearer, and easier to reach. So what is it that I need to achieve to know I have reached my goal?

Attainable

Is your goal attainable? Whilst it is tempting and sometimes appropriate to shoot for the stars, it is important to assess whether your goal really is achievable. Would it be realistic to be able to interpret 12 lead ECG's by the end of a four week placement? A more attainable goal may be to list the most common ECG rhythms and concentrate on recognising them.

Relevant

Is reaching your goal relevant to you? Do you actually want to be able to read MRI scans? Whilst it may be useful, it is recommended that your goals reflect your more immediate needs. The main questions to ask yourself here are - how will achieving this goal assist me with my everyday activities & why do you want to reach this goal?

Time-Bound

Everybody knows that deadlines are what makes most people switch to action. Your goals should include a timeframe for achievement. Make sure you keep the timeline realistic and flexible. Being too stringent on the timely aspect of your goal setting can have the perverse effect of making the learning path of achieving your goals and objectives into a hellish race against time – which is most likely not how you want to achieve anything.

Agreed & Aligned

These professional goals are aligned with the organisations goals and they are agreed to by all team members, managers and direct reports

Appendix III: Suggestions for creating a professional portfolio

Part A (available for others to view)

Professional history

- Curriculum vitae (current)
- Registration certificates
- Tertiary transcripts and awards
- Employment records
- Job descriptions

Professional development

- Performance development record
- Education plan
- Competencies (ICU & mandatory descriptors)
- Professional memberships

Continuing professional development

You are expected to have evidence of at least 20 hours of professional development per year for National Registration. One hour of active learning equates to one hour of CPD or one point

- Presenting case studies
- Attending meetings or in-services
- Acting as a preceptor or mentor
- Participating on accreditation, audit or quality improvement committees
- Conducting research
- Writing for publication or reviewing educational materials, journal articles, books
- Active membership of professional groups and committees
- Undertaking relevant on-line or distance education
- Developing policy, procedures or guidelines
- Participating in journal clubs or study groups
- Presenting at or attending workplace in-service sessions or skills workshops
- Undertaking postgraduate studies
- Presenting at conferences, lectures, seminars or professional meetings
- Undertaking supervised practice for skill development
- Mandatory in-service education that is directly related to an individual's context of practice

These following resources are located on the ICU intranet under 'Education Resources' – 'Nursing Professional Development'. They contain some templates for use to record your development.

Hunter New England Health (2010). *Nurse's Professional Portfolio (*Draft)

Hunter New England Health (2009). Greater Newcastle Cluster, *Professional Portfolio for Nurses*

NSWNA (2010) *Continuing Professional Development-Frequently Asked Questions*

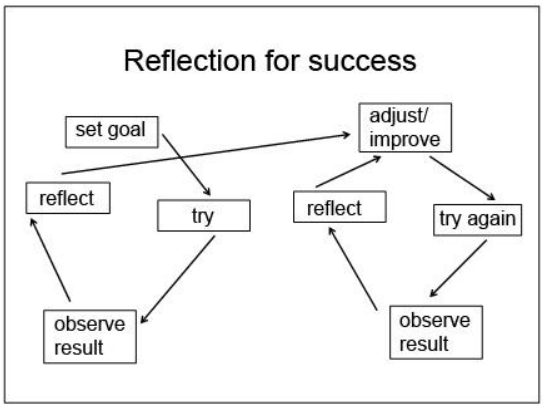
Part A (may be confidential)

Reflection

- Critical incident analysis
- Reflective diary
- Statements of intent
- Action plans for life and career

Appendix IV: The learning centre – structured reflection

Structured reflection just means thinking about and evaluating your experiences in a way that leads to positive change and growth. When you reflect on your experiences in a mindful way, you can turn every experience into a learning experience.



This diagram demonstrates how the reflective process works. For example, think back to when you first learnt to ride a bicycle. The following shows the steps of the process through which you achieved success.

Reflective Process	Learning to ride a bicycle
Set goal	Learn to ride a bicycle
Try	Put on bike helmet, sit on bicycle seat, put feet on pedals, try to turn pedals & ride away
Observe result	You fall off the bicycle
Reflect	Reflect that you have to balance your weight on either side of the bicycle or it will fall over
Adjust	Sit on bicycle, balance your weight evenly
Try again	Now turn the pedals while your weight is evenly balanced & ride away
Observe result	Success! You are riding a bicycle
Reflect	Reflect on what you have learned & what you need to do to ride your bicycle faster & with more confidence

Further information and guidance can be found at
http://learningcentre.curtin.edu.au/skills/structured_reflection.cfm Assessed January 5th 2012

Appendix V: Model for structured reflection – Johns model

The development of reflective practice review offers the practitioner a useful way to take responsibility for their clinical effectiveness. Reflection is used as a means of exploring approaches to clinical supervision, clinical effectiveness and clinical governance, as well as reflecting on your own skills. The following is an adaption of a model described by Johns (1993) to facilitate reflection

1. **Description of experience**
    - Write a description of the experience
    - What are the key issues within this description that I need to pay attention to?

2. **Reflection**
    - What was I trying to achieve?
    - Why did I act as I did?
    - What were the consequences of my actions:
        - For the patient?
        - For the patients family & significant others?
        - For myself?
        - For the people I work with?

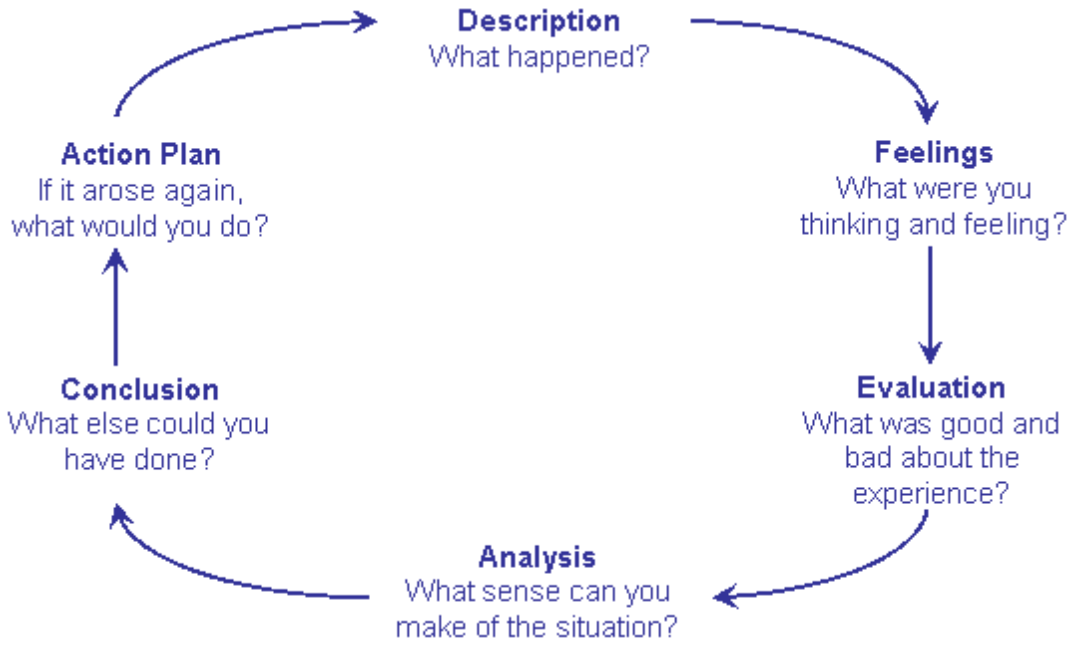
3. **Influencing factors**
    - What internal factors influenced my decision making & actions?
    - What external factors influenced my decision making & actions?
    - What sources of knowledge did or should have influenced my decision making & actions?

4. **Alternative strategies**
    - Could I have dealt better with the situation?
    - What other choices did I have?
    - What would be the consequences of these other choices?

5. **Learning**
    - How can I make sense of this experience in the light of past experiences?
    - How do I NOW feel about this experience?
    - Have I taken effective action to support myself & others as a result of this experience?
    - How has this changed my ways of knowing in practice?
        - Ethical
        - Personal
        - Aesthetic
        - Scientific

Adapted from Johns, C. (1993) *Achieving effective work as a professional activity* in *Towards Advanced Nursing Practice* (Ch 11) Eds:Schober, J.E., and Hinchcliff, S.M., (1995) Arnold

Appendix VI: Gibbs' model of reflection



Extracted from the Department of Practice Learning website from the Birmingham City University at www.health.uce.ac.uk/dpl/nursing/placement%20support/model%20