ORIENTATION PACKAGE FOR UNDERGRADUATE STUDENTS
Welcome to Calvary Wakefield Hospital.

Starting a clinical placement in a new organisation is an exciting time, but it can also seem rather daunting finding out all that you need to know to function effectively during your placement.

It is hoped that the materials in this package will help you to develop a functional or working knowledge of our environment, and provide you with an introduction to Calvary Wakefield Hospital, its people and its services.

Please take the time to read through these materials and make sure you ask the Clinical Educator or your Facilitator if there is any information that you are uncertain about.

To make the most of your clinical placement and the learning opportunities available, please be aware of the following:

- Although attempts will be made to assign you a preceptor in your clinical area, this is not always possible. You should ensure you are aware of which Registered Nurse or Midwife is accountable for your practice each shift (however, this does not exempt you from accountability!). If you have any concerns related to this discuss them with the Team Leader, Clinical Manager, Clinical Educator or Peri-operative Clinical Educator.

- The degree of student involvement in patient care is dependent on the patient’s wishes, suitability, as assessed by the registered nurse or midwife, and the consent of the doctor. It is not anticipated that this will heavily limit your experience but you should always introduce yourself and seek consent prior to administering care.

- You will get the most out of any given experience if you are prepared but also flexible. Ensure you have your objectives prepared early in your placement, ask for assistance from ward staff, your Facilitator, the Clinical Educator or the Peri-operative Clinical Educator. However, also keep an eye out for interesting opportunities that may be unexpected and advise staff of your interest.

Finally, we hope that you enjoy your placement at Calvary Wakefield Hospital and would encourage your feedback.

The Professional Development Team

Loren Madsen                                              Ami Rogers
Professional Development Manager                  Clinical Educator
8405 3333                                       8405 3316   Dect Phone 538
EMERGENCY TELEPHONE NUMBER - 345

<table>
<thead>
<tr>
<th>EMERGENCY</th>
<th>COLOUR CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire / Smoke</td>
<td>Red</td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>Blue</td>
</tr>
<tr>
<td>Bomb Threat</td>
<td>Purple</td>
</tr>
<tr>
<td>Internal Emergency (failure or threat to essential services)</td>
<td>Yellow</td>
</tr>
<tr>
<td>External emergency</td>
<td>Brown</td>
</tr>
<tr>
<td>Personal threats (Person threatening injury to others or themselves)</td>
<td>Black</td>
</tr>
<tr>
<td>Evacuation</td>
<td>Orange</td>
</tr>
</tbody>
</table>

For all clear, the relevant colour code will be stated, followed by “all clear”.

EMERGENCY PHONE NUMBERS

<table>
<thead>
<tr>
<th>All Emergencies</th>
<th>ICU Staff</th>
<th>Ext 345</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Emergency Team (MET Call)</td>
<td>ICU Staff</td>
<td>EXT 401</td>
</tr>
</tbody>
</table>

OTHER 24 HOUR EMERGENCY TELEPHONE NUMBERS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire Brigade</td>
<td>000</td>
</tr>
<tr>
<td>Police</td>
<td>000</td>
</tr>
<tr>
<td>Electrical Emergency</td>
<td>131 366</td>
</tr>
<tr>
<td>Gas Emergency</td>
<td>1800 558 811</td>
</tr>
<tr>
<td>Translating &amp; Interpreting Services</td>
<td>131 450</td>
</tr>
<tr>
<td>Poisons Info Centre</td>
<td>131 126</td>
</tr>
<tr>
<td>Water Services Emergencies</td>
<td>8207 1300</td>
</tr>
<tr>
<td>State Emergency Service</td>
<td>1300 300 177</td>
</tr>
</tbody>
</table>

OTHER CONTACT NUMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Direct Number</th>
<th>Dect Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ami Rogers</td>
<td>Clinical Educator</td>
<td>8405 3316</td>
<td>538</td>
</tr>
<tr>
<td>Loren Madsen</td>
<td>Professional Development Manager</td>
<td>8405 3333</td>
<td>Ask for Loren or 9 internally</td>
</tr>
<tr>
<td>Hospital Switchboard</td>
<td></td>
<td>8405 3333</td>
<td></td>
</tr>
</tbody>
</table>

REMEMBER: If making an emergency call you must state -
- The nature of the event or emergency
  (What’s wrong and who’s involved - patient or visitors?)
- Your name
- The exact location of the emergency
SHORT HISTORY
SISTERS OF THE LITTLE COMPANY OF MARY

Calvary Wakefield Hospital is owned and operated by the Sisters of The Little Company of Mary - a Catholic order of religious sisters founded in 1877 at Nottingham, England by Mother Mary Potter, to pray and care for those who were sick, dying and in need.

Mary was born on 22 November 1847 and had four older brothers. Their father left the family soon after Mary’s birth and never returned. So Mary grew up in a single parent family under the strict yet loving guidance of a mother who was an ardent convert to Catholicism and a very strong-minded woman who worked and struggled to keep her young family together.

Mary was not a well woman; she was a frail child with a congenital heart defect and experienced much ill health during her life. After entering the Sisters of Mercy at Brighton and leaving after eighteen months, she was seriously ill for nearly two years. During that time Mary came close to death and knew loneliness, fear, weakness and the inability to pray when it seemed she was about to die. She spent many hours in prayer and meditation before a small ivory crucifix in her room. It was here she received light from God as to what he was calling her to do and she conceived in her mind and heart the vision for the Little Company of Mary.

The Sisters of the Little Company of Mary were to live as companions of Mary, standing in spirit with her on Calvary while she watched over her dying son. In this spirit of love, compassion and apparent powerlessness, the Sisters were to pray and care for those who were dying, those who were ill and those who were in special need. They were to do this in a spirit of faith and trust in a loving God who had turned the apparent failure and death of Jesus Christ into a resurrection to new life for all humanity.

Mary was a reformer. She lived in Victorian England and was aware of the poverty in which many people lived and the lack of care for the sick and dying. With the approval of Bishop Bagshawe of Nottingham, she founded the Little Company of Mary in a disused factory in Hyson Green, a very poor area of Nottingham. The first five Sisters spent their time with those who were in need, particularly with those who were sick and dying.
They visited them in their homes and nursed and cared for them, although they themselves had little money or resources. In 1879 Mary had surgery for breast cancer and she continued to have many severe illnesses throughout her life. However, this did not deter her from continuing her work amongst the poor and opening new areas of care and service. Other women came to join the small group and the order continued to expand in England and also to other countries.

In 1882 Mary Potter travelled to Rome to seek the approval of the Pope for the Little Company of Mary. The approval of the Little Company of Mary as a Catholic Religious Nursing Institute was granted in 1893.

In those times, nursing was not considered as a profession and had no status. Health care was practically non-existent. However, Mary was insistent that those associated with the Little Company of Mary in the care and nursing of those who were ill should receive the best professional education and training available.

Little Company of Mary Hospitals were established in many different countries with Schools of Nursing attached in many instances. The Sisters of the Little Company of Mary established the first School of Nursing in Rome in 1906. The Sisters were committed to promoting and improving professional nursing standards in these facilities.

Mary Potter died in 1913. By that time she had received approval from Rome for the order and there were Sisters of the Little Company of Mary working in Italy, Ireland, Malta (Sisters were expelled in the 1980s) Australia, United States of America and South Africa. After her death the Little Company of Mary continued to expand. Today the Sisters are also in New Zealand, Tonga and South Korea.
THE EARLY HISTORY OF CALVARY WAKEFIELD HOSPITAL
1883 - 1937

This hospital was opened in about 1883-1884 by a Mrs Gardner, who was a widow with three young children. It is not known if she had any previous nursing experience beyond nursing her dying husband. Clearly her skill through this period impressed two doctors, Dr Way and Dr Gardner (no relation), because they subsequently employed her in their consulting rooms.

The two doctor's practice flourished and they persuaded Mrs Gardner to open a two-storey house in Wakefield Street as a private hospital with herself as matron. Accommodation was limited to 14 patients and the staff consisted of matron, 2 nurses and domestic staff. It is recorded that the first operation for the removal of a larynx was done in the Wakefield Street Hospital, so there must have been a theatre.

Mrs Gardner remarried after a few years and she then sold the hospital to Miss Alice Tibbits.

Miss Tibbits was an English woman born in 1854. She arrived in Australia and commenced her nursing career in 1879 and was the recipient of the first certificate of training issued by that hospital in 1881. She subsequently returned to England, and entered the London Hospital as a probationer in 1882, with the object of furthering her qualifications. It seems likely that an Australian Certificate was not recognised in England at that time and also that she wished to gain experience in adult nursing.

Having completed her general training at The London Hospital in 1884, she undertook a midwifery course at Endell Street Nursing Home, London. Towards the end of 1885 Miss Tibbits departed for Adelaide, and upon her arrival worked with Dr. William Gardner, who ultimately persuaded her to become Matron of the Wakefield Street Private Hospital, upon Matron Gardner's retirement in 1888.

Under the matron-ship of this remarkable woman, the hospital flourished and demands for accommodation increased, which resulted in extensions and additions being added. Miss Tibbits also established the first recognised private hospital training school for nurses, and purchased a cottage at the rear of the Hospital to accommodate them.

Later Miss Tibbits had constructed a two-storey building known as “Hatherton” on the eastern side of the original hospital, thereby increasing the capacity of the hospital from 15 to 30 beds.
The Hospital continued to flourish, and to counter the difficulty arising from the inability to meet the increasing demand for accommodation there, Miss Tibbits instituted the practice of sending out nurses to attend to patients in their own homes over 70 years ago.

In 1903, a Miss Hill was taken into partnership, and six months later Miss Tibbits sold the Hospital to her, and retired to a home at Mount Barker that she named “Hatherton”. There she died in January 1932 at the age of 78 years. A brass tablet was placed in the hallway of the Hospital by the Private Hospital Wakefield Street Nurses Association in memory of this outstanding nurse.

Miss Kate Hill was a children’s Hospital trainee and she remained as matron until 1913. Throughout her years in charge great changes took place, not only at the Hospital, but through her vision and foresight, but throughout South Australian Nursing.

Matron Hill attended nearly all operations and later would assume personal responsibility of the after care of patients in the wards. She had the theatre enlarged and modernised adding anaesthetic and sterilising rooms, and an autoclave and hot water service. In addition she personally supervised and lectured the trainees of her time and persuaded doctors using the Hospital to lecture as well. By 1903 the nurses were undergoing a 3-year training and receiving certificates and medals on completion of their course.

In 1905 a branch of the Australian Trained Nurses Association (ATNA) was established in South Australia. With Matron Hill having been a prime mover in this direction and a member of the first committee.

The training course was then increased to 4 years and the Hospital ceased to send its nurses to private homes. However Matron Hill maintained a separate staff of past trainee to continue this service for some years until this was taken over by private agencies.

For the trainees, practical lectures and demonstrations were conducted by Matron, and a panel of doctors appointed by the newly formed ATNA lectured to them in the evenings at the University. The first year course was on anatomy, physiology and general nursing. Second year covered medical and surgical nursing, third year gynaecological, eye and ear, nose and throat. The pupils sat for the final exam during the 4th year, receiving the ATNA Certificate when all exams were passed. The hours of duty were 7am to 9.30pm with two hours off duty; one evening from 6pm, one afternoon from 2.30pm, and five hours on Sunday.

The indoor uniforms were blue, with white aprons, stiff collars and cuffs and small caps tied with strings after the first year. The outdoor cloaks were black.
cloth, and with them was worn a velvet bonnet with silk tails and white stringed. This uniform was worn by nurses when attending lectures, or for short off duty periods. Nurses purchased their own uniforms, and pay rates during this period would have been about 5\(-\$1\) per week. Overtime and penalty rates were unheard of.

During Matron Hills time at the Hospital Miss Laurence joined the staff and was charge sister for some years. She greatly assisted Matron, particularly with training the nurses. In 1913 Miss Laurence purchased the Hospital from Matron Hill and remained there until 1926. During this period further improvements were carried out and electric light replaced gas.

By 1918 Miss Laurence had purchased three further cottages and also acquired the Adelaide College of Music Hall for night nurses sleeping quarters. The uniform for nurses remained unaltered through this period until 1934 when caps and collars were changed and trainees were no longer obliged to wear the outdoor uniform.

On Miss Laurence’s retirement the Hospital was purchased by Miss Rowe. Miss Rowe had been a trainee of Miss Laurence and subsequently spent 5 years as a theatre sister in the Hospital. She remained in charge for seven years. Miss Rowe came to realise that more suitable premises were becoming desperately needed, so she decided to form a company – The Wakefield Street Private Hospital Limited, which purchased the site at the corner of Wakefield and Hutt streets. On this site a new Hospital was built.

The building was finally completed in June 1934 and incorporated the very latest equipment and most modern conveniences for patients and staff. Miss Rowe happily transferred her staff and patients to the new premises – much of which we still see today. In 1936 a further step forward was taken when a private group installed x-ray equipment. By 1937 the nurse hours were changed. They were now permitted one full day off per week, in addition the usual three hours off on other days, when they worked from 7am to 8pm. There was of course no such thing as overtime and penalty rates still lay far in the unforeseen future. Pay by this period would have been approximately 10\(-\$2\) per week for first year trainees.

Wakefield Street by 1937 had accommodation for 50 patients and a staff of 10 sisters and 36 probationers. The nurses trained by these early matrons went on to hold many high positions in nursing in South Australia and elsewhere. Many also served with distinction in two world wars. The honour boards in today’s entrance are a constant reminder to us of these fine women who trained, and nursed under conditions that many of us today must find it hard to imagine.
Wakefield Hospital was originally a two storey house in Wakefield Street. It opened in 1883 to accommodate 14 patients and a staff of two nurses, domestic staff and the Matron.

Between 1888 and 1903, Wakefield Street Private Hospital was recognised as the first private hospital and training school for nurses. During this time a further two-storey building was constructed to increase the patient capacity to 30 beds.

Later a company was formed – The Wakefield Private Hospital Limited, who purchased the present site where the new hospital was built. The building was finally completed in June 1934 and was considered to include the very latest equipment and most modern conveniences for patients and staff. By 1938 the hospital had accommodation for 50 patients and staff of 10 Sisters and 36 probationary nurses.

In the early 1960’s it was considered more appropriate to alter the constitution and make the hospital “non-profit”. This meant changing the name to Wakefield Memorial Hospital Incorporated, but had the effect of reducing costs and providing more money for rebuilding, general repairs and equipment.

In 1975 a new wing was constructed which incorporated the operating theatre complex, recovery room, x-ray suite and ward areas.

In 1983 a further two wings were constructed which included 30 private rooms, thereby increasing the bed occupancy to 123. Mutual Community Limited acquired ownership of the Hospital in late 1983.

In 1985 the hospital was extensively renovated to include a new Special Care Unit, Recovery Room, staff and surgeons change rooms and lounges, administration offices, entrance foyer and upgrading of patient facilities.

April 1991 saw the completion of the Wakefield Clinic, which included an Auditorium on the 3rd floor and a Day Surgery Unit on the 1st floor.

Other tenants for the Clinic include the Wakefield Orthopaedic Clinic, Wakefield Sports Clinic, Adelaide Obesity Clinic, Perrett Medical Imaging, Clinpath Laboratories, Wakefield Anaesthetic Group, and Adelaide Cardiology.

The integration of the services provided by the specialists and allied health professionals in the Wakefield Clinic and the facilities and services offered by the hospital has proved extremely successful especially in the areas of cardiology, angiography and orthopaedic surgery.

In 1993 the hospital underwent another comprehensive upgrade and further expansion of facilities to accommodate acute care services such as Coronary Care, Intensive Care, Cardio-thoracic Surgery and
Cardiovascular Angiography. As such, the hospital now offers the community of South Australia excellent acute services and facilities and is only the second private hospital in Adelaide to do so.

In December 1995 Benchmark Healthcare took over Wakefield Hospital from Mutual Community.

In September 1996 the Wakefield Emergency Centre was opened. Although it is the third private emergency facility in South Australia, it is the only purpose built one.

Since its opening the Emergency Centre has proved a great success, and has helped keep the occupancy level of the hospital more stable. Staff in the critical care area care for many patients undergoing cardiac bypass procedures, and treat a variety of general intensive care patients.

The Hospital also provides a comprehensive cardiology and coronary angiography service. The Intensive Care Unit also boasts the only retrieval service in the private hospital sector.

Wakefield enjoys a close association with the Royal Adelaide Hospital. Registrars on rotation from the Royal Adelaide Hospital in the specialities of Intensive Care and Cardio-Thoracic Surgery provide a 24-hour service to our Intensive Care and Coronary Care Units.

As a Hospital we are also formally affiliated with the Adelaide University and assist in the planning and implementation of post graduate studies.

In keeping with the new direction of the hospital it was decided to change the name once again from Wakefield Memorial Hospital in 1994 to simply Wakefield Hospital. This was accompanied by a new logo and stationary as well as signage throughout the hospital.

Wakefield Hospital is fully accredited by the Australian Council for Healthcare Standards and provides a comprehensive range of highly specialised medical and surgical services with particular emphasis on orthopaedics, cardiac, gynaecology, plastic surgery, general and day surgery and general medicine.
A $16.4m redevelopment commenced in 2001 under Benchmark Healthcare and completed in 2004 under Ramsay Health Care included:

- 123 to 180 beds:
- New 32 bed Davidson Ward & 25 bed Cardiac Step Down
- Cardiac Step Down and Coronary Care Ward
  - Phillips wireless monitoring, the latest technology
- High Dependency and Intensive Care Unit upgrade
- New Patient Admission Centre
- New hospital entrance and Café 300
- Theatre redevelopment
  - two new Stryker Endosuite operating theatres, the first in SA
  - renovation of 6 existing theatres
- addition of 2 procedure rooms
- new Sterilising department
- Recovery Room and Day Surgery suite

- July 2004 Ramsay Health Care purchased the Benchmark Healthcare Group
- November 2004 – introduction of Neurosurgical Services
- Wakefield Hospital became a member of the largest publicly owned private hospital group
- May 2006 Wakefield Hospital purchased by the Little Company of Mary Health Care and became Calvary Wakefield Hospital, a member of Calvary Health Care Adelaide.

**Overview of Calvary Wakefield Hospital at this time**

172 in-patient Beds

- Centrally located in the city of Adelaide
- 6 Wards
- 8 Operating Theatres
  - 2 Stryker Endosuites
- 2 Procedures Rooms
- Day Surgery Unit
- ICU - 8 Beds
- HDU - 6 Beds
- Angiography Laboratory
- Coronary Care Unit - 9 beds
- 24 hour private Emergency Centre
- Wakefield Surgicentre - free standing day surgery located at 316 Wakefield Street
Specialities

- Orthopaedic Surgery
- Cardiology & Cardiac Surgery
- Medical
- Neurosurgery
- Advanced/ General Surgery
- Obesity Surgery
- Day Surgery (Oral, Ophthalmic, Scopes)
- Gynaecology
- ENT
- Plastic and Reconstructive Surgery

Calvary Wakefield Hospital
Executive Team

Mr Harold Kok          Chief Executive Officer
Ms Judith Parmiter    Acting Director of Clinical Services
Mr Garry Crispin      Director of Finance
MISSION, VALUES AND VISION
OF
LITTLE COMPANY OF MARY HEALTH CARE

MISSION
Our Mission identifies why we exist.

We bring the healing Ministry of Jesus to those who are sick, dying and in need through “Being for Others”

- In the Spirit of Mary standing by her Son on Calvary
- Through the provision of quality, responsive and compassionate health and aged care services;
- Based on gospel values; and
- In celebration of the rich heritage and story of the Sisters of the Little Company of Mary

VALUES
As stewards of the rich heritage of care and compassion of the Little Company of Mary we are guided by our values.

Hospitality
- We demonstrate and foster openness to others in a spirit of warmth, compassion and gracious receptivity.

Healing
- We anticipate and respond to the needs of people by the provision of holistic care.

Stewardship
- We ensure that our philosophy governs the way we relate to our peers and to the communities we serve, that we respect and care for our environment, and that we use our scarce health resources to the best advantage as a united group.

Respect
- We respect the sacredness of the gift of life, the value and dignity of all persons and our obligation to relate to all with justice and compassion.
OUR GOAL, OBJECTIVES AND LOGO

Our Goal:
To promote the Mission of the Sisters of the Little Company of Mary together with the development of our Service as a Centre of Excellence, Care and Compassion, through practising the Core Values of Respect for the person and for the gift of life and of Healing, Hospitality and Stewardship.

Our Objectives are:

- To embrace the needs of the whole person, physical, emotional and spiritual, in order to bring healing, hope and peace to all, in an environment of Christian compassion.

- To administer health care in the most efficient, effective and ethical manner with due regard for the dignity and privacy of all patients.

- To commit ourselves to fostering an environment in which all staff members are encouraged to achieve high standards of performance with the opportunity of continuing work satisfaction and personal development.

- To be involved in the continuing processes of evaluation and quality improvement in our pursuit of excellence, to which we are committed.

THE LOGO EXPRESSES THE MISSION OF THE NATIONAL LITTLE COMPANY OF MARY HEALTH CARE

- THE CROSS
  The life and healing ministry of Jesus for those who are suffering
  Mary standing by her dying Son on Calvary
  The Gospel values as an expression of Inclusive Love of Others

- THE OPEN HEART
  A Symbol of love and commitment to
  Quality, Responsive and Compassionate Health Care
  Through “Being for Others”.

- THE BLUE BACKDROP
  A reminder of the rich heritage and story of Mary Potter and the Sisters of the Little Company of Mary
FINDING YOUR WAY AROUND

We trust you will find that the building is generally well marked with directional signs and that our staff are pleased to provide you with assistance.

The three levels of the main building are connected by lifts located in the main entrance foyer. There are 2 other lifts available within the hospital, these are used mostly by the patient services staff.

Location of wards and areas

- **Ground Floor**
  Front reception, Cardiac Unit, Emergency Services, Lyon Medical Ward, Tibbits General Surgical ward, Bed Manager and Nurse Resource Manager Office, Pastoral Care Office, Clinical Educator Office, Allied Health Office, Pharmacy Office, Kitchen, Stores Department, Finance Offices, Hudson’s Café and Perret’s radiology.

- **First Floor**
  Operating Theatre, Recovery Suite, Booking Office, Day Procedure Suite, Angio Cath Lab, Jay ward, Kidd ward, HDU and ICU

- **Second Floor**
  Davidson Ward.

- **Wakefield clinic Building**
  Executive Suite, Clinpath, Consultants offices, Meeting Room and Auditorium
OCCUPATIONAL HEALTH AND SAFETY RESPONSIBILITIES

All staff, contractors and undergraduate students working for Calvary Wakefield Hospital have a responsibility to maintain a safe and healthy working environment. These responsibilities have been assigned to the levels of staff as per the specific requirements detailed in the OH&S&W Act 1986. Further individual responsibilities are contained in particular procedures and position descriptions.

Undergraduate Students

Undergraduate Students have an important role to play in achieving the Hospital’s health, safety and welfare objectives.

Undergraduate Students have a legal obligation and responsibility to:

1. Take reasonable care to protect their own health and safety while on placement.

2. Take reasonable care to protect the health and safety of others while on placement who may be affected by their actions or omission.

3. Report accidents / injuries / hazards to a hospital supervisor and make recommendations to the supervisor to avoid, eliminate or minimise any hazards of which they are aware regarding working conditions or methods.

4. Ensure that correct use is made of all equipment provided for health and safety purposes. (Personal Protective equipment)

5. Follow all instructions, eg policies, procedures, issued to protect their own personal health and safety, and the health and safety of others.

6. Ensure that they are not, by the consumption of alcohol or drugs, in such a state as to endanger their own safety while on placement or the safety of any other person at the worksite.

7. Maintain a safe work environment.

Failure to comply with the Hospital’s health and safety policies and procedures may lead to the Undergraduate Students placement being discontinued. If you have any specific questions ensure that you raise them with the ward manager, or your facilitator.
EMERGENCY SITUATIONS:

An EMERGENCY MANUAL is located in each department. The content within this manual expands on the content on the Emergency Flip Chart/poster. The following is a brief summary of the emergency procedures:

RESPIRATORY OR CARDIAC ARREST

As part of your orientation in your clinical area, ensure you become aware of the emergency call system that is in place. Some parts of the hospital use 3 rings of the nurse call bell, others have emergency bells. Remember if the bell does not appear to work – call for assistance!

You must also identify the emergency equipment in each room eg oxygen, suction and Laerdal mask and the emergency trolley for the ward / clinical area.

Medical emergencies are managed by Intensive Care Unit staff, but emergency treatment will be commenced by other staff until their arrival.

NURSE 1 - If you are the first nurse to discover the emergency you must not leave the patient. Alert other staff using the emergency call system. Make your patient assessment (D R A B C) and commence CPR as appropriate and using the Laerdal mask available.

NURSE 2 - Dial 345 and report the emergency then assist with CPR

NURSE 3 – Collect other emergency equipment. Consider the arrival of the Code Blue response team, ensuring they know where the emergency is. Also consider the management of visitors or other patients within the surrounding area.

Remember there may not always be three nurses, particularly on night duty; hence communication is the key to ensuring all tasks are done. Also, Nurse 1 and Nurse 2 do not stop CPR at the arrival of the emergency response team; they should continue, hand over verbally and follow instructions from the team leader of the response team.

Undergraduate Nursing Students are expected to follow instructions during this time.

FIRE SAFETY

Familiarise yourself with your working area, locate emergency exits, fire fighting equipment, fire alarm bell, fire doors and Red (WAP) Phone location.

What to do if the fire alarm sounds
When the fire alarm is activated the alert tone will sound

1. Go to the nearest red emergency phone and await further instructions.
2. The first person to the phone stays by the phone until All Clear.
3. The emergency officer or team leader will stands by the (WAP) red phone and await instructions. Follow the instructions of the team leader.
4. If you are in immediate danger or find a fire follow the RACE procedure.

<table>
<thead>
<tr>
<th>Remove</th>
<th>people from immediate danger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activate</td>
<td>the alarm by using a break glass manual call point</td>
</tr>
<tr>
<td>Contain</td>
<td>confine the fire - close doors and windows</td>
</tr>
<tr>
<td>Extinguish</td>
<td>the fire if safe to do so</td>
</tr>
</tbody>
</table>

- **DO NOT** move between fire compartments.
- **NO FIRE DOOR** should be opened unless to escape a fire or by authorised personnel.
- **NO LIFT** should be used.
- Follow directions of the Emergency coordinator (by PA System) to determine location of fire.
- If the fire alarm is activated in your area initiate a search if required by emergency officer.
SECURITY

Calvary Wakefield Hospital has security strategies in place to manage the personal safety of patients, staff and volunteers and the security of the facility and personal property. We ask all staff and volunteers to ensure they utilise security strategies to maintain a safe and secure environment.

Some areas have secured doors requiring ‘swipe cards’ or ‘pin codes’ to access. Please discuss this with staff in your designated area.

Remember to:
- Wear ID badges
- Report any unusual behaviour and / or theft / damage
- Report any security risks / hazards
- Read the “Emergency Manual” located in your area.

The locking up of personal belongings is essential in a public place such as a hospital. All staff and students have a role in maintaining a thorough “Hospital Watch” attitude and assist people who look lost or question people who appear at all suspicious.

All doors and gates to the outside of the hospital are to be operated or shut as indicated at all times (for operation from inside only).

Staff and students are encouraged to “Think Safety” and go out to cars at night with a colleague. If possible move cars before dark to the hospital car park.

Identification badges with photo are to be worn at all times whilst on clinical placement with in the hospital. Any breaches of security require the completion of a Security Breach Form, i.e. theft of personal belongings of a patient, visitor or staff; car break-ins; personal threats, etc.
MANUAL HANDLING

Calvary Wakefield Hospital is committed to minimising risk to staff, volunteers and students whilst at work. The organisation ensures all manual handling tasks comply with the OH&S Act, Regulations and approved Code of Practice for Manual Handling.

The Manual Handling Regulations under the SA Occupational Health Safety and Welfare Act, 1986 define Manual Handling as:

Any activity requiring the use of force exerted by a person to lift, push, pull, carry or otherwise move, hold or restrain, any person, animal or thing.

Every time you carry out a task that involves manual handling there is a potential risk of injury. You can however, minimise the risk by applying the correct principles and by thinking before you act.

General principles for safe manual handling

All staff who are involved in manual handling activities should consider the following basic principles:

1. Assess the size, weight and other physical characteristics of the object or person that is to be manually handled before attempting to move it/them.

2. Where there is any doubt as to the potential for injury the staff member must consult with his/her supervisor prior to moving the person or object.

3. Prior to moving an object assess the workplace/environment factors that could affect the manual handling task (e.g. wet floors, furniture in the way).

4. Prior to moving a person or object, decide on the type of transfer to be used.

5. Always ensure that there are adequate competent people to carry out the lift or transfer safely.

6. Safety boots or gloves should be worn at all times when a work situation warrants the use of this equipment.

7. Appropriate footwear should have a non-slip sole and preferably be lace up.

8. Always use mechanical aids when they are provided. (Take a little extra time to go and get the equipment when it is not in your area).

9. Always use correct manual handling principles:
   - Position your body as close to the load as possible before commencing any lift or transfer.
   - Use your body weight to maintain balance and move the load.
   - Use your leg muscles to lift lower and move loads.
   - Keep your back as close to its natural “straight” position as possible.
   - Never twist your body while you are bearing weight or attempting to move a load.

10. Wrist or neck chains should not be worn by nursing staff as they can cause injury to both nurse and patient by becoming tangled in hair and clothing.
INFECTION CONTROL

Infection Control is a multidisciplinary responsibility involving each hospital employee and all students on placement.

Infection Control precautions are work practices reflecting infection control risks, minimisation strategies that should provide a high level of protection for both patients and staff.

The objectives for Infection Control are:

- To provide an effective facility wide Infection Control Programme which demonstrates improving performance.
- To standardise practice relating to Infection Control
- To ensure a clean and safe environment for all who enter it, be they patients, employees or visitors.
- To reduce the risk of developing an infection.
- To identify the occurrence of infection.
- To control the prevention and spread of infection with procedures designed to minimise the risk of development or transmission of infection.
- To comply with relevant legislative requirements, Australian Standards and State and National Infection Control Guidelines.

Calvary Wakefield Hospital Infection Control Manual contains information which all staff and students are required to be aware of and abide by. This manual is located in every department for easy referral.

NB: Washing your hands before and after patient contact is the most effective way of decreasing the risk of transferring bacteria to patients and staff.

The Infection Control Co-ordinator is Rosie Fahey and can be contacted on ext. 368.
GENERAL WARD INFORMATION

PLANNING YOUR DAY

Ward
Arrive at least 5 minutes early for the shift. Obtain a patient communication sheet, check the allocation book for your patient load and then go to where handover is to occur. Obtain handover as a group from the Team Leader from the shift before. After the group handover go to your patient’s rooms and await a bedside handover. Whilst waiting start to check your bedside patient folders (especially the medication charts to ensure all medications are signed for). Receive the bedside handover, introducing yourself to each patient as you go.

OTS areas
Remember that you have to change into theatre clothes before the shift starts so give yourself enough time. OTS, Recovery and DSU are very different to normal ward routine – so expect that it will take you a little time to settle in.

1. **Ward shift times.** These times will vary in some clinical areas, however in general wards they are:-

   - Early 0645 - 1445
   - Late 1415 - 2215
   - Night 2145 - 0715

2. **Staff meal breaks** are taken, in consultation with the Team Leader, within the following times:-

   - Morning Tea 0900 - 1030 hours (10 minutes)
   - Lunch 1130 - 1330 hours (30 minutes)
   - Tea 1630 - 1800 hours (30 minutes)
   - Supper 1900 - 2000 hours (10 minutes)

   Night meal break – negotiated between wards - usually between 0200 – 0400

   Make sure that if you cannot take a break at the time allocated to you, you let the TL know as soon as possible so that it does not delay other team members.

3. **Patient meal times**-

   - Breakfast 0730 hours
   - Morning Tea 1100 hours
   - Lunch 1230 hours
   - Afternoon Tea 1430 hours
   - Tea 1715 hours
   - Supper 1900 - 2000 hours
4. Plan time into your day to write notes, add up fluid balance charts and check documentation.

5. Always use available equipment to assist with manual handling - Slippery Sams, pat slide mechanical lifter are available in all areas.

6. Clinical Manager or Clinical Nurse are responsible for staff rosters.

7. **Staffing**
   Unit staffing is based on skill mix with each ward having a Clinical Manager, Clinical Nurse(s), Registered Nurses, Enrolled Nurses and Assistants in Nursing. Student nurses also form part of the clinical team although they are not counted in staffing numbers for a shift.

8. Patients are allocated according to patient acuity and staff skill mix; NOT ACCORDING TO GEOGRAPHY.

9. Please notify your ward prior to start of shift if you are not attending work, eg sick leave.

---

**WORKING AS A TEAM**

“Leadership is the privilege to have the responsibility to direct the actions of others in carrying out the purposes of the organisation, at varying levels of authority and with accountability for both successful and failed endeavours.” (Wess Roberts, “Leadership Secrets of Attila the Hun”).

All people have a need for the following:-
- Recognition from others
- To feel worthy as a person
- To be needed
- To feel important
- To be appreciated.
ROLES OF THE NURSING TEAM

This will differ in the Perioperative environment – please refer to your Perioperative Educator for more information.

The Team Leader effectively coordinates and ensures smooth ward functioning on any shift over the 24-hour period.

The TL is required to -

· Communicate with CN / CM in relation to patient care, progress, changes, incidents, or problems (potential or actual).

· Maintain ward organisation and smooth running.

· Facilitate efficient discharge and admission of patients to ward.

· Communicate regularly through shift with Booking Office re patient discharges and inform of next day potential / actual discharges for forward planning.

· Allocate patients, where possible, for continuity of care.

· Liaise with Nurse Manager / Coordinator for staffing / nursing hours requirements.

· Allocate staff meal breaks, ensure staff go on time, as others will be delayed - if staff member not ready - send another who is ready.

· Maintain record of controlled and recordable substances.

· Organise supervision of the Enrolled Nurse (s) / Agency / Relieving staff.

· Liaise with other members of the Health Care Team

· Liaise with ancillary staff & other departments for ward needs eg. Housekeeping, Pharmacy, Maintenance, Materials Management etc.
Team Nurses are required to -

- Adopt a “you find it, you fix it” attitude - so issues do not snow ball shift to shift.
- Inform Team Leader / CN of any patient changes - update regularly with TL.
- Liaise with other members of the Health Care Team.
- Attend visiting Doctors and ensure that their instructions are incorporated into patient care.
- If you see stock is low - re-stock as you go - do not leave things empty for the next person.
- Re-stock trolleys after use and weekly, check items are there before use.
- Provide comprehensive nursing care to allocated patients, based on Best Practice, Doctors orders and Hospital Policy and Procedures.
- Complete all documentation in relation to patient care in accordance with current legislation and Hospital Policy.
- Maintain ward organisation and smooth functioning - assist other team members or ask for assistance when needed.
- Maintain a safe environment for patients, all staff and visitors - identify hazards & implement solution process
- Participate in ward activities, staff development and quality improvement activities.
- Check oxygen and suction supply/equipment in-patients rooms - replace after use & weekly.
- Handover patients verbally or on tape.
FOLDERS / MANUALS TO READ

1. Hospital Policy Manual
2. Procedure Manual (on line)
5. Doctors standing orders and preferences manuals
6. Infection Control Manual (HICMR)
7. Area specific manual, for example
   - ACORN standards
   - OTS Policy manual
   - Manual of Midwifery Practice
8. Ward Communication book - read regularly for changes

All manuals can be found in the Nurses Station/Handover Room.

DOCUMENTATION

NB - All documentation by Undergraduate must be countersigned by a REGISTERED nurse

1. Clinical Pathways must be completed and signed for every shift. You will note that we have implemented some Dr Specific pathways. For those procedures & Drs that do not have a specific pathway, please use a blank pathway. If you are unfamiliar with Clinical Pathways please ask for assistance.

2. All variances (any alteration from normal) are to be documented on the variance chart. If detailed descriptions need to be documented please write it in the Clinical Record and document on the Variance chart to refer to that.

3. Any changes to the routine and expected care are to be documented in the Clinical Record.

4. Doctor’s visits are to be written in blue / black ink in the Clinical Record chart. Doctors MUST write their own notations.

5. Charts are to be kept in their correct order within the case-notes.

6. Fluid Balance Chart to be kept up-to-date during shift & signed at end of each shift.

7. Label each chart with patient sticky label.

8. Patients are to sign and be given the original of the GP Discharge letter prior to DC. Please plan ahead with this document and start filling out what you can in the days prior to DC.
9. Case Notes and all other documents with a medical records number on them are a legal document. They cannot be tampered with or altered, crossed out (without still being able to read what is on them) etc. They may be used in a legal case for up to 7 years (or 21 years in Maternity!)

When writing in a Clinical Record the following must be recorded:

- Date of entry, time of entry, name printed, designation (e.g. RN, EN FUNS) and signature
- A blue or black pen must be used
- The use of pencil is strictly prohibited
- The use of white out is strictly prohibited
- All entries must be legible
- Please refer to the policies’ Nursing Documentation Approved Abbreviations and Medical record Content in the hospital’s policy manual
- Abbreviations used must be listed in the Australian Dictionary of Clinical Abbreviations Acronyms and symbols
- This book can be found on all wards

The discharge entry must contain: date and time of discharge; details of who the patient left with; patient destination i.e.: home, Nursing Home or Hospital (print name); and mode of travel: i.e. home by car or transferred by ambulance to Hospital (print name).

Remember - If it has not been documented, it is not done.

These excerpts were taken from actual hospital charts and released by Preece Marketing and Consulting firm – frivolous, yet please take note!!

1. She has no rigours or shaking chills, but her husband states she was very hot in bed last night.

2. The patient is tearful and crying constantly. She also appears to be depressed.

3. The patient has been depressed since she began seeing me in 1993.

4. Discharge status: Alive but without my permission.

5. Healthy appearing decrepit 69 year old male, mentally alert but forgetful.

6. Patient’s medical history has been remarkably insignificant with only a 40-pound weight gain in the past 3 days.

7. She is numb from her toes down.

8. The skin was moist and dry.
9. Patient was alert and unresponsive.
10. Rectal examination revealed a normal size thyroid.
11. She stated that she had been constipated for most of her life, until she got a divorce.
12. I saw your patient today, who is still under our care for physical therapy.
13. Skin: somewhat pale, but present.
14. Dr Blank, felt we should sit on the abdomen and I agree
15. Large brown stool ambulating in the hall.

**TERMINOLOGY**

THE FOLLOWING ARE COMMONLY USED ABBREVIATIONS.

- BP ............................... Blood Pressure
- BSL ............................... Blood Sugar Level
- NAD ............................... No abnormalities detected
- O² ............................... Oxygen
- TPR ............................... Temperature, Pulse, Respiration
- U/A ............................... Urinalysis

**MEDICAL ABBREVIATIONS**

- CVC ............................... Central Venous Catheter
- CVP ............................... Central Venous Pressure
- ERC P............................. Endoscopic Retrograde Cholangio-pancreatography
- ESWL ............................. Extracorporeal Shock Wave Lithotripsy
- IADSA ............................ Intra-Arterial Digital Subtraction Angiography
- IVP ............................... Intra-venous pyelogram
ACCEPTABLE TERMS AND ABBREVIATIONS

The following are considered acceptable abbreviations by the Australian Commission on Safety and Quality in Healthcare (www.safetyandquality.gov.au). You may see other abbreviations used, however this can be a confusing and dangerous practice and is best avoided.

**Dose Frequency or Timing**

- mane ...................................... (in the) morning
- midday ...................................... (at) midday
- nocte ...................................... (at) night
- bd .......................................... twice a day
- tds ......................................... three times a day
- qid ......................................... four times a day
- every 4 hrs, 4 hourly, 4 hrly .......... every 4 hours
- every 6 hrs, 6 hourly, 6 hrly .......... every 6 hours
- every 8 hrs, 8 hourly, 8 hrly .......... every 8 hours
- once a week ............................. once a week and specify the day in full, eg, once a week on Tuesdays
- three times a week ................... three times a week and specify the exact days in full, eg three times a week on Mondays, Wednesdays and Saturdays

- pm ............................................. when required
- stat .......................................... immediately
- before food ................................ before food
- after food .................................. after food
- with food .................................. with food

**Route of administration**

- epidural .................................. epidural
- inhale, inhalation ........................ inhale, inhalation
- intraarticular ............................ intraarticular
- IM ............................................ intramuscular
- intrathecal ................................ intrathecal
- intranasal ................................ intranasal
- IV ............................................. intravenous
- irrigation .................................. irrigation
- left .......................................... left
- NEB ......................................... nebulised
- NG ............................................ naso-gastric
- PO ............................................ oral
- PEG ........................................... percutaneous enteral gastrostomy
- PV ............................................ per vagina
- PR ............................................ per rectum
- PICC ......................................... peripherally inserted central catheter
- right ......................................... right
- subcut ....................................... subcutaneous
- subling ..................................... sublingual
- topical ..................................... topical
ACCEPTABLE TERMS AND ABBREVIATIONS (CONT)

Units of Measure and Concentration

- g ........................................ gram(s)
- International unit(s) ............... International unit(s)
- unit(s) ................................... unit(s)
- L ........................................ litre(s)
- mg ........................................ milligram(s)
- mL ........................................ millilitre(s)
- microgram, microg .................. microgram(s)
- % ........................................ percentage
- mmol .................................... millimole

Dose Forms

- cap ....................................... capsule
- cream .................................... cream
- ear drops ............................... ear drops
- ear ointment ........................... ear ointment
- eye drops ............................... eye drops
- eye ointment ........................... eye ointment
- inj ........................................ injection
- metered dose inhaler, inhaler, MDI ... metered dose inhaler
- mixture ................................. mixture
- ointment, oint ........................ ointment
- pess ....................................... pessary
- powder ................................. powder
- supp ...................................... suppository
- tablet, tab ............................. tablet
- PCA ...................................... patient controlled analgesia

REMEMBER: BE SAFE AND ALWAYS ASK QUESTIONS IF YOU ARE NOT FAMILIAR WITH WHAT YOU ARE DOING.
HELPFUL HINTS FOR GIVING ORAL HANDOVER REPORTS

At the end of each shift, you will be required to give a short and precise report on each of the patients in your care for the duration of your shift. This will be delivered at the bedside with the oncoming staff member. Below are some important points to include whilst trying to keep handover time to a minimum (ie around 20 mins).

1. Patient’s name (it is not necessary to mention age, Dr, diagnosis and / or date of surgery or mental status if it is abnormal or it has changed as this information is already handed over in the first 10 minutes during critical handover and will be documented on the handover sheet).

2. Return to ward time if post-op.

3. Medication and observation chart- looking for omissions.

4. Check all lines and drains inserted into patient (IV’s, Drains, IDC’s, NGT, UWSD, PCA, Epidural) with oncoming staff member.

5. Only report observations if abnormal (if not mentioned, it is assumed to be normal), such as mobility status, risks of pressure area care, diet, risks of fall etc.

6. Wound - check this with oncoming staff member (e.g. inflammation / ooze) or if there are special dressing requirements.

7. New orders / tests (eg CT scan, blood work, X Rays etc).

8. Think Holistically.
PARKING

Limited car parking is available for designated staff in the Wakefield Hospital Staff Car Park. General staff parking facilities are available to students after 5:00pm in the Wakefield Hospital Staff Car Park (opposite CBC College on Wakefield Street). This is dependent upon availability. On entry to the car park please take a ticket, however a security officer will assist you in departing the car park with out cost to you.

Other alternatives are paid parking facilities nearby. Flinders street U-Park costs approximately $14 per day for early bird parking before 8am. There is also restricted Council Street parking near the Hospital or all day parking for minimal charge at the end of Wakefield Road, past Hutt Street (refer to map below).

![Map of parking locations](image)

PUBLIC TELEPHONES AND MOBILE PHONES

Students are not permitted to make personal telephone calls from hospital telephones. However, two public telephones are available to staff for use during breaks. They are located at the rear of the hospital foyer and in Kidd ward, adjacent to the patient sitting area.

Mobile phones are not be carried by students or answered while working on the ward/unit. They can however be used during break time away from patient care areas. Not adhering to these guidelines regarding mobile phones may result in your placement being discontinued.

SICK LEAVE - NURSING

Students taking sick leave are to notify the ward that they are working on as soon as possible. Please call the hospital switchboard on 8405 3333 and ask to be forwarded to the correct ward or unit. Students are also asked to notify their Clinical Facilitator / Principle Academic. You do not need to notify the Clinical Educator.
PROFESSIONAL DEVELOPMENT

Professional Development activities at the Calvary Wakefield Hospital are aimed at helping all employees and students to work in a highly effective, efficient and rewarding manner. Ongoing learning and sharing of knowledge is recommended at all times. All students are invited to attend in-services and education sessions. Flyers can be found on the Professional Development Board in the tea room and on the Professional Development boards within the ward.

Contact:

Ami Rogers
Clinical Educator
8405 3316, Dect Phone 538
arogers@calvarysa.com.au

CUSTOMER SERVICE

Aims;
- To make it easy for people to get what they want and need.
- To help people to meet their basic needs:
  - To Feel Important - to have their worth as a person recognised.
  - To Be Understood - to have their requests and problems understood by service givers.
  - To Feel Good About Themselves - to know that their requests are considered reasonable.
  - To Be Appreciated - by those who benefit from their patronage.
  - To Be In Control - to have the chance to know what is going on and their options, so they can make their own decisions.
  - To Feel Safe and Secure

ALL STAFF, PATIENTS, VISITORS, DOCTORS AND OTHER DEPARTMENTS ARE YOUR ‘CUSTOMERS’