STUDENT

PORTFOLIO OF

LEARNING OPPORTUNITIES

WARD 8
CHILDRENS SURGICAL
DAY UNIT

NEWCASTLE HOSPITALS NHS TRUST

TRACEY LOWERY, SISTER, AND HELEN SHIPLEY STAFF NURSE
REVIEW JULY 2015
Welcome to Ward 8. During your allocation, your mentor will be ____________ and your associate mentor will be _________________.

Every effort will be made to ensure that you will work with either your mentor or associate mentor, but in certain circumstances this may not always be possible. However, there will always be a named member of staff for you to work with.

We hope you will enjoy your allocation with us and that you will find it a rewarding experience.

If you have any questions or concerns regarding your allocation, please discuss these with your mentor or education link nurse Tracey Lowrey. The direct number for the ward is 01912826008 and the dect phone is 01912829011.

Carol Middleton
Sister.
NEWCASTLE NHS TRUST
RVI WARD 8

Our ward nursing philosophy reflects the beliefs and goals of our nursing staff in caring for children in hospital. We aim to offer a friendly relaxed atmosphere in order to minimise stress and promote optimal health.

Our beliefs and aims:

We recognise that your child and family are unique and that the interest of your child is paramount.

All staff will listen to your child and strive to understand their perspectives, opinions and feelings. We acknowledge their rights to privacy.

We recognise that your child has the right to information according to age and understanding, and will ensure appropriate information is given to ensure informed decisions are made regarding their care.

We offer a family centred approach to care, and recognise the right of the child to have their parents present during procedures and investigations, if it is thought to be in the child’s best interest.

We provide holistic care and will accommodate cultural, spiritual, social and psychological needs in a non-judgemental manner.

Each child / carer will be given information in appropriate terminology and will be kept informed and updated on their condition.

The nursing team encourage active participation from parents / carers. All staff offer encouragement, support and supervision as required. We recognise that not all parents wish to or are able to participate in the care given.

We will encourage your child to maintain their usual routines. Play and education will be provided to maximize your child’s potential and maintain an element of normality.

All qualified staff are specifically trained and educated to care for your child and aim to provide high standards of research-based care.

July 2009
Learning Opportunities.

Students Overview at a Glance.

Ward 8 is a regional children’s day unit that cares for children from birth up to 18 years of age. It comprises of four main areas including play room, admission bay, recovery bay and discharge lounge. There are also three isolation cubicles and a treatment room. Ward 8 is situated on the fourth floor of the new Victoria wing.

Ward 8 allows all levels of students the opportunity to gain many different skills during their time on the ward. Ward staff welcome the opportunity for students to come for a pre-placement visit and if possible to meet their mentor and associate mentor, who will have been allocated to you prior to your placement.

Ward 8 will offer you the opportunity to care for children requiring short stay admissions. Day case surgery lists include circumcisions, hernia repairs, undesended testicles and removal of cysts. Also gastroenterology, rheumatology, plastic surgery, ophthalmology, orthopaedics and airway lists. Many of the children catered for are usually healthy who require one off procedures, however some have varying degrees of special needs and you will gain experience in many complex medical conditions within the scenario of day case surgery.

A multidisciplinary approach to care is offered, during your time on the ward you will be able to liaise and work with other members of the team. These are all tied in with your learning zones and will assist in enabling you to complete your learning outcomes.

Your off duty may already have been written for you. We try to ensure that you work 50% of your time with your mentor, spending the remainder with your associate mentor or a named member of staff.

Your working week is 35 hours and usually consists of three long days per week. Any remaining hours not worked to be negotiated with your mentor. Your shift will be referred to as 15 on the off duty and is 07.30am to 8pm. During the shifts we have two 30minute breaks that are taken around 9.30-10.30am and lunchtime around 1.30-2.30pm.

Off duty is usually planned at least 4 weeks in advance around your mentor(s) off duty to ensure a quality placement. If you require a specific request you must inform the educational link nurse: Tracey Lowrey or your mentor as soon as possible.
**SICKNESS**

You must report any sickness or absence from work to the nurse in charge as soon as possible after 7.30am, similarly when returning back to work. You should also report any sickness or absence to the university as per policy. Infectious illness should be reported initially to the nurse in charge then if required occupational health. Anyone suffering from sickness and/or diarrhoea must not return to work for 48hrs following your last episode.

**UNIFORMS**

Uniform policy can be found on the trust intranet and in the student handbook. General neatness and tidiness is required at all times. Recommended practice is that decorative jewellery should not be worn, with exception of wedding rings. Also nail-varnish and false nails are not acceptable. Hair should be above level of collar at all times. Lockers are situated off the ward in communal changing rooms, where your belongings will be kept safe. A 10 pound refundable deposit is required when obtaining a key from hotel services. You must change into your uniform prior to coming on to the ward and change back into your clothes prior to leaving the hospital.

**SECURITY**

The entrance and exit door are locked and are accessible by swipe card, which you will have to obtain from general office. You must not allow anyone else to use your swipe card. Parents and visitors gain entry by ringing the buzzer and waiting for entry, which is given by using the release button at the nursing station, identification must be sort at all times. Whilst on placement student identification must be worn at all times.
## Portfolio of learning opportunities

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<thead>
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<td>▪ Hospital intranet</td>
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<td>▪ Patient blood results</td>
<td>Doctors</td>
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<td>▪ Internet access/email</td>
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<td>Ward Clerks</td>
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<td>Infection control</td>
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<td>Play and recreation</td>
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<td>▪ Parents/carers/families</td>
<td>Teachers</td>
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<td>▪ Patients/special needs child</td>
<td>Play Specialist</td>
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<td>▪ Diversional play therapy</td>
<td>Nurses</td>
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<td>▪ Communicating/working with</td>
<td>Other MDT members</td>
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<tr>
<td><strong>Multidisciplinary Team (MDT)</strong></td>
<td>Physiotherapist</td>
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<tr>
<td>▪ Ward staff</td>
<td>Dietician</td>
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<td>▪ Medical staff – ward rounds</td>
<td>Chaplain</td>
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<td>▪ Ward Clerk</td>
<td>Pharmacist</td>
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<td>▪ Paediatric continence advisor</td>
<td>Radiologist</td>
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<td>▪ Other MDT members</td>
<td>Interpreters</td>
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<td>▪ Other directorate wards/departments</td>
<td>Social Workers</td>
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<tr>
<td>▪ Directorate management team</td>
<td>Psychologists</td>
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</tbody>
</table>
Airway/Breathing
- Assessment of airway: Nurses
- Care of postoperative airway: Doctors
- Administration of oxygen therapy via: Anaesthetist
- Nasal cannula, face/tracheal mask
- Suctioning of airway: Ward 12
- Care of tracheostomies: Physiotherapist
- Teaching parents/carers

Delivery of care
- Patient assessment: Nurses
- Care planning: Doctors
- Implementation of care: MDT
- Evaluation of care

Monitoring and recording observations
- Temperature, blood pressure, pulse, weight, height, respirations and blood glucose monitoring
- Oxygen saturation: Nurses
- Urinalysis: Medical staff
- Stoma assessment: Anaesthetic team
- Wound checks: Continence nurse
- Neurological observations
- Cannula observation

Monitoring dietary intake
Calculating, checking and administration of medicines
- Oral: Nurses
- Subcutaneous: Doctors
- Intramuscular: Pharmacist
- Intravenous: Dietician
- Per rectum
- Per gastrostomy/nasogastric tube
- Controlled drugs

Care of peripheral, central venous devices
- Portacath
- CVC line
- Picc line
- Renal line

Care of nasogastric tubes
- Passing of tube
- Aspiration of tube
- Removal of tube
- Use of feeding pumps
Care of gastrostomy tubes
- Changing of AMT button
- Feeding
- Aspiration

Administration of IVT and TPN
- Preparation of lines
- Connecting to patient
- Line flushing
- Use of alaris/syringe driver
- Monitoring cannula/line site

Administration of blood products
- Accessing IV devices
- Taking blood samples
- Aseptic technique

Elimination and Hygiene
- Skincare
- Mouth care
- Pressure area care
- Tracheostomy care

Catheter cares
- Urethral
- Supra pubic
- Mitrofanoff
- Bladder washouts
- Self catheterisation

Stoma care
- Ileostomy
- Colostomy
- Ace Washout
- Mitrofanoff
- Toilet training

Fluid Balance
- Accurate recording of charts
- Monitoring fluid intake
- Monitoring fluid output i.e. stool, urine, aspirate from ng tube or gastrostomy
- Wound drains
- Rectal drains
- Fluid replacement
- Normal/disturbances in electrolyte balance
Care of surgical wounds

- Aseptic technique
- Removal of sutures, drains (yates, redivac, stents, suprapubic catheters and chest drains.)

Infection Control

- Isolation/barrier nursing
- Hand washing
- Screening: specimen collection:
  - Stool
  - Urine
  - Culture/virology swabs
  - Nasopharyngeal aspirate
  - Blood cultures
- Aseptic technique
- Source of infection

Transmission and treatment

Moving and handling

- Use of aids/devices
- Post operative patient
- Special needs/ immobile child

Medical devices

- Ivac pumps
- Syringe drivers
- Patient controlled analgesia
- Oxygen saturation monitoring
- Feeding devices
- Reporting faulty equipment

Legal/ethical

- Patient advocacy
- Family centred care/partnership
- Child protection
- Parental responsibility
- Consent: Gillick competent

Nurses
Doctors
Tissue viability
Nurses
Doctors
OT, physio
Moving and handling
Nurses
Doctors
Electronics
Anaesthetics
Nurses
Doctors
Child protection nurse
Social worker
STUDENT LEARNING RESOURCES

We hope that you will experience many learning opportunities that are both exciting and challenging.
All hospital policies and guidelines are available on the intranet and parent information sheets are available on the ward, so please ask member of staff if you wish to view them.
As a student you are able to use the library facilities and the hospital intranet provision. The RVI has a library that all trust staff can use, which stocks current and past journals, books and professional documents. You may also have access to the internet and databases.
On arrival to the day unit you will meet your mentor and co-mentor and be able to discuss your learning needs and outcomes required for the placement.
We hope that you enjoy your placement with us. If you experience any problems/difficulties, please discuss these with a member of staff. We welcome any ideas you may have to improve your placement/ experience of the ward.
Parents are to stay with the children at all times whilst on the day unit, but may pop downstairs for a beverage whilst their child is in theatre. Unfortunately, there is no parents room available on the day unit, so parents are encouraged to use hospital facilities i.e. costa coffee, vending machines etc. There are also takeaway eateries situated on the second floor of the atrium. Parents are discouraged from eating/drinking in the playroom/admission bay out of consideration for fasting children. Hot drinks are only allowed on the ward if they have a plastic cover on them. Cash point facilities available in Leazes wing on same floor as main reception.
USEFUL INFORMATION

Crawford House
This is a charity funded residential accommodation attached to the RVI. The facility is accessible to all families whose child is a patient within the hospital. There is an initial voluntary small charge requested. Accommodation is available on a first come first served basis and can be booked via the ward clerk. Bookings can’t usually be made until the day of admission. All rooms have an internal phone extension for parents to contact the ward and vice versa. For this reason it is essential to record each family’s extension no in their child’s assessment sheet.

Parking
Parents/carers are encouraged to park in the multi-storey, please note that we are no longer able to offer any discount. Other nearby car parks includes St James, Richardson Road and Claremont Road.

Ward Routines
As the ward is only open during the week and most of the children are discharged home, there is no need to hand over to other staff. If the child is transferred to another ward then nursing staff from the day unit would hand over to the inpatient ward staff.

Ward Rounds
The surgeon or doctor comes on to the ward to review their patients once they have finished their theatre list. Once the doctor is happy and the child has completed their two hours and has tolerated diet and fluids they may be discharged. Otherwise, the child may be assessed by specialist nurse Judith Taylor or Sisters on the ward and complete a nurse led discharge.
Admissions
Day surgery is performed Monday to Friday. If admission is for the morning list, the patients arrive at 7.45am, afternoon list patients arrive at 12md. Initially, the children are put into the play room until a space in the admissions bay is available. If there are several lists running, the first four children on the list go into the admissions bay. Once they go to theatre the next child on the list gets moved into their space. On returning from theatre the children go into the recovery bay, where they may drink. Once children are mobile and ready to eat they can then be moved into the discharge lounge. All children that have undergone a general anaesthetic must stay on the ward for two hours post procedure, as hospital policy states.

Out patients
A number of children return to the ward to be seen by the registrar or consultant, for the removal of drains/catheters etc. Division of tongue tie is carried out on young babies out on the ward by a consultant or registrar. You will have the opportunity to observe this procedure.

Cubicles
Priority for admission to a cubicle is given to a child requiring isolation, a very ill child or children under 1 year old. We also give consideration to adolescents and a child /young person whose surgery may result in embarrassing after effects i.e. colonoscopy. Children who are barrier nursed have to be nursed in a cubicle and there should be a visible sign saying that they are barrier nursed.

Play Therapy / playroom
The day unit has two hospital play specialists who work from 7.30am -6.30pm, they engage the children in a wide variety of play and their skills are invaluable in preparing children for theatre / painful procedures. You will have the opportunity to work closely with them. Parents are responsible both for supervision of their children in the playroom and for tidying up afterwards. Play station games and consoles are available for older children
Common terminology in relation to surgical procedures

Oscopy at the end of a word usually indicates: looking inside something e.g. bronchoscopy: the bronchus, laryngoscopy; the larynx and tracheoscopy; the trachea to name but a few.

Otomy at the end of a word usually means, an opening into e.g. tracheotomy, laparotomy.

Ectomy at the end of a word usually means removal of e.g. appendicectomy, nephrectomy (kidney) and colectomy (colon).

Laparotomy
This is used to access the abdominal organs. It involves the surgeon making an incision through the abdominal wall into the abdominal cavity.

Laparoscopy.
Instead of a laparotomy, the surgeon may just want to look into the abdomen. In this case he will use a ‘scope’, a thin tube with fibre optics, which he can use to look into the abdomen.

Bowel operations

Ace - Ante grade colonic enema.
Reason for surgery: chronic constipation and soiling. Used to give daily enemas directly into the colon to remove and prevent the build up of constipated faeces.
The appendix is used to form a tract that goes from the abdominal wall through into the bowel. A catheter is usually left in situ for approx eight weeks. After eight weeks the tract would have healed to form a tube into which a catheter can be passed daily and enemas given as required to clear out the bowel. When a catheter is no longer in all the time, a stopper is placed in the opening to prevent it narrowing.
The muscle of the abdominal wall prevents leakage from the bowel to the surface of the abdomen.

Caecostomy Tube.
In a similar operation, using the appendix, a tract is made through the abdominal wall into which a tube is inserted into the caecum. An enema can then be given as required directly into the caecum.

Colostomy.
This is performed for a variety of reasons where the child’s bowel is not functioning, e.g. hirschsprung’s disease, ulcerative colitis or necrosis.
Sometimes the colostomy is permanent whilst other times it is used as a method to rest the bowel and is later reversed.
An incision is made through the abdominal wall and a section of the bowel being the colon, is brought to the surface of the abdomen, and sutured into place.
The bowel then performs its function, passing faeces into a colostomy bag, instead of passing through the whole large bowel and out through the rectum.
An ileostomy is where part of the small bowel, ileum, is brought to the surface in a similar manner, for similar reasons.

Anastomosis of the bowel.
This operation is performed through a laparotomy to remove part of the bowel, which is diseased or necrotic and join up the ends, thus avoiding a colostomy.

Appendicectomy.
This operation is required if the child shows signs of appendicitis. Appendicitis is the inflammation of the appendage of bowel that is attached to the lower portion of the ascending colon. If it becomes inflamed it can cause severe abdominal pain. If left un-treated it may become infected, necrotic and eventually rupture (perforate) spilling pus into the peritoneum, causing possible life threatening peritonitis. The appendix is removed either laparoscopically or through a laparotomy incision.

Gastroschisis
Unprotected intestine protruding through a defect in the abdominal wall. Treatment involves replacing the protruding bowel into the abdominal cavity and repairing defect. The baby will require IVT until the bowel is working effectively and this may take several weeks or longer.

Exomphalos
Is similar to gastroschisis, but the herniated abdominal contents are covered with peritoneum or abdominal membrane. This sac may include liver, intestine and stomach.

Intussusception
Obstruction of the intestine caused one portion ‘telescoping’ inside another. Symptoms may include intermittent severe abdominal pain where the baby draws up his/her knees and is inconsolable, vomiting, the passing of blood, mucousy stool resembling redcurrent jelly, shock and pyrexia. May be treated by air or barium enema which is pumped into the bowel, otherwise surgery is required.

Necrotising Enterocolitis
The lining of the bowel dies and sloughs off, possibly as a result of bacterial infection. This condition is primarily seen in premature babies. Symptoms include the passing of blood in stool, abdominal distension, vomiting, feeding intolerance and pyrexia. Sometimes surgery is needed to remove the dead bowel and the child may need a temporary colostomy.
Kidney operations

Nephrectomy
This is the surgical removal of a kidney that is not working or diseased. The kidney is removed through an incision, made over the kidney area.

Ureterectomy
This is the surgical removal of the ureter that drains the urine from the kidney into the bladder.

Nephroureterectomy
This is the surgical removal of both the kidney and the ureter.

Pyelolithotomy
This is a surgical removal of stones in the kidney

Nephrostomy
This is an opening into the kidney; a tube is inserted to drain of accumulated urine from around the kidney.

Pyeloplasty
In this operation, the outlet of the kidney is refashioned in an attempt to make it drain more efficiently

Mitrofanoff
This operation is performed on children who are unable to pass urine due to some mechanical problem e.g., spina bifida.
The appendix is used to make a tract in through the abdomen and into the bladder.
The children will learn how to catheterise themselves regularly throughout the day.
This operation helps to eliminate incontinence in these children.

Cystoscopy
This is a procedure where a scope is passed in through the urethra to investigate the bladder.
Other Procedures

**Gastrostomy.**
A gastrostomy is usually performed on children who are either unable to take food orally or who need supplementary feeding e.g. over night feeds, directly into the stomach.
The procedure involves an opening in through the abdominal wall into the stomach. A gastrostomy tube is passed into the stomach through the opening and left in situ for eight weeks until the hole becomes semi permanent. The initial tube is then replaced in theatre with a gastrostomy tube that can be changed on the ward as required, without anaesthetic.

**Tracheostomy.**
This is an operation that is required to assist the child in breathing. If for some reason the trachea is not patent, an incision is made surgically into the trachea and a tracheostomy tube is put into the hole. This tube allows air to enter the lungs, bypassing the obstruction. A tracheostomy can be either temporary or permanent, depending on the reason for needing it.

**Thyroidectomy**
This operation is the removal of the thyroid gland in the neck. It is usually required for an over active thyroid gland which produces excessive amounts of thyroxin or a swollen thyroid gland which presses on the neck, or is unsightly. The patient who has their thyroid gland removed will need to take oral thyroxin for the rest of their life.

**Splenectomy.**
This is the surgical removal of a spleen that is either damaged or for a child with sickle cell anaemia. The job of the spleen is to break down any damaged red blood cells ready for the bone marrow to produce healthy ones to take their place. A child with sickle cell anaemia produces sickle shaped red blood cells, which the body sees as damaged cells, therefore it breaks them down at a rate too fast for the bone marrow to keep up with. The splenectomy solves this problem and the liver takes over the job to a lesser degree.

**Pyloric Stenosis**
A narrowing of the pylorus (the outlet from the stomach to the small intestine-caused by a thickening of the pylorus muscles). This can prevent the stomach emptying into the small intestine, so symptoms include vomiting/projectile vomiting becoming more forceful. Failure to gain weight/weight loss, dehydration, diarrhoea, peristaltic motion of abdomen. Treatment is a surgical division of some of the thickened muscle to enlarge the opening – pyloromyotomy.

**Abcess**
A localised collection of pus – fluid, white blood cells, dead tissue, bacteria or other foreign matter. An abcess can occur almost anywhere in the body as a result of infection. Most common abcesses are perianal and neck ones. Symptoms include swelling, pain and maybe oozing of pus and warmth around site. Antibiotics may be appropriate or the abcess may need a surgical incision and drainage.
Hirschprungs Disease
The absence of the nerve supply to part of the bowel prevents peristalsis and so digested matter may not pass through. Milder cases may not be diagnosed until later in infancy or childhood. Symptoms may include failure to pass meconium or to pass a first stool within 24-48 hours of birth, abdominal distension, constipation, vomiting, explosive watery stool. Surgery removes the affected part of the bowel, the child may require a temporary colostomy before the bowel is rejoined.

Spina Bifida
This condition covers a range of degrees of severity, it is a defect of the brain and spinal cord where the bones of the spine do not form completely and the spinal canal is incomplete, allowing the spinal cord and its membrane to protrude – myelomeningocele. Spina bifida occulta is where the spinal bones do not close, the spinal cord and meninges remain in place and skin usually covers the defect. Meningocele is where the spinal cord remains in place and the meninges protrude through the defect. The position and severity may affect the bladder and bowel control and there may be a lack of sensation or paralysis in the lower limbs. Surgical repair may be necessary.
**Daycase Procedures**

**Circumcision**
This is an operation to remove surgically, the foreskin for either medical reasons or religious practice.

**Herniotomy**
This is an operation to repair a weakening in the muscle of the abdomen through which the organ beneath it protrudes and causes pain.

**Orchidopexy**
This is an operation to ‘bring down’ one or both of the testes which have not descended into the scrotum. If left in the abdomen the child may become infertile or the testes may become malignant.

**Orchidectomy.**
This is the removal of a testis that is either necrotic or damaged in some way.

**Hydrocelectomy or ligation of patent processus vaginalis**
This operation is required for a boy whose testicle is swollen, filled with fluid. The fluid is from a patent channel that connects the peritoneum with the testes, usually in combination with a hernia. When standing, peritoneal fluid drains into the testes causing the swelling. The repair is that of an inguinal hernia where the weakening has been caused when the testes descended into the scrotum in utero.

**Hypospadias**
Where the urethral opening is found down the shaft of the penis. This results in spraying, when passing urine and may cause complications when older, on ejaculation. This operation is required, sometime in stages, to move the urethral opening to the tip of the penis.
STUDENT NURSE INDUCTION CHECKLIST

NAME:                       START DATE:

STUDENT INTAKE
This programme is a guide to assessors to aid the integration of student nurses into the working environment. It is good practice to have the document completed within the first two days of the placement.

Student nurses must be allocated an assessor at least one week before the commencement of the placement. At this time, an “off-duty” is produced around the assessor’s shifts to allow the first day of placement to be together. NB. It must be remembered that the student must work 50% of the week with her/his assessor.

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<tr>
<th>ORIENTATION CHECKLIST</th>
<th>SIGNATURE</th>
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<td>Shown around the working environment</td>
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<tr>
<td>Introduced to staff members</td>
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<tr>
<td>Introduced to clients/patients</td>
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<td>Off duty organised</td>
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<td>Procedure for reporting sickness</td>
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<tr>
<td>Discuss dress code</td>
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<tr>
<td>Given student nurse profile and philosophy</td>
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TO BE SHOWN
Health and Safety File                                ☐
Hospital Policies                                    ☐
Control of Infection Policies                        ☐
Nursing Care Plan and Relevant Documentation          ☐
Nursing Standards File                                ☐
Risk Assessment File                                  ☐
Royal Marsden Handbook (where applicable)             ☐
Emergency Exits                                      ☐
Fire Drill                                            ☐
Fire Extinguishers                                    ☐
Restaurant                                            ☐
Parking                                               ☐
Getting to know the ward

Dear Student, once you have been shown around the ward please complete this questionnaire and hand it to your mentor.

Fire Safety
- What is the fire alarm telephone number?
- Where is it written?
- Name 3 fire exit routes
- Identify 2 types of fire extinguisher
- When would you use type 1?
- When would you use type 2?
- Where would you find type 1?
- Where would you find type 2?
- How would you know there was a fire in your area?

Cardiac Arrest
- What is the cardiac arrest telephone number?
- Where is it written?
- State the position of the cardiac arrest trolley
- Find and test the bedside oxygen masks and suction apparatus.
- Arrange with your mentor to explain the cardiac arrest procedure.

Patients
- Identify patients on the bed allocation board
- Identify named nurse and associate nurse for each patient
- Identify position of patient’s admission sheets and medical notes
- Identify position of theatre lists
- Where would you find the patient’s nil by mouth times?

Staff
- Identify mentor, associate mentor and other members of the ward team.
- Identify the position of on duty rota and off duty request book
- Introduce yourself to the ward clerk and the ward domestic, they will help you.

Ward Environment
- Identify the position of dirty utility room
- Identify the position of the clean utility
- Identify position of the treatment room
- Identify the position of the ward toilets
- Identify the position of the drug cupboard and fridge
- Identify position of ward textbooks and policies/procedures on the intranet

If you have any difficulty in completing this questionnaire, please discuss this with your mentor.