# Assistant in Nursing vs Undergraduate Student of Nursing/Midwifery

The following table represents the core activities of an Assistant in Nursing and highlights additional activities suitable for an undergraduate student who has completed 2nd year of a recognised Bachelor of Nursing (BN) or Bachelor of Midwifery program. It is expected an Undergraduate Student Nurse or Midwife (USN/M) employed from year 2 of a BN/BM program can safely and effectively perform the general activities of an Assistant in Nursing (purple column). Additional activities of a USN/M are outlined in the blue column. Additional detail about USM duties is found in the USM Core Duties and Exclusions List.

## **Comparison Table**

|  |  |  |
| --- | --- | --- |
| **Area of Care** | **Activities for AINs** | **Activities for USN/M’s** |
| Health Consumer Assessment Activities |  | Where the USN/M has completed the necessary education and competency assessment relevant to the duty, the USN/M may perform and record the following activities, supervised and co-signed by the RN:   * Temperature, Heart Rate, Respiratory Rate and Blood Pressure * Urinalysis * AVPU assessment * Glascow Coma Score (in some areas where GCS is practiced routinely) * Blood glucose level & glucometer calibration * Simple wound dressing such as IV cannula dressings, skin tear dressing using aseptic technique |
| Hygiene | * Oral Hygiene – brushing teeth, denture care, mouth wash/toilet * Simple eye care – eye toilet * Brushing and washing hair (exclusion: spinal, head and neck surgery and/or related injuries) * Showering, washing and bed baths * Dressing and undressing * Shaving (exclusion: patients with facial/neck surgeries or injuries) * Grooming – brush hair, apply non-medicated skin care and makeup * Removal of makeup and nail polish for procedures * Hand-hygiene * Pre-operative site preparation (with surgical clippers only) | Assist in care of deceased patient  Bathing and settling babies |
| Toileting | * Change pads or aids * Change soiled bedding/underpads * Empty, record and provide urinary bottle/pans * Empty, record and provide commode chair * Empty and record urinary catheter bag drainage (exclusion: 1/24 urine measures) * Change of IDC anchoring device (exclusion: urinary surgery patients) * Document and report elimination amounts to RN, reports any abnormalities, including but not limited to - increased frequency in passing urine - offensive odour of urine - unusual colouring of urine - unusual consistency of urine - constipation and consistency of excreta, as per Bristol Stool Chart * Assisting patient with emptying of long-term ostomy bags (exclusion: stoma < 6 months old) * Specimen collection of faeces and/ or urine (exclusion: midstream urine specimen collection) | Hourly urine measures |
| Manual Handling & Mobility | * Maintain dignity and confidentiality during all manual handling processes, explain what you are going to do with them and seek consent before commencing the process. * Assist with patient transfers, pushing in wheelchair, sitting patients out of bed/on toilet/commode/chair using transfer equipment assessed as suitable by RN * Assist patients to change position with multidisciplinary team, as directed by RN * Provision of pressure area care (including assist with log roll) * Mobilising patients (assisted up to independent) * Use manual handling hoists/aids determined appropriate by RN * Assist allied health professionals to help patients i.e. with mobility, and to apply orthoses/splints/braces as prescribed by the treating professional * Assist during the application of plaster of paris and/or softcast by holding/supporting a limb as directed by RN (exclusion: not applying the plaster of paris or softcast) * Escort for discharge i.e. transit/discharge lounge, or to hospital exit points (exclusion: patient awaiting transfers to other facilities) Transfer of patients from cubicles to waiting areas or from emergency to fast-track area (exclusion: patients with any level of oxygen therapy, infusions, intercostal catheters, complex drains, CPAP/BiPAP or ventilated, traction or new tracheostomies) * Re-application of anti-embolic stockings after mobilising (exclusion: initial measurement & fitting of stockings) * Application of red socks for falls prevention during mobilisation | Transfer of stable patients from Emergency Department to Radiology (no infusions, cardiac and invasive monitoring or C-spine mobilisation e.g. x-rays of simple fractures/abdominal x-rays) |
| Nutrition | * Assist patients with menu selection, after RN nutrition assessment * Undertake safe meal setup, cut up food, adjusting table and opening packages if required * Assists with feeding patients under direction of RN (exclusion: high risk patients with feeding difficulties, parenteral or enteral nutrition) * Provide water/refilling water jugs or making drinks for patients (exclusion: patients with fluid restrictions, dysphagia, modified diet/fluids or nil orally) * Report nutrition and fluid intake on fluid balance chart, co-signed by RN |  |
| Environment | * Ensure falls prevention strategies are in place – call bell, phone, bedside table in reach, bed/trolley lowered, trip hazards removed * Maintain infection control standards by adhering to 5 moments of hand hygiene and quarantine/isolation precaution processes as directed * applying fit-tested masks and undertake donning/doffing processes, including watching others undertake these processes * tidy the patient surroundings and greater work area environment by putting equipment away, changing linen bags, cleaning and tidying utility rooms, cleaning wash bowls, and placing urinals and pans in the sluice * Mop up any small slip hazards and notify RN if cleaners are required, place hazard signs if needed * Make beds/tidy trolleys |  |
| Communication | * Introduce yourself and your role to members of the health care team, healthcare consumers, carers and families/visitors each shift, develop positive rapport and let them know who they can escalate any concerns with. * Report and/or escalating all care and concerns to supervising RNs * Maintain confidentiality, dignity and explain what, why and how you are doing a care activity, seeking consent before providing care. * Answer call bells including staff assist, referring to RN for advice/guidance/direction on anything outside of the duties listed. * Answer and transfer calls/intercom (exclusion: advice, clinical or confidential information) * Refer all aspects of care out of scope to RN, including notifying RN about infusion pump alarms, wandering or confused patients and any clinical or wellbeing issues related to the patient or mental health consumer * Assist with communication tools for patients (iPads/Wi-Fi etc) * Provide companionship and general conversation with patients and families after discussion and support from the supervising RN * Apply simple diversion and behaviour interventions aligned with hospital policies and procedures for cognitively or emotionally impaired people, aligned with a risk assessment, documented plan of care and communication by the supervising RN * Respond to, and report emergencies as per hospital policy * Attend handover and local team meetings or education sessions, determined by supervising RN/Team Leader/CDN or CNC * Orientate patient and family/carers to the environment * Seek regular feedback from supervising RN/s and reflect on practice |  |
| Documentation | * Record Vital Signs, report to RN * Complete fluid balance chart: oral input and urine/faecal output, report to RN * Complete food and bowel charts * Complete weight and height and report to RN * Assist in the documentation of valuables * Assist in completing communication boards * Complete incident reporting as per local hospital policy * Access and undertake documentation within scope of USoN in the Digital Health Record |  |
| Maintenance | * Restock non-emergency supplies and equipment * Cleaning and putting away equipment between use i.e. infusion pumps, bed frames, equipment maintenance (e.g. cleaning, storing) |  |
| Patient watch/Constant Patient Observer (CPO) | * may work as a patient watch/CPO aggression (i.e. low level risk only not requiring a RN/EN) provided managing clinical aggression education has been completed and a risk assessment has been undertaken by the supervising RN |  |
| Other duties | * Support RN in gathering/provision of equipment i.e. infusion pump, ‘scout/runner’ in an emergency situation * Packing and unpacking patient belongings * Attend professional development sessions * Conducting department audits and surveys |  |

Acknowledgement of Country 
Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. We acknowledge and respect their continuing culture and contribution to the life of this city and region.

Accessibility: Call (02) 5124 0000
Interpreter: Call 131 450
canberrahealthservices.act.gov.au/accessibility

© Australian Capital Territory, Canberra Health Services 2023